Healthcare and the Oppression of Sexual and Gender Diverse Communities in Bangladesh

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Abstract

Since Bangladeshi society is socio-culturally and religiously conservative, sexual and gender diverse communities live with stigma, violence, and discrimination. One form of discrimination lies in the healthcare system. The purpose of this study is to investigate the healthcare experiences of these communities to depict the oppression they face, and to understand the continuing influence of colonialism and patriarchy that maintain this oppression. To investigate this, healthcare is argued as either a human right from the social justice point of view or a tool for oppression for marginalised communities.

The methodology used is phenomenological to examine the lived healthcare experiences of the participants. To collect data, I used qualitative methods including participant interviews, a focus group discussion, and key informant interviews. I worked as a volunteer with one local agency that works with sexual and gender diverse communities in Bangladesh. Volunteering helped to build networks and recruit participants. Thematic methods are used for data analysis and full ethics approval is obtained from Massey University, New Zealand.

The participants live in a repressive environment with stigma, harassment, limited education and employment opportunities, lack of family support, mental health issues, and inadequate health support. They frequently experience — depending on their disclosure — humiliation, neglect, insults, and discrimination in healthcare settings. Lack of awareness and an unsupportive attitude from government representatives and institutions further contribute to their oppression. Although healthcare, in theory, is regarded as a human right, it is not fairly and equally provided for marginalised communities and thus cannot be claimed as a universal human right. Discriminatory healthcare experiences, stigma, colonial law, and sexual assaults imply that colonial values and patriarchy have an influence on the overall oppression of these communities.

The most significant contribution of this study is to expose the patriarchal nature of Bangladeshi society as a legacy of the British Regime. This study offers methodological insights into how to conduct research in politically sensitive environments, which is another unique contribution to methodological knowledge. As a result of this research, it is clear that the Bangladeshi government needs to change its attitude, acknowledge the existence of these communities, and take initiatives to provide equal healthcare facilities for all.

Dedications

This study is dedicated to sexual and gender diverse populations from all over the world who live with stigma and oppression just because of who they are. Also, this research is dedicated to sexual or gender diverse persons who have been deprived, neglected, insulted, and humiliated in healthcare settings. I also want to dedicate my research to the activists who lost their lives (Xulhaz Mannan and Mahbub Rabbi Tonoy) to work for the rights of sexual and gender diverse people in Bangladesh.

This research is also dedicated to my maternal grandfather (*nana*) who passed away on the 24th of December 2020 and due to the COVID-19 pandemic, I was unable to go to Bangladesh and see him for the last time. I pray his soul is in peace. I also want to dedicate this research to my newly born niece who is the first daughter of our family, and I have not been able to see her in person yet as I cannot travel to Bangladesh due to the pandemic situation.

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List of abbreviations and terms

bishwa Ijtema	A yearly and global peaceful gathering of Muslims in Bangladesh
BoB	Boys of Bangladesh
BSWS	Bandhu Social Welfare Society
CARE	Cooperative for Assistance and Relief Everywhere
CDHRI	Cairo Declaration of Human Rights in Islam
Cis-het	Cisgender and heterosexual
FGD	Focus group discussion
guru	Community leaders in hijra communities
HTC	HIV testing and counselling
IASSW	International Association of Schools of Social Work
ICDDRB	International Centre for Diarrheal Disease Research, Bangladesh
ICT	Information and communications technology
IFSW	International Foundation of Social Workers
INGO	International non-governmental organisation
jholka	Alms
KII	Key informant interview
madrasa	A school for Islamic education and guidance
MSM	Men who have sex with men
NGO	Non-governmental organisation
khusra or *uvoylingo*	Intersex individual
kothi	A male who takes on a passive role in same-sex behaviour
panthi	The active (insertive) male partner of a same-sex relationship
Patri-normativity	Patriarchal normativity
pouroshavas	Local government municipalities of Bangladesh
rupantorito nari	A biologically male person who changed their gender presentation and social role to female, also known as a transwoman.
rupantorito purush	A biologically female person who changed their gender presentation and social role to male, also known as a transman.

Sati	A voluntary act as a symbol of being an obedient wife to follow the deceased husband to the afterlife
somokami nari or *somopremi nari*	A woman who is sexually attracted to other women, also known as lesbian
somokami purush or *somopremi purush*	A man who is sexually attracted to other men, also known as gay
Takatāpui	Takatāpui is a Māori (indigenous people of Aotearoa New Zealand) word, historically meaning 'intimate companion of the same sex'
Te Tiriti o Waitangi	The Treaty of Waitangi
tona tona dhurpit	Same-sex behaviour of two men
UDHR	Universal Declaration of Human Rights
Ulti	A community language, spoken in hijra communities
union parishads	The union councils that are the smallest rural administrative and local government units in Bangladesh.
upazila parishads	Formerly known as *Thana*, is an administrative region in Bangladesh, they function as sub-units of a district
uvoykami or *uvoypremi*	Bisexual
vatli dhur	Anal sex or the person who engages in anal sex
WHO	World Health Organization

Chapter One: Introduction

1.1 Introduction

My understanding of sexual and gender diverse identities was very limited when I started online consultation with my PhD supervisor in 2014, about four years before beginning my PhD research. Over the last seven years, my understandings have been honed in many ways, and one of these is that this research is not just about the participants (sexual and gender diverse communities), it is just as equally about me. I am Bangladeshi by origin and a heterosexual male. Although I understand the socio-cultural structure of Bangladeshi society very well, understanding the worldviews of sexual or gender diverse individuals was a real struggle, because my standpoint toward sexuality were different from the participants of this research. I assumed that the majority of the heterosexual population held the same stance as I did due to our shared upbringing in a religiously conservative society, and it is this stance that significantly influences the attitude toward sexual and gender diverse identities.

I like qualitative researchers because they are ready to accept their limitations and to accept their lack of — or difference in — understanding of certain knowledge. I am no different, because as a social work student from Bangladesh I was rarely encouraged to examine the values and beliefs that I had grown up with. This was arguably one reason why studying the sexual and gender diverse population was not encouraged. I am Muslim, and, due to several contestable religious interpretations, a research issue regarding sexual and gender diverse communities was not amongst the most common fields to study in Bangladeshi academia. I use the phrase ‘contestable religious interpretations’ to indicate that there are (or have been) multiple interpretations of an event or text, and that informed opinion may draw differing conclusions.

At most, one can be encouraged to inquire into issues faced by hijra communities — those who are assigned male at birth but identify themselves as female or neither female nor male. But investigating the issues of broader sexual and gender diverse communities (lesbian, gay, intersex, transsexual, and bisexual) is thought-provoking and often discouraged. Intersex refers to a variety of situations in which an individual is born with a sexual or reproductive anatomy that does not conform to the conventional orientation of male or female. To a degree, it is unfair to hold academics responsible for such discouragement because there is a certain degree of risk and safety issues when studying sexual and gender diverse communities in Bangladesh. I come from this academic environment where academics, bloggers, and scholars may experience violence when studying sexual and gender diverse people (Mendos, 2019). This is why it was quite challenging for me both personally and intellectually to pursue this research.

I posit that access to healthcare is a human right, but that human rights are incompatible with the cisgender and heterosexual (cis-het) male privilege that establishes boundaries around acceptable and unacceptable behaviours and identities that challenge that patriarchy. Busse et al. (2019) state that healthcare refers to a broad range of health facilities that involve the acute, chronic, restorative, preventive, and rehabilitative care that is provided in various settings by various healthcare providers. In this thesis, healthcare is referred to as the organised provisions of services provided by a country or an organisation for medical treatment for both physical and mental illness. Patriarchy has been defined as an integral system of male dominance enforced by violence, control of female sexuality, and enacted by religion (Christ, 2016). In the Bangladeshi context, I shall use the notion of patriarchy to mean the complementary integration of social, religious and legal systems that not only reinforces historical male dominance and privilege, but also represses gender and sexual identities and expressions that are at variance with cis-het male norms and expectations. Cist-het patriarchy refers to a system of cisgender and heterosexual male privilege by which cisgender men attempt to control cisgender females, and sexual and gender diverse people (Valdes, 1996); I use the term ‘cis-het patriarchy’ in this thesis to stress the discrimination and oppression experienced by women and sexual and gender diverse communities.

I embarked on this research to study sexual and gender diverse people as ‘others’, but as I progressed, I began to realise that the issues were bigger than I had anticipated. To clarify, the real issue was not the gender and sexually diverse people, but the male privilege that stigmatises and marginalises certain groups of people in order to maintain that privilege and social control. It was overwhelming to find myself standing on the other side of a society that stigmatises sexual and gender diverse communities.

Because of this project, I gained an awareness of how I have benefitted from male privilege. Challenging the same privilege shows growth and a willingness to grow personally from this research — how I started with one purpose and learned from the data that the truth was something else. My assumption at the beginning of this project was that healthcare discrimination is an issue of human rights. Nevertheless, I came to understand that human rights may not be as universal as I had thought them to be. Most interestingly, patriarchy is an obstruction when considering healthcare as a human right for disadvantaged groups of people in Bangladesh. This thesis showcases arguments relating to human rights and male-privilege to argue how patriarchy does not allow equal rights for sexual and gender diverse populations.

This thesis contains significant discussion regarding the epistemological differences between the researcher and the participants and how these differences can be managed, as well as how they impact on research findings. The arguments presented in this thesis are essential to relate human rights theories and healthcare theories. Also, the concept of patri-normativity is introduced in this research based on the notion of how heteronormativity has developed in society. Heteronormativity is the norm of heterosexuality based on the concept of gender binary and assumes that marital and sexual relationships (and the privileges that accrue from these opposite-sex relationships) can or should only happen between individuals of the opposite sex, and patri-normativity (patriarchal normativity) is a system where masculine attitudes and male dominance are taken as default or normal values in society. The findings are also important for policy level agendas in Bangladesh to address the issues of marginalised groups of populations. From a social work practice point of view, the fieldwork of this research is influential to identify how social workers can work with stigmatised communities by maintaining confidentiality, respect, justice, and equality.

1.2 Background

The term ‘patriarchy’ commonly refers to a male dominant system (Biaggi, 2006), but patriarchy is arguably more than that. This traditional understanding of patriarchy does not manifest, but rather confounds, the multifaceted aspects that allow patriarchy as a system to perpetuate and sustain (Christ, 2016). Hence, I elaborate on the understanding of patriarchy as a collective term to explain the complex set of elements so that we can critique a patriarchal system that perpetuates masculine social control. To understand patriarchy, German philosopher Hegel expresses patriarchal power as a tension between state and family. While distinguishing between matriarchy and patriarchy in the 19th century, it was regarded that patriarchy in the family was a key factor of state oppression; further, in the 20th century, the patriarchal system was deemed as a feminist explanation for the oppression of women, and an attempt to perpetuate the dominance of men (Miller, 2017).

Before the introduction of Islam in the Indian subcontinent region, the Persians and Arabs were the main traders along the Indian coastline and in Indian waters. Wink (1997) describes that after the Islamisation of the Persians and Arabs, they continued their trading operations and many married low-caste Hindu women: this matrimonial alliance was found to be the first peaceful way of introducing Islam in the subcontinent region (As cited in Avari, 2016). Eaton (1993) discusses that during the early 13th century under the Turco-Afghan Delhi Sultanate, Islamic missionaries were able to convert lower-caste Hindus to Muslims through egalitarian behaviour and piety, which was the second peaceful way to spread Islam: they went to the remote parts of the country, including eastern Bengal, to reach out to remote Hindu tribes (As cited in Avari, 2016). Since Hindu women from lower castes and tribes were marrying the Arabs and Persians, one can argue that this very first matrimonial method of spreading Islam in India had kept women who had converted to Muslim after marriage under the dominance of Muslim husbands. This is because the women who married Muslim men perhaps felt obligated to serve their husbands, which implies how deeply rooted male dominance and patriarchy was in the subcontinent region since the beginning of the spread of Islam.

In the South Asian region, the system of male dominance had reached its current brutal form (Nainar, 2013). The factors that strengthen patriarchy are modes and production of labour, state-regulated laws and regulations; monopoly in culture and religion; and control of sexuality (Nainar, 2013). As a part of the control of sexuality, patriarchy influences the way male same-sex relationships are perceived. An essay by Gul Ozyegin presented at a conference on Islam and Sexuality emphasises that same-sex relationships between men are culturally and historically perceived through gendered categories: men who penetrate other men are taken as active and masculine, whereas receptive male partners are deemed as passive or feminine (Gutiérrez, 2012).

This categorisation somewhat indicates that the expression of patriarchal masculinity manifests male dominance even in same-sex male relationships.

Homosexuality is a sexual expression or orientation of individuals who are emotionally and sexually attracted to same-sex persons and it is also a category of sexual behaviour: by having a relationship with another same-sex person, or desiring to have one, an individual can express their homosexuality (Gilfoyle et al., 2007). Religion is frequently used to justify the stigmatisation of homosexuality as socially deviant. For instance, Islam, in theory, is considered as an extremely homophobic religion that strictly prohibits same-sex behaviour (Siraj, 2012). In various religious interpretations, women were not given the right to deny the satisfaction of their husbands' sexual desires (Gutiérrez, 2012), indicating the dominance of men over women. Hence, a passive male partner taking on the subordinate role of a woman does not seem to reconcile with patriarchal principles, thus homosexual practice is deemed as socially deviant.

While considering homosexuality in South Asian history, there were collisions and conflicts amid the cultures in this region during the period from 1550 to 1800 (Vanita, 2002). Consequently, most early Mughal kings and, later, the British Regime tolerated Hindu cultural rituals and beliefs associated with eroticism and gender violence; this led to artwork and poetry in the Mughal Empire, along with the Persian translation of Sanskrit sexual literature, which depicts same-sex sexual activity performed for the rulers' amusement (Penrose, 2006). However, understanding ideas relating to gender and sexuality from pre-colonial history does not necessarily lead to a utopia of gender variance and same-sex behaviour (Zwilling & Sweet, 2000), but does lead to the considerations of sex segregation, misogyny, conflict of caste or class, and different religious prohibitions (Penrose, 2006). People from a higher class and caste, mostly from Hindu communities who practised homosexual behaviour, tended to retain masculine power due to the fear of stigmatisation of being a passive partner — one who was supposed to be a male from a lower class or caste (Penrose, 2006). Similarly, in Muslim societies, male receptive partners perceived as feminine remained highly stigmatised (Gutiérrez, 2012). Although the British hegemony in the South Asian region was the root cause for major exploitation in different sectors such as agriculture, industry, health, and trade, the slavery system was abolished and the Sati system was banned by the British Regime (Bejgam, 2014). Nonetheless, the British Regime imposed their colonial values. One of these values was the sexual values that criminalised sexual and gender diverse populations in South Asia. Consequently, this led to oppression and social control of these populations in the 19th century, and was sanctioned by the introduction of Section 377 which banned sexual activity as ‘against the order of nature’.

The nature of patriarchy for binary division between male and female can conceal the oppression experienced by sexual and gender diverse people (Bruneau, 2018). Stigma is an expression of a heteronormative-patriarchal society by maintaining the domination or privilege of men over women, people who are constructed as women, and sexual or gender diverse individuals. Hence, with increasingly visible gender and sexually diverse individuals and communities, it is an urgent matter for investigation to understand who or what is responsible for perpetuating this domination and who is benefitting from such cis-heteronormativity. The maintenance of cis-het patriarchal privilege requires the establishment and maintenance of clear boundaries between genders, and what is acceptable and unacceptable public behaviour. Maintaining these boundaries becomes a prime mission of patriarchal privilege: women must know their place, and any hint of social deviance must be stigmatised, marginalised, and, where possible, extinguished. As an extreme example of this need to maintain boundaries, two gay activists in Bangladesh, Xulhaz Mannan and Mahbub Rabbi Tonoy were assassinated in 2016 (Sanzum, 2017, May 19).

The oppression faced by sexual and gender diverse communities needs to be studied, and healthcare discrimination and human rights are important lenses to view the larger picture of the social control maintained by the male privileged society. To prepare for this, online meetings were held with two organisations that work with sexual and gender diverse communities in Bangladesh. These organisations stated that they also advocated for improved access to healthcare, which is a primary and urgent need for these communities. Therefore, it is important to study the healthcare experiences of sexual and gender diverse communities, and address how the healthcare system articulates a rights framework and affects public health. I regard healthcare access as a human right because every individual is entitled to maintain their health. Healthcare must eventually be accessed by all persons, and it forms the basis for the maintenance of public health in a society or nation. Thus, access to healthcare provides a useful and even critical lens to consider the maintenance of cis-het patriarchy. To understand this social control and oppression against sexual and gender diverse minorities by a patriarchal masculine society, it is also essential to delve into how sexual and gender diverse people live with stigmatising consequences such as sexual abuse, public harassment, and police violence.

1.3 Context of the research

Bangladesh is a South Asian nation with a population of more than 160 million as of 2020. Throughout its history, the socio-cultural construction of this country has been shaped by socially conservative values (Riaz & Rahman, 2016). Patriarchy has been deeply rooted in society since at least the Mughal Empire; it was reinforced by Islam and the British colonial authority (Hussin, 2016).

To understand the male dominance in different sectors in contemporary Bangladesh, we can look at the gender ratio in areas such as the parliament and labour force participation. The Parliament of Bangladesh consists of 350 members. Among these, only 50 seats are allocated to women members (Parliament of Bangladesh, n.d.). In rural local government (*Upazila parishads* and *Union parishads*) and urban local government (city corporation and *pouroshavas*) the participation of women is not as equal as men: seats reserved for women are at most one-third in most local government bodies. For administrative positions in public organisations, there are recruitment quotas of 10 per cent women, and 15 per cent non-gazetted posts for women (Asian Development Bank, 2017). These indicate a gender disparity among the employees in the government bodies.

The World Bank reports that the female share of the total population in Bangladesh was 49.42 per cent in 2019 (Trading Economics, 2020). The statistical data of 2016-2017 show that the labour force participation of males was 43.5 million, whereas female participation was only 19.9 million. Also, the data from the same fiscal year show that 42.2 million males were in employment, while, for women, this figure was 18.6 million. The reason for such a difference in numbers is that almost one-third (29.1 per cent) of women who are recorded in the labour force engaged in unpaid activities such as a family business or farms; they are not in a position to exercise financial agency despite being involved in the labour force (Raihan & Bidisha, 2018).

One may still argue that the rate of female employment and empowerment is greater than it was in the past. I, however, argue that women’s contribution to the national economy is much lower than it could be. This is because there is a growing assumption that women workers are less capable than men in the areas of technological development and increased automation, which suggests that women are locked into an inferior position in the labour market (Raihan & Bidisha, 2018). All these data make it transparent that the dominance of males exists in every sector.

Repression of sexual 'deviance' is only the most recent manifestation of a longstanding male-privileged society. In addition, several contestable religious interpretations are frequently reinforced in Bangladesh to maintain a patriarchal society that is highly male-dominated (Cain et al., 1979). Similarly, Islamic values have led the majority of the population to believe that homosexual behaviour is prohibited (Gutiérrez, 2012). Thus, patriarchy seems well-equipped to control and define gender identities, particularly for transgender populations (Snigdha, 2019). The social, religious, and economic values of the country are experienced as collective oppression by sexual and gender minority communities. Rashid, Standing, et al. (2011) explain that there is a culture of collective denial of the existence of same-sex relationships that is perhaps influenced by religious sentiments; an overtly heterosexual discourse of marriage and reproduction has not allowed sexual and gender diverse identities any legitimacy status.

Although traditional Islamic tenets tend to avoid the acknowledgement of sex and sexualities (Murray & Roscoe, 1997), Islamic laws are mainly concerned with public behaviour, thus no strict condemnation of homosexual behaviour is evident if it is not publicly displayed (Yadegarfard & Bahramabadian, 2014). The expression of same-sex love by poets and artists was always public and mostly tolerated, but one can only imagine what happened in private between same-sex individuals (Gutiérrez, 2012). Islamic beliefs and patriarchal attitudes derived from colonialism toward sexuality and homosexual behaviour have joined to influence conformity in a society where same-sex relationships are not accepted by most people (Ferdoush, 2013). Additionally, sexuality is taken as a very private matter, often as a taboo, in Bangladesh (Riaz & Rahman, 2016). Even in the context of HIV, there is little public discussion of sexuality. Therefore, non-conforming genders are treated as socially deviant and marginalised (Bondyopadhyay & Ahmed, 2011), and quite literally abominable.

The repressive social environment deprives sexual and gender diverse communities of human rights such as healthcare, education, and employment. British colonialism served the goals of the pre-existing masculine values because it had a common goal with patriarchy to establish or preserve male social, political, and economic dominance. Stigmatised people under a patriarchal system are kept hidden by the government by not collecting basic demographic information (Chakma & Maitrot, 2016). There is, for instance, no estimate of the total number of sexual or gender minority persons in Bangladesh. Historically, the government has frequently been successful in depriving them of human rights by treating them as non-existent in the society. Thus, the deprivation of rights leads to social control over marginalised populations.

Healthcare as a human right is an essential need for every person. In order to investigate the importance of healthcare in the Bangladeshi context, the concept of health first needs to be clarified. According to the World Health Organisation (WHO), health is a complete state of physical, mental, and social well-being, and not merely the absence of disease or infirmity (Felman, 2020). This understanding of health highlights well-being, which is an inclusive concept that interconnects socio-economic development, health promotion, psychological, and environmental development. This project uses healthcare as a standpoint through which we may understand the overall oppression of disadvantaged groups of people. The Universal Declaration of Human Rights (UDHR) proclaims (Article 25) that every person is entitled to have the right to proper health, well-being and medical healthcare (Global Citizenship Commission, 2016). Despite having no legal obligation to follow UDHR, Bangladesh has incorporated many human rights from the Declaration: one of these is medical care, which is mentioned as a 'basic necessity' (Part II - Article 15) in the Constitution of Bangladesh (Rahman, 2006). This makes healthcare a legal right for every citizen of Bangladesh that is largely influenced by the promotion of UDHR.

In short, healthcare is one of the most important basic needs and is a human right. Thus, healthcare discrimination against sexual and gender diverse communities is a human rights issue. By using access to healthcare as a lens, we can understand the overall oppression of sexual and gender diverse communities.

Healthcare is an urgent issue because sexual and gender diverse communities often experience harassment and abusive behaviour during healthcare delivery. In 2015, a group of hijra were required to attend a government hospital for medical check-ups as part of an employment package. During this so-called ‘medical examination’, doctors ordered non-medical staff (custodians) to touch the hijras’ genitals in both private rooms and public spaces while other staff and patients mocked them (Human Rights Watch, 2016). Doing such a thing is an injustice and a humiliating way to dehumanise marginalised people. Doctors, who were meant to be providing healthcare, were only facilitating the humiliation of their patients. This hints at the way government and male privileged society treat and discriminate against the most vulnerable people in present-day Bangladesh.

The conservative social environment and impact of the colonial legal system have kept sexual and gender diverse communities hidden, with very little public visibility. Perhaps, this lack of public visibility allows the state to continue to oppress and control them in more private domains, such as healthcare. Healthcare deprivation, therefore, can be used as a primary tool to socially control and oppress these communities. The state may use this deprivation to socially control marginalised people in order to prevent them from being organised and employed, and from maintaining proper health. For this reason, the healthcare experiences of sexual and gender diverse communities can provide a way of understanding the consequences of stigma.

Universally declared human rights are generally accepted in UN member nations. Despite considering healthcare as a basic necessity under a human rights framework (Tellier, 2017) and incorporating many rights from the UDHR including healthcare (Hosain, 2013), it is often denied to sexual and gender diverse communities in Bangladesh. Therefore, healthcare provides a convenient and urgent lens to examine the status of the rights of gender and sexually diverse persons, and particularly hijra, in Bangladesh. Hence, the purpose of this research is to investigate how healthcare discrimination, a human rights violation, can help us understand the overall oppression against sexual and gender diverse communities in a male-dominated society.

1.4 Rationale for the research

The passion to conduct this research is mostly socio-political, though it is also deeply personal. It is personal because, as a social worker originally from Bangladesh, I value human life as the strongest form of human rights. Incidents such as the assassination of Xulhaz and Mahbub had a strong impact on me, and I ask myself what it would be like to be a sexual minority person in my country, particularly as a Muslim. Moreover, human rights may differ in theory and practice, especially for a non-welfare state like Bangladesh. Therefore, the political system and legal structure are frequently held to be responsible for these murders in marginalised populations. Consequently, the assassinations of these activists are rationalised by excuses such as legal prohibition and conservative socio-cultural norms. Yet the political agendas behind these incidents have remained hidden. Thus, I envisioned myself conducting this research by using healthcare as a way to understand the oppression of sexual and gender diverse communities in a Muslim majority country. In this way, we may be able to understand the realities of oppression beyond the borders of Bangladesh.

Access to healthcare is a fundamental right for human rights practice (Ghoshal, 2013; Holttum, 2016), which is often unavailable for sexual and gender diverse communities in Bangladesh. I used healthcare as a lens to understand the wider society. For the first time, the 7th Five Year Plan (FY2016 – FY2020) published by the government of Bangladesh includes people with HIV, transgender people, and male and female sex workers, emphasising their ‘health insurance’ and HIV response (Planning Commission, 2015). It indicates that healthcare for stigmatised people is gradually becoming more visible and important.

The influence of Islam

Many people would argue that the focus of this research is not important in a Muslim majority country due to some debatable interpretations of Islam toward homosexuality. As a practising Muslim, I subscribe to Islam with my whole heart and spiritual faith. Thus, I would like to strongly object and argue in favour of this focus. Islam has led me to trust the reasons why I believe what I believe, as there is no point in believing something blindly. I do not propose that Islam or the Quran’s passages are incorrect. I assume that there is a need to think through the interpretations of the passages and understand these issues more profoundly. The holy Quran contains the smallest details about important aspects of life and relationships, marriage and divorce, however, the only indication in the Quran about the so-called homosexual behaviour is the story (e.g. Quran, 27:55) in Sodom and Gomorrah relating to the Prophet Lut (Edudivers, 1998; Henrickson, 2009). It is better, I propose, to look for the deeper truth by considering the socio-cultural environment behind the story of Sodom and Gomorrah rather than depending on contestable interpretations. There can be various interpretations of Lut’s story. For instance, one interpretation suggests that the Prophet Lut offered his daughters to satisfy those who were creating anarchy (Quran, 11:78), and many would argue that it somewhat represents the oppression of women as sexual objects with no rights. Another interpretation refers to the socio-cultural custom where there was a prime rule in Lut’s society to provide hospitality for travellers. By disobeying this rule and creating anarchy, the inhabitants of Sodom sought to rape male strangers (travellers) as a show of inhospitality and humiliation. This interpretation implies that this behaviour was not about their desire for the same sex. Many would, therefore, argue: What if Allah punished them because of their actions toward inhospitality (Edudivers, 1998)? In this story, the interpretation of the term ‘lust’ (شَهْوَةً) is also contested by many scholars (Edudivers, 1998): What does ‘lust’ actually mean? Is it sodomy? Non-marital sex? Oral sex? Adultery? Or does this mean any abusive manner of sexual activity?

One may argue that since the Quran explains clear details of every aspect of life, and if homosexual activity is a crime, then why does it not clearly say so (Edudivers, 1998). It was generally assumed that people in Sodom and Gomorrah were punished by Allah because of their homosexual activities. A hermeneutic approach to this story suggests that it is equally possible that these people were not only engaged in same-sex behaviour but other immoral activities such as robbery and inhospitality (Edudivers, 1998). Hence, it is unusual to conclude that they were condemned just because of their homosexual activities without considering their other immoral activities. Since Islam itself claims to provide support for marginalised people, it is important to study how sexual and gender diverse communities can access healthcare in a Muslim majority country. The above examples demonstrate the complexity of investigating gender and sexually diverse persons in Islamic-dominated contexts.

1.5 Research question

The socio-cultural structure of Bangladesh can be studied by using different perspectives such as patriarchy, healthcare, sexual and gender diverse communities, and human rights. These perspectives contributed to the development of this project and its primary research question.

Main research question: How can access to healthcare help to understand the oppression of sexual and gender diverse communities in Bangladesh?

Sub-questions:

- What is it like to be a sexual or gender diverse person in an Islamic patriarchal society?
- How do sexual and gender diverse communities perceive and experience healthcare in Bangladesh?
- How can the experiences of sexual and gender diverse communities help us to understand the continuing influence of patriarchy and colonialism in Bangladesh?

1.6 Structure of the thesis

This beginning chapter provides a background of the research topic by explaining who sexual and gender diverse people are and what their situation in Bangladesh is. This chapter also includes the research questions to focus on what is investigated throughout the thesis. The rationale of conducting this research is also justified in terms of socio-cultural perspectives and personal point of view. The second chapter contains a critical analysis of previous and relevant literature on the research topic. The literature review discusses some of the major concepts of the research such as patriarchy and colonialism, history of sexual and gender diverse people and their situation, understanding healthcare, and the healthcare system in Bangladesh. Further literature is reviewed to understand healthcare, public exposure, sexual abuse, and police harassment faced by sexual and gender diverse people. A further segment in this chapter analyses the theoretical framework of this research based on patriarchy, human rights theories, limitations of human rights, healthcare theories, and rights-based practices and their challenges.

The third chapter mainly focuses on the research methodology. This includes the discussion of research philosophy, epistemology, and methodology. Further, I discuss the assessment of the research quality and qualitative research method with the justification for choosing this research method. A significant segment of this chapter is research design, which describes the research area and population, participant recruitment, data collection techniques, data analysis method, and ethical framework. Another segment in this chapter elaborates the limitations of the research. A fieldwork journal describing my data collection experiences is at the end of this chapter.

The following five chapters (Chapters Four to Eight) focus on the findings and analysis of the thesis, which are mostly based on the data. The fourth chapter contains a brief description of the participants, and discusses how they identify themselves. The fifth (findings) chapter focuses on the understanding of the post-colonial state, the impact of masculinity in a patriarchal society, and the relationship between healthcare and Section 377. The sixth (findings) chapter elaborates what it is like to be a sexual or gender minority person by articulating self-identification expressions, fear of disclosure, different struggles of the participants, sexual abuse, and harassment by police. The seventh (findings) chapter describes implications of healthcare with society, law, government, taboo, and religion. The final findings chapter explains common health and healthcare issues of the participants and their individual healthcare experiences. This chapter also explains the argument of healthcare as a human right, and includes a segment regarding rights-based practices and their barriers.

Chapter Nine is an integrated discussion of the findings. This chapter discusses the findings in relation to relevant theories and provides opinions and assumptions based on the findings. This chapter mostly examines whether healthcare can be considered as a human right and whether the deprivation of healthcare is a tool for oppression: it is here that the main research question will be answered. The last chapter includes a conclusion and recommendations for further research.

1.7 Summary

I considered healthcare as a human right because an individual is entitled to health regardless of their age, gender, race, and cultural background. To investigate healthcare from a human rights perspective by analysing healthcare experiences of sexual and gender diverse communities, we need to understand major contexts such as the societal context of Bangladesh, how healthcare is understood, and who sexual and gender diverse people are. I discussed these introductory contexts in this chapter in order for the reader to gain a proper understanding of what is happening in Bangladesh for sexual and gender diverse people. In this chapter, I also described the research questions and justifications from a religious perspective to conduct this research.

Chapter Two: Literature Review and Theoretical Framework

2.1 Introduction

This chapter critically discusses literature relating to major aspects of the research topic. The literature review involves discussions about key themes that will be considered in this thesis. This will include a range of areas including a) healthcare: theorising healthcare, the healthcare system in Bangladesh, the state's attempt at healthcare policy, b) history and the present situation of sexual and gender diverse communities in Bangladesh, c) theories of patriarchy and the relationship between colonialism and patriarchy, and d) theories and philosophies of human rights, and rights-based practices. Since human rights are constructed differently in different regions of the world, analysing these key areas can contribute to the discussion about whether healthcare can be deemed as a human right for sexual and gender diverse people.

2.2 Healthcare

2.2.1 Understanding healthcare

In general, healthcare is a set of provisions or services to restore and sustain mental and physical well-being by registered and well-trained professionals (Körner et al., 2016). In many societies, healthcare is constructed as a human right (Holttum, 2016), and the meaning of healthcare is often related to human existence and empowerment. According to Shannon and Young (2004), there has been a healthcare revolution, empowering people with regard to their health and their ability to negotiate with healthcare providers: this revolution arguably began with the AIDS epidemic in the 1980s. Modern allopathic healthcare can often make people feel powerless because of the dominance of a profit-driven, high-tech, and fragmented structure of healthcare practice. However, the philosophy of modern healthcare stresses a new worldview of healing instead of the sole importance of biomedical cure (Shannon & Young, 2004). It does not only focus on medical cure and pathology but emphasises the environment, society, and other people. Chadha et al. (2012) write that healthcare is a strategic process that includes diseases and illness, and prevention, diagnosis and treatment of an injury, and which aims for the improvement of human health. The authors state that healthcare does not only refer to allopathic care but involves mental and social well-being.

Holistic concepts of well-being do not seem to fit within a developing nation, particularly where many people live with social stigma and vulnerability. According to Uddin and Mazur (2014), the socio-economic status of vulnerable households represents a lack of wealth — a key factor when accessing healthcare — which also affects their health seeking behaviour. Moreover, the classical liberal theory and the socialist theory of healthcare challenge each other about who can afford to pay and who cannot (Shannon & Young, 2004). Amin et al. (2010) find that a household's socio-economic status and poverty level influence the health-seeking behaviour of poor women in rural areas of Bangladesh. The authors add that poor economic status and a lack of education and awareness discourage them from seeking healthcare. Moreover, inequalities in healthcare can be one way to socially control vulnerable people by preventing them from living a healthy life (Amin et al., 2010; Uddin & Mazur, 2014).

There are several international, voluntary, and rights-based organisations whose opinions indicate that healthcare is an urgent issue for sexual and gender diverse communities. The Asia Pacific Transgender Network (2018) advocates that healthcare for transgender and gender diverse people is one of the major challenges for stigmatised people at a regional level. They also propose that more resilient and self-reliant 'trans' movements are needed in Asia and the Pacific to influence policymakers, international agencies, and healthcare professionals. The American Cancer Society, for instance, has found that lesbians and bisexual women carry higher risks for breast cancer and receive less routine healthcare than heterosexual women (Simon, 2017, June 01). The same study mentions that many gay and bisexual men have low rates of health insurance. These men also tend to hide their identities because of the fear of discrimination and negative behaviour by physicians. Additionally, Neville and Henrickson (2006) explain that sexual and gender minority male persons are less likely to disclose their sexual identity to physicians than female persons, mostly due to questions about birth control, which are rarely asked of men, but usually asked of women. United Nations High Commissioner for Refugees (2013) emphasises that both mental and physical healthcare are required for the betterment of lesbian, gay, bisexual, transgender, and intersex refugees. The first-ever report of the United Nations on the rights of sexual and gender diverse communities also prioritises the importance of healthcare (United

Nations News, 2011). The United Nations' *Agenda 2030: Sustainable Development* Goal 3 highlights healthy living for everyone. It aims to promote LGBTI-inclusive societies to address discriminatory healthcare issues (Perez, 2017).

Rana et al. (2016) mention that surveys and national hospital-based surveillance in Bangladesh record that many hijra in Dhaka City have been identified with HIV and syphilis. The authors also write that perhaps hijra were infected with other sexually transmissible infections (STIs) such as chlamydia and gonorrhoea. The sex work of hijra is arguably the reason for their infection with HIV and other STIs. But as we shall see, the social and legal environments leave hijra little choice other than to do sex work, which exposes them to these health risks. Hence, it is important to examine what the social and working conditions are that lead to these STIs and establish if there is any access to condoms, proper education, and awareness about their healthcare provisions.

A report from Home Office (2017) states that the Bandhu Social Welfare Society (BSWS) delivers relevant information and support for healthcare in 39 health centres for male sex workers (MSW) and men who have sex with men (MSM). This report also presents a study conducted by Boys of Bangladesh (BoB) which found that healthcare discrimination against MSM is extreme in urban areas. People living with HIV/AIDS in Bangladesh constantly experience internalised stigma, which is often called 'self-stigma' (Hasan et al., 2012). According to the country reports of the United States Department of State (2016), populations at increased risk from HIV in Bangladesh are suffering from social stigma, particularly MSM and transgender people. This report also explains that people suffering from HIV stigma frequently face detention, social ostracism, and denial of human rights such as healthcare. In addition, information and services relating to HIV cannot not be accessed by many people because of the social norms about gender. Many physicians in Bangladesh struggle to understand hijra identities and are afraid to associate with them, so hijra fail to access proper healthcare (Family Health International, 2013).

Healthcare experiences of sexual and gender diverse communities have a direct link with public exposure, harassment, and rape. Many of them are afraid to disclose their identities to healthcare providers because disclosure would expose them to abusive behaviour. Therefore, I considered a tension between public exposure and healthcare experiences of both hijra and other sexual and gender diverse communities. Harassment and abuse by police have a negative impact on the physical and mental health of sexual or gender minority persons, which is an important issue to investigate. Moreover, it is important to address the possibility of spreading STIs and HIV by rape perpetrated by members of law enforcement agencies, and its implications for public health and healthcare.

2.2.2 Theorising healthcare

Shannon and Young (2004) write that the classical liberal theory of healthcare suggests that individuals are entitled to healthcare for diseases or conditions they acquire. The authors add that this theory is individualistic and symptom-focused, and in order to be treated the individual must seek out physicians or other healthcare providers. The classical liberal theory characterises that healthcare is required for an illness that emerges from the deviation of the normal behaviour of the people (Shannon & Young, 2004). Moreover, the industrial society theory urges that the main healthcare issue is the behaviour that causes the disease. The industrial society theory defines that cultural patterns and social structures determine illness and healthcare in a society (Barr & Dowding, 2015). This theory also underpins a public health approach because it considers health not as an individual matter but a matter for the whole society. Consequently, not only the medical treatment sector but also health policy, community, and social medicine are emphasised by this theory. For example, raising social awareness and community support are two major preventive measures that resulted from the AIDS pandemic. As a limitation, both the liberal and industrial theories of healthcare explain that people should be able to pay for healthcare. But there must be a consideration for working class, middle class and poor people, which is urged by the socialist theory.

A socialist theory of healthcare defines that quality of life can be worsened by inequality and discrimination in society (Dlugacz, 2017). Unsafe work, occupational diseases, stress from work, and unemployment are stressed by this theory to discuss ill-health disproportionality of poor people (Shannon & Young, 2004). For example, in developing countries, sexual and gender minority people may consider sex work for their livelihood, which may raise a concern of HIV. Subsequently, socio-economic factors of health and illness must be considered, particularly for sexual and gender diverse communities. This is why the socialist theory of healthcare is a good fit in the present project. As noted above, the denial of rights and the humiliation of hijra and other sexual and gender diverse communities are designed to exert social control over them. Hence, a constructivist approach to healthcare theory can emphasise the social control aspect of healthcare delivery. This approach also challenges the technologies of healthcare delivery and critiques the other theories of healthcare I identified above. Therefore, a constructivist approach is similarly appropriate in my project because it considers a co-operative and reciprocal practice for healthcare through community-level consumer control and global thinking (Barr & Dowding, 2015). Community-level consumer control can ensure that healthcare is supported by the community, which decides what services are given to whom.

Different healthcare theories have different implications, but discrimination and social control are two of the major areas that my project focused on. To cover these areas, I consider that a socialist and constructivist theory of healthcare is most relevant in this project. I do, however, anticipate that the theoretical choices of my research may be challenged. For instance, one may argue that both the classical liberal and the industrial theory of healthcare could be more appropriate for this research because they emphasise the behaviour that causes illness. However, I considered the socialist constructivist theory because the principles of this theory particularly prioritise the healthcare needs of the populations who are disadvantaged and oppressed, which significantly aligns with the principles of anti-oppressive social work practice. Anti-oppressive social work practice is a critical social work approach based on social justice and humanistic values, taking into account the experiences and views of oppressed populations (Dalrymple & Burke, 2006). Since healthcare is shaped so much by social, cultural and political contexts, I posit that the social constructivist theory is more relevant than classical liberal and industrial theories of healthcare. Therefore, I investigated the healthcare experiences of gender and sexually diverse individuals who are marginalised and oppressed by the social, cultural and political contexts in which they live, and considered their experiences from a human rights framework.

2.2.3 Healthcare system in Bangladesh

The healthcare system in Bangladesh is managed by the Ministry of Health and Family Welfare (MOHFW) in terms of planning healthcare services, formulating policies, and implementing them. Under the regulations of the Ministry, other services have developed, such as specialised cadres of health professionals, training institutions supporting services, health facilities, and information systems (Vaughan et al., 2000). In the early years after the independence of Bangladesh in 1971, the healthcare systems were primarily focused on rural areas to improve child and maternal health and raise awareness about family planning (Islam & Biswas, 2014). MOHFW significantly improved the primary healthcare at district and sub-district levels during the 1980s (Vaughan et al., 2000). At that point, there was neither a comprehensive national health policy nor a separate health sector plan to design medium or long-term health plans, and Five Year Plans were used to set goals for all sectors including health. Gradually, measures such as the Health and Population Sector Program (1998-2003) were taken to be more comprehensive for the health needs of the populations. Also, in the second half of the 1990s, while government funded health systems were broadening, the government required public-private partnership for efficient health service delivery (Islam & Biswas, 2014).

Support from private organisations was initially needed to expand the publicly funded health services, and, subsequently, a trend toward privatisation of the health system gradually started to form. Rahman (2019) describes that although the health sector of Bangladesh has undergone a trend of privatisation, this has brought very limited benefit to the overall health improvement of the population: this is because privatisation of the health sector not only makes health services costly but also reduces accountability and equity in the provision of services.

In 2017, Bangladesh allocated 2.3 per cent of GDP to the public health sector, and in the Financial Year 2021 the budget has reduced to less than 1 per cent of GDP (Hossain & Ahmed, 2020). In contrast, neighbouring countries such as Nepal (which spends 5.6 per cent of GDP), India (3.8), and Sri Lanka (3.8) have higher rates, indicating that Bangladesh is lagging behind other regional countries in health expenditure (Imdad & Saif, 2021, January 13). About 65 per cent of Bangladesh’s 2021 allocation is used on allowances and salaries and the rest is supposed to be utilised for development. However, because of the lack of overall capacity of the health sector, even this proportionately reduced allocation is not fully utilised.

The lack of a formal healthcare sector resulted in an increase of informal healthcare providers in rural areas who provide a questionable quality of care by prescribing drugs that are mostly inappropriate and potentially harmful (Future Health Systems, 2019). Due to their 24-hour availability, flexible payment methods, established relations within the community, and sympathetic approach, these village doctors are preferred by most rural residents. Bangladesh's health system is quite complex due to the lack of synergy between public and private healthcare organisations and the unregulated practices of village healthcare providers, which has led to a constantly changing healthcare system.

The government, non-government organisations (NGOs), and donor agencies are the major funders of healthcare. The Bangladesh National Accounts 2017 Report indicates that annually US$2.3 billion is spent on healthcare, which rationalises to US$16.20 per person (Hazzard, 2017). This places Bangladesh at 118th position in the global ranking of total per capita health expenditure as estimated by the World Health Organisation. Child health, maternity health, HIV prevention, tuberculosis treatment, and malaria prevention have been progressing efficiently in recent years, and allopathic healthcare plays the most important role in this progression in healthcare. Homeopathy and spiritual healthcare (e.g. holy water given by a religious leader or saint) are also visible mostly in rural areas, and yoga, Ayurveda, and acupuncture are gradually being introduced among urban people. However, mental health, social health, and environmental health are often ignored in the healthcare strategies of Bangladesh (Uddin & Mazur, 2014).

State's attempt at healthcare policy

The inclusion of sexual minority people in the current government Five Year Plan is consistent with the United Nations Sustainable Development Goals (SDGs). Yet, interestingly, this plan does not include any provision for rape and assault against sexual and gender diverse communities, whereas these have obvious negative health consequences. It is also important to study how the government rationalises this evolving policy in the face of what must be conservative Islamic opposition. Even the definition of hijra is not clearly stated by government plans, which creates controversy about who should be identified as hijra. It needs to be understood that perhaps this is a deliberate attempt to keep hijra under social oppression by disputing their definition, or maybe it is just sloppy policy that assumes that everyone has a common understanding of hijra.

The policy that includes sexual minorities for the first time indicates a sudden change among the government initiatives to take account of stigmatised people, especially in terms of their healthcare needs. This initiative could either be a response to international pressure following the assassinations of LGBT activists or just to attract foreign donors. But the government should deem healthcare as a human right, which requires more evidence and research relating to this issue. Very few studies have been done regarding healthcare issues of sexual and gender diverse communities in Bangladesh, and these are discussed in the next section along with other relevant literature.

2.3 Sexual and gender diverse communities

2.3.1 Brief history

Many would argue that homosexual behaviour has never existed in Muslim societies, which is not true (Schmitt & Sofer, 1992). Homosexual activity has been visible since ancient times, and it is unreasonable to conclude that it is exclusively a modern-day phenomenon (Pattanaik, 2002). Greek and Hindu mythologies convey various examples of same-sex relationships among both gods and humans. Additionally, homosexual activity existed in the sub-continent in pre-colonial times and was not criminalised before the British Regime in 1860 (Aldrich, 2003; Vanita, 2002). The British Regime introduced Section 377 of the Indian Penal Code, which has remained as a template for anti-sodomy laws in Bangladesh (Bhaskaran, 2002). Hence, it was the British Regime which perpetuated the patriarchal oppression of sexual and gender diverse communities in the Indian sub-continent through anti-sodomy laws. The history of homosexual behaviour and anti-sodomy laws has frequently shown clear signs of deliberate attempts to suppress expressions of sexual and gender diversity.

2.3.2 Sexual and gender diverse communities in Bangladesh

Sexual and gender diverse communities are a multifarious group of people whose sexual identity and orientation vary from the majority of society. According to Grace and Wells (2015), in many societies sexual and gender diverse communities are often referred to as ‘queer people’ or ‘LGBT’ (lesbian, gay, bisexual and transgender). However, there are arguments against the taxonomy ‘LGBT’ because it does not cover many other sexual and gender orientations emerging from non-Western and non-liberal humanist cultures: for example, *kothi* (or *koti*) and hijra in the South Asian region, particularly in Bangladesh. *Kothi* refers to a male who takes on a passive role in same-sex behaviour. Hijra are individuals whose birth sex is male but present themselves as female, or as neither male nor female (Hinchy, 2019). Sometimes, transgender and intersex are also identified as hijra in Bangladesh.

The government has yet to provide a clear definition of hijra. However, Pakistan's Transgender Persons (Protect of Rights) Act 2018 defines hijra (transgender person) as someone who is "a) intersex *(khusra)* with a mixture of male and female genital features or congenital ambiguities; or b) 'eunuch' who was assigned male at birth but undergoes genital excision or castration; or c) a transgender man, transgender woman, *Khawaja Sira* or any other person whose gender identity or gender expression differs from social norms and cultural expectations based on the sex they were assigned at the time of their birth" (Redding, 2019). About 10,000 hijra live in Bangladesh (Hossain, 2017), but the total number of sexual and gender diverse people is yet to be estimated. There are other groups of vulnerable people such as the physically disabled, the aged, street children, and homeless people. However, I chose to study sexual and gender diverse communities because they are the only group of people who are widely stigmatised by culture, religion, and the state. Moreover, they remain undefined, uncounted and publicly threatened, unlike other groups of vulnerable people. This is because the government is not ready to accept their existence and rarely reports violence against sexual and gender diverse communities. The government, for instance, reports violence against religious and ethnic minorities in the United Nation's Universal Periodic Review but never reports the violence perpetrated against sexual and gender minorities (e.g. Office of the High Commissioner for Human Rights, 2018).

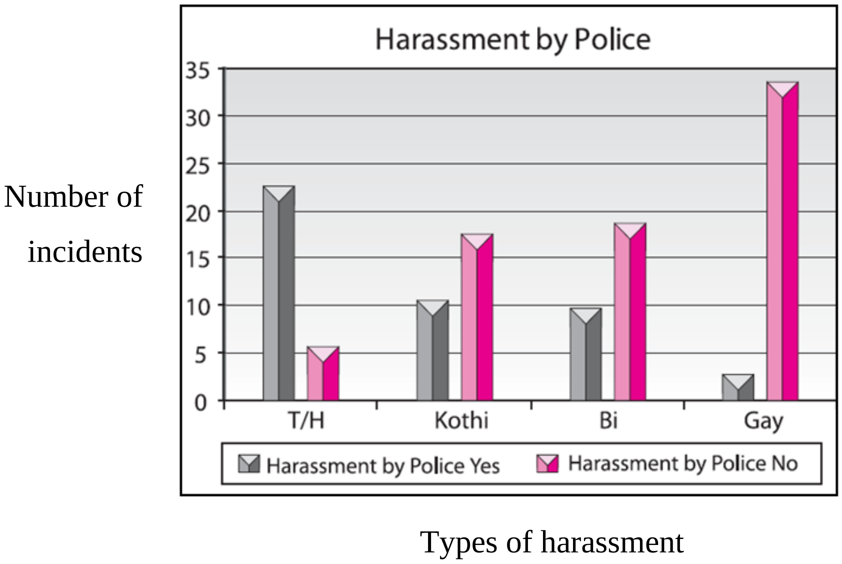
2.3.3 Public exposure: A two-edged sword

Since 2000, underground groups of gay men — mainly from the middle and upper-class — have formed, silently using public spaces and the Internet to meet others (Rashid, Standing, et al., 2011). Sanzum (2017, May 19) explains that sexual and gender diverse communities (except hijra) fear disclosing their identities because of being targeted by extremists. After the murders of Xulhaz and Mahbub, leading LGBT advocates either left the country or went underground, which brought more struggle for sexual and gender diverse communities. For the hijra community, public exposure is considered positive in order to gain recognition as a third gender. But public exposure for other groups of sexual and gender diverse communities remains dangerous. Hence, public exposure appears to be a two-edged sword with both positive and negative consequences, even in healthcare experiences. This paradox requires closer study and careful analysis since hijra are also a stigmatised group of people.

2.3.4 Harassment by police

Bondyopadhyay and Ahmed (2011) explain that prohibition of homosexual behaviour in Bangladesh exposes sexual and gender diverse communities to social oppression in the form of abuse, harassment, and rape. Figure 2.1 indicates the number of incidents and the categories of victims by harassment: T/H (transgender/hijra), Kothi (feminised males), Bi (bisexual) and gay.

Figure 2.1: Harassment by police in Bangladesh 2011



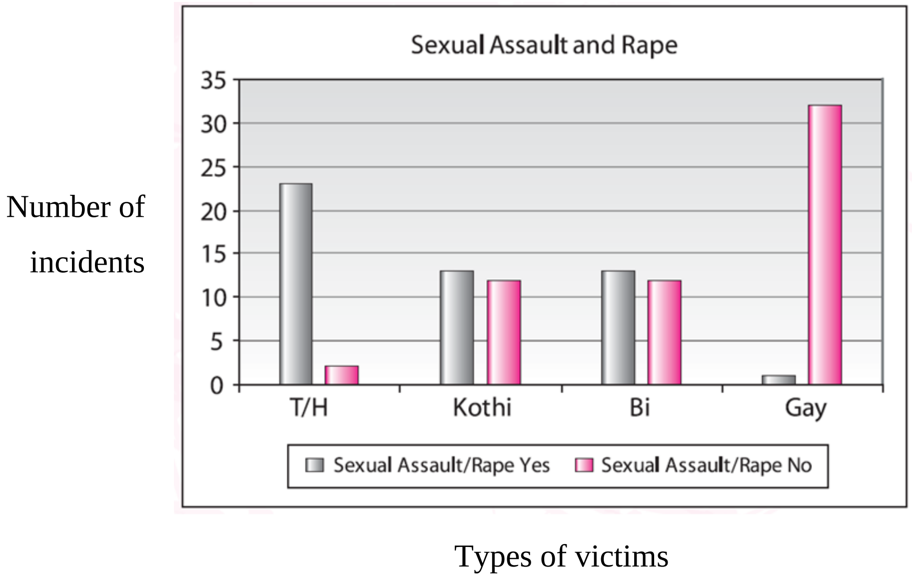
Source: Bondyopadhyay and Ahmed (2011), p. 21

Figure 2.1 shows that harassment by police of sexual and gender diverse communities is noticeable in Bangladesh. Extortion, beatings, threats, sexual assault, and restricted movement are major forms of harassment faced by sexual and gender diverse communities (Mendos, 2019). Harassment by police (shown in Figure 2.1) indicates brutality toward humanity. According to Odhikar (2018c), the total number of incidents of torture by all law enforcement agencies in Bangladesh was 67 in 2010, and 46 in 2011, gradually reducing to 29 in 2017; it is also reported that the harassment and torture by law enforcement agencies of the general public have been reducing in recent years. Moreover, a study needs to be made of whether or not the harassment and torture against sexual and gender diverse communities are also reducing.

2.3.5 Sexual assault and rape

Sexual assault and rape are also two major threats to sexual and gender diverse communities in Bangladesh (Figure 2.2). Odhikar (2018c) reported that the total number of reported rapes was 456 in 2009, 559 in 2010, and 711 in 2011. Odhikar (2018a) also found 13 reported rape incidents committed by law enforcement agencies in Bangladesh during 2009-2011.

Figure 2.2: Sexual assault and rape in Bangladesh 2011



Source: Bondyopadhyay and Ahmed (2011), p. 22

Figure 2.2 shows the number of sexual assault/rapes has been increasing in Bangladesh and law enforcement agencies are playing a part in this. It is not clear from the data if the sexual assault/rape is of a female or male person. Raping a male person is same-sex behaviour, but it could be either the desire for same-sex sexual satisfaction or the expression of male dominance that motivates these rapes. For example, during war, victors rape defeated soldiers to humiliate them by treating them like females (Edudivers, 1998). Similarly, perhaps police rape male persons as a form of humiliation and insult. Additionally, the statistics of rape reported by Odhikar (2018a) do not separately show male-to-male rape. Rapes committed by law enforcement agents of sexual minority (male) persons are not counted, possibly because to count them would require the government to acknowledge that such rapes occur. However, Bondyopadhyay and Ahmed (2011) recommend that government agencies and policymakers need to take immediate precautions to prevent rape and assault in sexual and gender diverse communities.

Studies regarding public exposure, harassment, and rape by police towards sexual and gender diverse communities are discussed because healthcare experiences are intertwined with each of these aspects. Healthcare cannot be delivered appropriately if one is not comfortable enough to expose their sexual identity. Harassment and rape of sexual or gender minority persons also have negative health consequences. While understanding healthcare issues of sexual and gender minorities from different perspectives, we can assess how healthcare is theoretically understood in terms of human rights. Furthermore, patriarchy, the Islamic notion of human rights, and rights-based practices are discussed theoretically in the next sections.

2.4 The legacy of colonialism and patriarchy

2.4.1 Theorising patriarchy

Patriarchy implies that men not only rule the women in the family but also the younger men (German, 2006). The understanding of patriarchy from theoretical aspects is a broad spectrum. However, scholars discuss several theories of patriarchy. For instance, a post-classical theory of patriarchy is based on historical incidents in China’s Ming Dynasty where widowed women were not encouraged to marry again (Lin, 1935/2010). Despite the fact that societal power was evenly distributed in the religious domain in ancient Japan, the then Japanese emperor shifted the modes of Japanese worship to prioritise the supremacy of male deities by suppressing the goddesses and their spiritual power: this created a patriarchal revolution (Ellwood, 1986). From a modernist theoretical perspective, many scholars during the 16th and 17th centuries agreed with Aristotle’s idea of the status of women in society. It was not until 1680 that theorists began to address political obligations based on the patriarchal family. In that year, British political theorist Sir Robert Filmer’s *Patriarcha* defended the divine right of kings by assuming it was inherited from Adam, the first man of the human race based on Judaeo-Christian beliefs (Schochet, 2020, December 22). However, this belief was challenged in the latter half of the 18th century as theorists considered that both mothers and fathers had responsibility for the children and family matters.

One of the most prominent theories of patriarchy is a feminist theory that is primarily based on the concept of women's oppression. According to radical-libertarian feminists (e.g. Shulamith Firestone), women should take control over reproduction so that women can be emancipated from male oppression: men tend to take the power over women's sexuality and reproductive capacity, which is an outcome of patriarchy (Lerner, 1986). Other scholars argue that capitalism and patriarchy work together to oppress women. Many Marxist and socialist feminists state the term 'patriarchal capitalism' to clarify the relationships between a patriarchal system and capitalism to reinforce women's oppression (Tong, 2019).

Some feminist scholars discuss biological factors to justify male dominance, which is further noted in the biological theory of patriarchy. Estrogen and testosterone are female hormones and male hormones respectively that play important roles in developing the human brain and behaviour. They also influence masculinising and feminising attitudes in human behaviour: for instance, testosterone causes aggressive, dominant sexual behaviour (Ellis & Hoskin, 2015). This biological characteristic of humans implies that men are biologically dominant by nature. To critique biological theory, sociologists disagree with the biological impact on gender roles because socialising functions are mainly responsible for defining gender roles in society (Henslin, 2019).

The sociological theory further discusses the divergence of sexual egalitarianism with economic factors (Goldberg, 1989). However, sociological constructions are pronounced in society with traditional cultures and less economic development (Macionis & Plummer, 2012). In contemporary societies, gender messages carried by mass media, family and other institutions significantly support male dominance (Henslin, 2019). Lastly, for our purposes, the psychoanalytic theory emphasises that the revision of the neurotic family as described by Freud uses the analogy of the story of Oedipus (Mulvey, 1989). Those who fall beyond the Oedipal triad of father/mother/child are less subject to male authority (Butler, 2000). The distribution of power in such incidents is often performed psychologically and unconsciously. From a psychoanalytic point of view, patriarchy is interpreted as the 'rule of father'. Some scholars believe that patriarchy not only refers to the males' control over females but an expression of the dominance of age and gender (Ehrenreich, 1992).

Perhaps such psychoanalytic influence of patriarchal expression of dominating gender is relevant in this research to understand patriarchal oppression of sexual and gender diverse communities. However, while attempting to theorise patriarchy, Feldman (2001) relates the feminist theory for the interpretation of male dominance based on women's movements and their participation in the labour market (the garment sector of Bangladesh). But investigating patriarchy from a different theoretical perspective to understand how the patriarchal system tends to oppress sexual and gender diverse populations is equally important.

2.4.2 Relationship between colonialism and patriarchy

To discuss the relationship between colonialism and patriarchy, I consider the concepts of colonialism and masculinity from the Bangladeshi context. In general, colonialism refers to a system or practice of control and domination over other people and regions (Osterhammel, 2005). The controlled or dominated regions are known as colonies and the purpose of establishing colonies is to obtain economic dominance (Rodney, 2018). During British colonialism, the British Regime colonised the South Asian region to expand their economic dominance and gradually imposed their religious beliefs, language, economics, and other cultural practices on people in this region (Barrow & Haynes, 2004). The nature of colonialism can be twofold: external or foreign colonialism, and internal or domestic colonialism (Gordon, 2006). External colonisation refers to the exploitation and oppression of indigenous people by foreign authorities, and internal colonialism oppresses minority populations within a polity or society (Spencer-Wood, 2016). Despite the external colonisation of the British Regime in the South Asian societies, internal colonisation can still be maintained by oppressing marginalised populations. British colonialism may have further influenced the socio-cultural structure in Bangladesh, particularly by shaping the attitudes around masculinity.

Masculinity is a set of roles, behaviours, traits and attributes associated with men in different contexts and location that attests to their quality of manliness (Jaiyeola & Isaac, 2020). The expression of these attributes and traits is reinforced when men exercise of their power over women; when this occurs over time and in multiple places, this socially embedded privileging of male power is referred to as ‘patriarchy’ (Connell & Messerschmidt, 2005). If these traits and attributes are passively expressed (e.g. taking receptive roles in sexual behaviour), it is understood as subordinate masculinity, which is devoid of power and challenges patriarchal expectations of the ideal man (Gurfinkel, 2012). Since the practice of masculinity is dynamic and can differ by race, class, and time (Gurfinkel, 2012), perhaps there is a particular Bangladeshi dominant masculinity based on Bangladeshi or South Asian culture. Bangladeshi culture may therefore be described as a complex interaction of historic patriarchy, colonialism, pressure to modernise or westernise socio-cultural and political practices, and the impact of religiously conservative attitudes of the general population, therefore making it difficult to identify a specific type of masculinity in practice. However, the type of contemporary masculinity adopted by the Bangladeshi society is mostly influenced by British colonialism. The racialised colonial norms of treating women of colour as slaves and objects (Benard, 2016) were imported to the South Asian region by the British Regime, and were later reinforced by the previously held patriarchal culture supported by religious beliefs and rituals.

Not only the masculine attitudes but the religious behaviour and local politics have been influenced by the British Regime. The British invasions of Java (1811) in today’s Indonesia, and Kandy (1815) in today’s Sri Lanka are two examples where assistance from India was evident to gain control over colonial conflicts; therefore, ‘British India’ gradually became the maritime frontier, enabling the British Regime to take greater control of the Indian subcontinent (Sivasundaram, 2020, p. 229). This control over the subcontinent region steadily expanded in a way that impacted other South Asian societies, particularly in the domains of local politics and religious orders (Sivasundaram, 2020, p. 229). Therefore, the colonial legacy and construction of a post-colonial state, particularly in the South Asian nations, substantially affected the understanding of sexuality, healthcare, and sexual health of sexual and gender diverse populations. The societies and states that underwent the historical experience of decolonisation — a process of British withdrawal and recognition as independent nations — in the mid-to-late twentieth century are often defined as post-colonial states (Memmi, 2013), thus Bangladesh is referred to as a post-colonial state in this thesis.

Scholars have yet to sufficiently investigate the malevolent synergies between colonialism and marginalisation (Mulé et al., 2009). Although the South Asian societies were predominantly patriarchal during pre-colonial history, sexual and gender diverse communities were not penalised. But the British Regime successfully used Islamic interpretations to legalise the oppression of sexual and gender diverse people by introducing Section 377. As a post-colonial state, Bangladesh has maintained this punitive law even though it gained independence almost five decades ago. Other post-colonial South Asian states (India, Pakistan and Sri Lanka) have also maintained this law. However, India repealed Section 377 in 2018 and Sri Lanka and Pakistan have started to repeal this law, whereas the Bangladeshi government has yet to make an effort to do so. This indicates that the colonial values are still predominant not only in socio-economic aspects but also in the legal system. Religious interpretations are used to define the status and position of women in the South Asian region (Cain et al., 1979). As a result, a male-dominated society has attempted to oppress not only women but also people who present any gender roles other than male. Gradually, as a post-colonial state, Bangladeshi society continues to serve the patriarchal interest that has existed since the Mughal Empire, or even before, and was further maintained by the British Regime. Therefore, this oppression may affect the deprivation of fundamental rights of marginalised populations, including the right and access to healthcare.

The relationship between patriarchy and colonialism contributed to how women were treated in South Asia. According to the feminist scholar, Stoler (1989), ‘who could bed and who could wed’ was one of the fundamentals in the construction of a colony. In other words, women of colour could be involved in concubinage and prostitution but only white women could be married; such a colonial norm exposed women of colour to sexual exploitation through the system of concubinage and rape (Benard, 2016). These racialised gender norms were imported into the South Asian region by the British Regime and since women in this region were not white, they were mostly regarded as objects or sex slaves. As several religious interpretations of Islam and rituals like *Sati* from Hinduism had already helped to maintain male dominance in the South Asian region, it was therefore easy for the British Regime to reinforce their racialised gender norms on women and preserve patriarchy.

Benard (2016) explains that patriarchal colonialism is a system of white patriarchy that is violent and exploitative. It also refers to the double oppression of women because they have to deal with both sexist and racist attitudes (Guerrero, 2003). Patriarchal colonialism greatly relies on ‘ownership’ of black and brown bodies which can lead to the systems of structural violence that routinely violate human rights (Benard, 2016). An additional consideration in the present project is whether patriarchal colonialism contributes to the denial of equal healthcare to sexual and gender diverse communities and, consequently, whether there is any evidence of a systematic denial of human rights to these communities.

Since the relationship between colonialism and patriarchy contributes to the oppression of women, I searched for literature on the experiences of women sexual or gender diverse individuals in Bangladesh. Some may be found in ‘grey literature’ such as theses, reports, or the general media, but little has been published in the peer-reviewed literature. As this thesis is not about women but about sexual and gender diverse communities, I do not include the ‘grey literature’ about women sexual and gender diverse individuals. There is a lacuna in the academic literature on sexually diverse persons in South Asia who present as women; the present research attempts to address this gap by specifically seeking to include participants who identify as lesbian as well as transwomen.

2.5 Human rights and rights-based practices

2.5.1 Philosophical views of human rights

According to UDHR, the right to health and healthcare is one of man’s most fundamental needs as well as a human right (Global Citizenship Commission, 2016). Human rights are a set of ethical standards that help to measure the methods that governments use to treat people (Husak, 1985). But the debate regarding the origin of human rights continues: rights are either natural/inherited, or they are outcomes of state laws (Campbell, 2013). The idea of natural rights was developed by Aristotle. Thomas Aquinas was the leading contributor to the idea of natural rights in his *Summa Theologica,* published in 1485. But in 1651, Thomas Hobbes offered the critique that God did not seem to influence the State of Nature, including the political activity of human beings (Grotius, 2012). Immanuel Kant critiques Hobbes’ work in the 17th century: a state-structured society was a congregation of people to protect everyone from violence against each other (Kant, 1970).

La Déclaration universelle des droits de l’homme (The French Declaration) in 1789 acknowledged 17 rights as natural and sacred. Burke (1890) critiques the *Declaration* that rights were the advantages won within every individual society because the rights among French and English were different as they emerged from different political fights through history. Paine (1791/2012) defends the *Declaration* as he distinguishes the concepts of natural and civil rights. "Natural rights are those which appertain to man in right of his existence" and "civil rights are those which appertain to man in right of being a member of society" (Paine, 1791/2018, p. 68). However, Bentham (1843) argues that rights were formulated by laws of the state so there could be no natural rights. The purpose of the state's laws is to allow society to protect the people because the role of the state is to safeguard the rights that people are unable to defend (Rousseau, 1762/2018). Nevertheless, Waldron (2014) argues that rights are concoctions of bourgeois society where a human being was detached from society, and capitalist states needed rights to protect individuals from the state (As cited in Heard, 1997).

According to Waldron (2014), human rights may not be universal because they are founded by Western societies, and are based on Western values that believe human beings are detachable from the society. There are three generations of human rights. The first generation of human rights emphasises freedom and participatory principles in political life leading to civil-political rights; the second generation of human rights focusses on equal treatment and opportunities that lead to socio-economic rights including healthcare (Vasak & Alston, 1982). The third generation of human rights is developed by the principle of fraternity that brings collective-developmental rights involving a set of rights that is universally recognised by agreement and treaties (Vasak & Alston, 1982).

2.5.2 Human rights theories

Rights that are inherent to all human beings regardless of sex, race, nationality, ethnicity, religion, language or any other status are known as human rights; some example of human rights are right to life and liberty, freedom from torture, freedom of opinion and expression, right to health, work and education (United Nations). Human rights are referred to as central and fundamental principles of social work in the *Global Definition of Social Work* in 2014, *Global Agenda of Social Work and Social Development* and the *Global Social Work Statement of Ethical Principles* — the global professional social work organisations (Androff, 2018). Theories relating to human rights are developed from the notions of dignity, human development and well-being, and human existence. But the human rights framework in Bangladesh mostly follows a universalistic approach (Noh, 2017). This approach claims that rights are similar in every socio-cultural context and should apply to everyone no matter their race, gender, colour, ethnicity or background. However, Donnelly (2013) writes that human dignity is the core foundation of human rights. This foundation is also endorsed by the *Global Social Work Statement of Ethical Principles* approved by the International Foundation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW) in Dublin, 2018 (International Federation of Social Workers, 2018).

Human dignity is a moral vision of human rights: rather, Gewirth (1985) states that "agency or action is the common subject of all morality and practice". Human evolution and human development are stressed by O'Manique (1992): if one wants to survive then one needs to develop for the fulfilment of life. Galtung (1994) explains that perhaps all humans enjoy human rights with the requirements of their physical subsistence. But this physical existence can ensure a minimum degree of comfort despite keeping one's body functional, as human existence also consists of being capable of functioning. Theories based on dignity and development are inspired by the urgency of promoting quality of life. Feder (2014), for instance, discusses that dignity is a central ethical principle to approaching surgical management of infants born intersex; this approach is adopted from the International Criminal Court in the Hague, which redefined rape as a war crime because it violated the dignity of a woman. On the other hand, the subsistence basis of human rights draws attention to a general perspective of surviving life itself (Heard, 1997). But the most common fact among all these understandings and inspirations is the subsistence rights because they are relevant to dignity, development, and well-being, which value adds to protect the qualities of life that reflect on rights to subsistence.

Why human rights in this research?

This project has adopted a human rights framework due to a rising trend over the last decade of social work literature that includes human rights (Androff, 2018). Contemporary social work curricula have come to gradually focus more on human rights issues, particularly on healthcare. Social work and human rights also share many common founders: a common history of origins and similar ethics and priorities (Albrithen & Androff, 2014; Healy, 2008). The role of social work can help to promote healthcare as a human right (Healy, 2008), which inspired me to consider a human rights approach. Despite there being an interrelationship between human rights and social work, there are few limitations to taking human rights as a theoretical approach.

Limitations of human rights

Many scholars have criticised human rights as fictional, slippery, and tricky concepts. Different types of human rights, and their philosophies and theories, are criticised because of the different interpretations in diverse socio-cultural contexts (Mutua, 2002). Perhaps, the variation among cultures is an issue in the human existence theory of human rights. For example, needs may differ, and even the nature of healthcare practice may be interpreted in different ways in different regions (Preis, 1996). Professionals in social work and human rights settings may lack awareness of each other (Androff, 2018). Another challenge is the division of the three generations of human rights into civil-political, socio-economic (healthcare), and collective rights. These divisions have emerged from the Cold War between the USA and Soviet nations (Saito, 1996). The division of rights into these categories is a drawback for an interdependent and holistic understanding of human rights and healthcare. Brown (1997) writes that there is also a challenge to the universalistic notion of human rights because rights are only seen as products of Western societies.

2.5.3 Islamic notion of human rights and justice

In the 7th century, the Caliph Ali ibn Abi Talib wrote to Malik al-Ashtar, the governor of Egypt, emphasising the model of Islamic governance to treat the people justly and equally. According to Shah-Kazemi (2006), this letter identified the needs of people who have no resources, such as the physically disabled, destitute, orphans, and the elderly — those who are most in need of justice (As cited in Keshavjee, 2016, p. 613). This indicates the care for people who are poor, disadvantaged and marginalised has an extensive, if implicit, history in Islam. The concept of justice in Islam was emphasised even in the 7th century, inferring that Islam must be used for social justice for marginalised people instead of using contestable interpretations to oppress them.

Littman (1999) explains that the universalist approach to human rights is criticised by the Cairo Declaration of Human Rights in Islam (CDHRI). CDHRI emphasises basic human dignity that prevents discrimination in social life. Traditionally, an Islamic approach to human rights can differ from a universalist approach of human rights because freedom of expression and association for sexual and gender diverse communities is often denied in Islamic societies (Littman, 1999). As criticism of CDHRI, Kurtz et al. (2009) explain that the importance of free expression and prevention of minority harassment in Islamic nations are overlooked. CDHRI is not universally acknowledged, even in Islam, because many Islamic countries, including Bangladesh, do not strictly follow Sharia laws. Despite Islamic beliefs about human rights, they are important in this research because these rights do not allow any form of discrimination, and emphasise providing support for marginalised populations (Mayer, 1994).

2.5.4 Rights-based practices: Research and action

To empower marginalised people to secure their rights, rights-based practices can be influential. Love and Lynch (2018) write that a conceptual framework of human rights-based practices aims to empower people to identify and claim their rights by improving the capability of the individuals. The Office of the High Commissioner for Human Rights (2006) defines a rights-based practice as a conceptual framework for the structure of human development that is standardised on universal human rights and aims to promote and protect human rights. A rights-based practice is determined to promote health, well-being, and social inclusion of marginalised groups of people such as sexual and gender diverse communities (Forbes-Genade & van Niekerk, 2017; Gauri & Gloppen, 2012). In this thesis, the term ‘rights-based practice’ is used to refer to the rights-based approaches that can be used interchangeably as rights-based frameworks or movements or campaigns. Healthcare issues for marginalised populations is one of the most useful fields of research for the rights-based practices (Broberg & Sano, 2017; Choondassery, 2017). Therefore, social workers who work for the health and well-being of marginalised people also play a useful role as policy officers/advocates or group activists in political change, which can be beneficial for policy development (Ife, 2012). Social workers/researchers can utilise rights-based practices to emphasise five major aspects that help to promote rights: dignity, non-discrimination, participation, transparency, and accountability (Androff, 2016). Moreover, Sheldon (2017) explains that health and rights are inextricably linked. Healthcare and public health are key to working with rights-based practices by social workers/researchers.

Challenges of rights-based practices

An action-based social researcher or practitioner can undoubtedly face difficulties in advocating policies or healthcare as a right for stigmatised populations. Ife (2012) writes that social workers and human rights workers are exposed to threats such as kidnapping, torture, arrest, and imprisonment without trial while working for stigmatised people. Furthermore, in many cases a social work practitioner or researcher might be unable to perceive and understand the problems of marginalised people from their perspectives. Thus, an action-based approach could be problematic due to the epistemological differences between the researcher and the target population. One can still question why I did not use a justice or transitional justice model that emphasises accountability and compensation for the healthcare of marginalised people as the main analytical framework. For clarification, although I did not use a justice model as the main analytical framework, I made a connection between the participants' rational choice of disclosure with justice models, which is described in the discussion chapter (see section '8.2 Health, justice, and patriarchy' in Chapter Eight). I considered rights-based practices more relevant as they can empower sexual and gender diverse communities to play an active role in their futures rather than depending on authorities to promote healthcare rights. A rights-based practice is the first step, and then other frameworks could follow.

2.6 Summary

Based on existing literature, this chapter provided critical understandings of the major facets of this research. The analysis of secondary literature was also essential to develop a deep understanding of the healthcare and healthcare system in Bangladesh. I reviewed existing literature relating to the sexual and gender diverse populations and their situations relating to public exposure, harassment, and sexual assault and rape to demonstrate what has been happening in recent years. This chapter also discussed the theories of patriarchy and the relationship between colonialism and patriarchy in the Bangladeshi context. I then discussed theories and philosophies of human rights and their limitations, and reviewed theories of healthcare and rights-based practices and their challenges.

Chapter Three: Research Methodology

3.1 Introduction

Investigating healthcare experiences of sexual and gender diverse communities can help us understand if healthcare is a human right or can be used as a tool for oppression. The research question focuses on how sexual and gender communities live in a patriarchal society, how these communities experience healthcare, and how these experiences can help us to understand the continuing influence of patriarchy and colonialism in Bangladesh. It is necessary to describe the methods and techniques I employed to address the questions that I am proposing. To explore these issues, I employed qualitative research methods including interviews, a focus group discussion (FGD), and key informant interviews (KIIs). The methodological choice was one of the biggest challenges in my project because the target population is publicly threatened, and not easily identified and reached. In this chapter, I discuss interpretivism research philosophy, the study area, participant recruitment, the data analysing process, and ethical issues. This chapter also discusses the research philosophy, epistemology and methodology. I also review the limitations from the methodological point of view so that the readers can understand what I did, and what could have been done differently. I further describe the research methods and research design and I include a fieldwork journal that elaborates the challenges of fieldwork and strategies to overcome them.

3.2 Research philosophy

Interpretivism and social constructionism are two branches of research philosophy that are relevant to this research. Despite similarities between these two research philosophies, there are also some dissimilarities in their application in social research. Early in the process, I considered applying positivist research philosophies in this research. But the reason I did not want to apply a positivist research philosophy was because I did not want to have a pre-existing assumption about the findings and I wanted to be led by my data: consequently, I was encouraged to follow interpretivism and social constructionism.

Interpretivism

To understand interpretivist research philosophy, we must examine the basic question of a research paradigm. Guba and Lincoln (1994) stress that what is the reality of the subject matter (healthcare)? This question is also considered as an ontological query. The belief of reality discussed by ontology is whether there is a single reality or no single reality of the subject matter (Scotland, 2012). However, interpretivist research philosophy allows a researcher to examine the subject matter from multiple realities with diverse interpretations. The exploration of healthcare experiences of stigmatised people is an attempt to fill the knowledge gaps about understanding how vulnerable groups are treated in Bangladeshi society. Saunders et al. (2012) write that interpretivism allows the researcher to differentiate between individuals in their roles as social actors. They add that interpretivist research philosophy holds that there is no single reality because the reality of a subject matter (healthcare) may vary in terms of different contexts, cultures and people. This philosophical standpoint is essential to obtain a shared understanding of the research topic by understanding the lived experiences of the participants (Jackson et al., 2018). Interpretivist research philosophy is a good fit for my research because the meaning of healthcare is considered from a number of different perspectives and contexts. For example, healthcare is not only regarded as a treatment process for sexual and gender diverse communities but is often considered as a tool for social control by the government, and a way to dehumanise stigmatised people by healthcare providers. Therefore, healthcare experiences are investigated from multiple aspects through descriptive and qualitative narratives, which is an application of interpretivism research philosophy.

Social constructionism

Since I considered healthcare from multiple perspectives, this created a connection with social constructionism. Social constructionism proposes that reality is socially constructed in context (Scotland, 2012), and emphasises that knowledge emerges through the interactions of people with the environment in the course of experience (Bastalich, 2020). This research philosophy is quite similar to interpretivism and is also a good fit in my research because different contexts may indicate different realities and understandings of healthcare. Both social constructionism and interpretivism are often called ‘interpretive’: this is because both these philosophies aim to understand the way individuals make meaning of their experience. Interpretivism examines a different emphasis on the empathic understanding of the cultural context, and social constructionism is based upon the mediation of social interaction and language (Bastalich, 2020). Nevertheless, social constructionism is slightly different from interpretivism in its emphasis upon social interaction and language as mediators of meaning.

3.3 Epistemological stance

Epistemology of research addresses how we get knowledge and what the theory of validating knowledge is (Guba & Lincoln, 1994). Since participants experienced healthcare in different ways, clearly there is no single unitary meaning of healthcare or understanding healthcare; thus there is a need for interpretation of the research question and the responses. I listened to the healthcare experiences of sexual and gender diverse communities and opinions from healthcare providers and people who work with this issue. My epistemological stance was iterative and evolved throughout the project. The epistemology I chose is interpretivism in order to have a shared understanding of the healthcare experiences through hermeneutics, symbolic interactionism, and phenomenology (Scotland, 2012). An interpretivism epistemic framework is appropriate because it prevented me from anticipating the findings or forming an assumption. I kept myself open to different directions of findings and was led by data rather than preconceived notions. I did not just want to hear participant experiences but to understand the meaning that participants make of those experiences. Thus, I co-constructed knowledge with sexual and gender diverse communities by encouraging and co-creating a shared understanding of healthcare experiences and the oppression that is happening in Bangladesh. I also considered using a positivist epistemology, but it was almost impossible to collect statistical data with a sufficiently robust sample. This is because sexual and gender diverse communities are hard-to-reach communities in Bangladesh, so I had to discard the choice of positivist epistemology at the outset.

3.4 Phenomenological methodology

The methodology of the research is phenomenological, which is based on the lived experiences of sexual and gender diverse communities in the healthcare sector. Phenomenology can be categorised into two types: interpretive and descriptive. Descriptive phenomenology, introduced by Husserl, a German philosopher, is defined as the situation where “everyday conscious experiences were described while preconceived options were set aside” (Reiners, 2012, p. 1). Nevertheless, a researcher can often hold preconceptions about the research issue (Merriam et al., 2001). Following a descriptive phenomenological approach demands the researcher set aside any personal assumptions and preconceptions. In contrast, interpretive phenomenology is a concept promoted by Heidegger, a German philosopher who supported the concept of being in the world rather the knowing the world (Reiners, 2012). This type of phenomenology aims to understand the meaning of certain phenomena being studied where the investigator “does not bracket their bias or prior engagement with the question under study” (Reiners, 2012, p. 2). The purpose of interpretive phenomenology is twofold: to understand the participants’ world and describe what it is like; and to interpret such understandings in the participants in the context of their larger socio-cultural settings (Larkin et al., 2006). In this study I co-created meaning with sexually and gender diverse communities for the phenomena this research studies, thus an interpretive position is more suitable. However, phenomenology can sometimes reject the claims of social constructionism and interpretivism that people may not get beyond cultural awareness in their experience, aiming to interpret phenomena as it appears in their conscious minds, or in their immediate experience (Bastalich, 2020).

3.5 Positioning as a researcher

Positionality is an important factor in qualitative research that needs to be discussed to explain the positioning of myself as a researcher. Since I am originally from Bangladesh, I consider myself as an insider in Bangladeshi society. I know the socio-cultural context very well, and how people behave and act toward sexual and gender diverse communities. On the other hand, even though I am a Bangladeshi, I am not a sexual or gender diverse person. Hence, I also consider myself as an outsider because I never lived with the stigma and fear of disclosing my sexual and gender identity. This has put me in an ‘open field’ where I did not know what the experiences and findings were going to be.

According to Merriam et al. (2001), either being in an insider or outsider position can have both advantages and disadvantages as a researcher. However, in this research I, as the researcher, hold the position of both insider and outsider. Due to my insider-outsider positioning in this research, I admit that I might have had some preconceptions regarding the participants and the research issue. However, I dealt with the complexities that I could have had as an outsider by learning and understanding the worldviews of the participants through volunteering experiences and community engagement. I utilised the benefits of being an insider to apply my socio-cultural knowledge and native language to maintain fluent communication and negotiation for building rapport, gaining trust, and obtaining access to potential participants.

For this research, direct in-person negotiation and communication by someone from the same socio-cultural setting who speaks the same language and perceives the contexts of the culture made it possible to understand what was being communicated. Hence, a non-Bangladeshi researcher is very unlikely to be able to understand or make meaningful sense of the language and expressions shared by the participants. This kind of positioning as a researcher is very important in qualitative research to make sense of the full array of the meanings shared in the interviews (Costley et al., 2010). I collected, analysed, and presented the data (including participants’ excerpts) in Bengali, with English translations available in this report for non-Bengali readers. I did this because I planned to make sure that I maintained the integrity and subtle meanings of participant experiences in their own language and vocabulary and did not impose the hermeneutical problem of translating and then analysing in English.

My positioning as an insider and outsider at various levels is relevant to participant observation as I was able to observe and learn throughout the volunteer involvement process. I am aware that a researcher is likely to develop relationships and allegiances during this involvement process. In my fieldwork and data collection activities I built relations with key informants and participants through trustworthy behaviour and an empathetic attitude. This — in some cases — made me feel somewhat morally obligated to help participants who were in need of assistance to find employment. Nevertheless, as a social work researcher, I maintained my professional boundaries and I was aware that I was not allowed to extend my relations with key informants and participants to a personal level. In situations when I thought such boundaries were hard to maintain, I had to explain to the key informant or participant what I am ethically and professionally expected and allowed to do as a researcher. Therefore, I was able to maintain professional relationships with key informants and participants.

3.6 Qualitative research approach

A phenomenological research methodology using an interpretivist philosophy can be effectively conducted by a qualitative research approach. The explanation of particular social norms can be critically and diversely discussed through qualitative analysis that requires specific tools and techniques (Lune & Berg, 2017). Many people would consider that healthcare discrimination against marginalised communities is a common incident in Bangladeshi society, which attempts to justify the oppression of marginalised communities as a social norm. Qualitative methods can help to examine such norms, which are often overlooked by mainstream society. Qualitative research is popular among social scientists because it helps to investigate the meaning of actions, attributes, behaviour, and interactions of people (Godwill, 2015). Thus, I chose to apply this research approach in order to understand how sexual and gender diverse communities experience healthcare in terms of social norms, behaviour, and attitudes to diverse gender identities.

Qualitative research methods are considered to be effective ways to understand people and their lived experiences within their frames of reference (Taylor et al., 2016). Similarly, McLeod (2001) explains that qualitative study can produce new ways of understanding and perceiving issues in the social world. For this research, it was essential to explore individual understandings of the participants about their worldviews, and how they conceive healthcare. According to Teddlie and Tashakkori (2009), a qualitative research approach involves the collection, analysis, and presentation of narrative information in a way that respects the experiences and understandings of participants. Qualitative research methods were the best way to answer my research questions because I wanted to hear the stories and narratives of the participants and honour their experiences.

Qualitative research has the advantage of studying how people manage themselves in the community, and how other people of the community make sense of their existence through rituals, symbols, and social roles and structures (Marshall & Rossman, 2006; Strauss & Corbin, 2008). Another benefit of using a qualitative method is to collect information by human experience and observation. This kind of information is very important in this project for interpreting how sexual and gender diverse communities experience healthcare. There are disadvantages of qualitative research including (a) qualitative data robustness is comparatively complex for interpretation and assessment, and (b) new or unexpected data may distract the researcher in different directions. Healthcare issues can be complex and can be compared to ‘smoke’ that does not stand still in order for us to understand it. Therefore, we depend on qualitative methods and analysis to go deeper and capture the ‘smoke’.

On the other hand, quantitative data have been frequently and traditionally used to look for a single understanding of truth or reality (a positivist view) with a pre-assumption or hypothesis. But the purpose of qualitative research is not to arrive at a single reality, but to understand the meaning of reality for each individual, which may lead to multiple understandings and perspectives of reality. However, positivist thinkers would argue that there is only one reality, and qualitative data may not be so scientific because it does not often give us the answer that there is one reality (Cheek, 2007). However, this depends on one’s understanding of ‘science’. If ‘science’ refers to knowledge, quantitative research uncovers only one kind of knowledge, whereas qualitative research allows for many different kinds of knowing and knowledge. I employed qualitative methods, not in an attempt to uncover one reality or one kind of knowledge but to try and understand the phenomena in question more deeply. The phenomena I interpreted were the healthcare experiences of sexual and gender diverse communities. And every single person might have different understandings of healthcare.

3.7 Research design

3.7.1 Research area and population

The study area for this research is Bangladesh because, as a South Asian nation, this country has created a difficult situation for sexual and gender diverse communities. The absence of a robust human rights framework, the impact of social stigma, violence, and abusive behaviour against sexual and gender diverse communities are the paramount reasons for choosing this country. Members of all the sexual and gender minority groups in Bangladesh were the unit of analysis or target population in my research. There is also a need to understand why the government has continued to oppress sexual and gender diverse communities after the end of the British Regime. The legal jurisdiction in South Asia, especially in Bangladesh which fought for independence, continues to follow the colonial values against stigmatised populations. For this reason, this country was a good choice for this research area.

3.7.2 Recruiting participants

There are many challenges to conducting meaningful research with a marginalised group of people, especially with sexual and gender diverse communities (Meezan & Martin, 2009). Recruiting participants for data collection in sexual and gender minority research was the biggest challenge from a methodological point of view (Elze, 2009). Nonetheless, I took this challenge and planned to gather healthcare experiences of sexual and gender diverse communities. Becoming trusted by the participants, my positioning in this research, and the risks of public exposure of the participants and myself were the major risks while recruiting participants. Establishing contacts, networking, listening to their interests, and creating rapport with sexual and gender diverse communities were the keys to gaining trust, which enabled me to recruit participants. The participants bore the risk of exposing their identities, so I used a range of interviewing techniques, including online interviews instead of face to face, where they did not need to meet me in public or disclose their identities and details. I also suggested that they use an alternative account to communicate online to be more secure. For example, Ostitto suggested that we communicate using an Android application called ‘signal private messenger’, which is supposed to maintain confidentiality in our conversations. Ostitto is a community organisation that voluntarily helped me with community involvement and participant recruitment: the term ‘Ostitto’ (‘Existence’ in Bengali) is used to ensure the anonymity of this organisation.

I also encouraged face-to-face interviews for the participants to share their healthcare experiences where anonymity and confidentiality were ensured. I made sure human ethics and other ethical issues were strictly maintained to keep their identity hidden. I discuss the ethical approval process in the latter part of this chapter (see section ‘3.7.5 Ethical framework’ in this chapter). Yet, while making contact, I expected to be mistrusted — perhaps they thought I was a government informant or a fraud. By creating a bona fide (my supervisor), I was able to start communication with them. I contacted Bijito and Ostitto regarding my situation by being transparent about my identity, details, intention, and my supervisor’s details. Bijito is another organisation that voluntarily assisted me to build networks and collect data: the term ‘Bijito’ (‘Winner’ in Bengali) is used to ensure the anonymity of this organization. I had online meetings with key informants from Bijito and Ostitto and their responses were positive and encouraging for my fieldwork. These meetings gave me hope that I could recruit participants to obtain data about their healthcare experiences. Since I was trusted by them and my information sheet was prepared, I requested them to share it among their organisational networks so that interested participants could voluntarily contact me. There were other key individuals: an academic, a religious leader, a human rights activist, and a healthcare professional who were participants in key informant interviews. Also, to gain the trust of organisations and individuals, I supplemented the interviews with my own observations.

3.7.3 Data collection methods, tool, and relevant organisations

I worked as a volunteer for Ostitto as a part of my intended commitment. Active volunteerism helped me apply a participant observation method for data collection. This helped me to spend time with the participants and understand their issues from their perspectives. I also considered the potential risk of exposing myself publicly by working as a volunteer for them. But since I was working as a volunteer discreetly with Ostitto, my engagement with this organisation was not publicly exposed. *Roopbaan* is a magazine forum for the transgender community in Bangladesh which had accepted my request to be a volunteer to assist with their day-to-day events and be an anonymous blog writer for their website. But due to my engagement with Ostitto and other limitations, I was unable to work with *Roopbaan*. Giving Way is an international volunteer network that offers opportunities to work with the hijra community. I applied to work with them but did not receive a response. Since hijras are not threatened with public exposure, it could have been interesting to work with Giving Way as it would not have involved any potential threat for either the hijras or me.

I conducted 13 qualitative interviews with participants from all groups of sexual and gender minority people (lesbian, gay, bisexual, transgender, and hijra). Qualitative interviews helped me to gain deeper and shared understandings of the research issue (Punch, 2013). I utilised the findings of qualitative interviews to understand how human rights and a rights-based practice can be influential in terms of creating healthcare awareness about a marginalised group of people in a Muslim society. Owing to the strong patriarchal influences, no visible female same-sex subculture exists, and even in sexual and gender diverse communities there are very few identified lesbians (Rashid, Standing, et al., 2011). Thus, I assumed that publicly identified lesbian and bisexual persons are very rare in Bangladesh. I anticipated that it was going to be difficult to find and recruit participants from each of these groups. However, the networks of Bijito and Ostitto were extremely influential in helping me find and recruit participants from each of these groups.

In a qualitative study, focus group discussions have extrinsic benefits to gain effective research findings and outcomes (Stokes & Bergin, 2006). I conducted one focus group discussion (FGD) but this is where the organisational cooperation from Bijito and Ostitto was necessary. Since I was able to build a good relationship with these two organisations, it helped me to build trust and rapport with them. These organisations were used as community consultants or local advisors in my research. I requested them to arrange an FGD with potential participants. But FGDs usually have a challenge: if one participant wants to withdraw their response from the FGD, then it might disrupt the whole process. The data collector may then need to delete their opinions and any responses which were stated in response to their opinions. Therefore, an FGD runs the risk of losing the whole session. I managed this situation by making sure that the participants did not withdraw, so every participant was completely trusted to continue the session before I conducted the FGD.

Through face-to-face interviews, participant observation was performed as evidence of learned understanding (Tracy, 2010), symbolic interactionism, and level of comfort of the participants while sharing information, which also increased the data rigour (Kumar, 2011; Neuman & Kreuger, 2003). In many cases, phone calls or internet calls were used, and in such cases, informed consent was taken to share the information. The audio recording was used upon the consent of the participants for transparency of data collection. I protected this electronic form of data by uploading them to a password-protected cloud storage account (e.g. Google drive) just in case authorities confiscated this data from me. I did not reveal the existence of this cloud storage data to anyone in-country.

Key informant interviews (KIIs) were an essential technique to understand how people perceive stigma and react to healthcare services (Huggins et al., 2016). I requested the staff of Bijito and

Ostitto, and others who work on healthcare and sexual minority issues, to help me conduct four KIIs. From the outcomes of the KIIs I also tried to understand the influence of non-liberal cultural constructions on the existence, acceptance, and awareness of sexual and gender diverse communities. The results from interviews, the FGD, and KIIs assisted in the interpretation of healthcare experiences of sexual and gender diverse communities and provided an insight into how these experiences can help us to understand the continuing influence of patriarchy and colonialism in Bangladesh.

In terms of data collection instruments, I employed semi-structured interviews, an FGD, and KIIs to collect data. One-to-one interviews, particularly by using semi-structured interview guidelines, allowed flexibility to explore research issues effectively through the responses of the participants (F. Ryan et al., 2009). Despite using a semi-structured interview structure, I was mostly able to maintain an informal environment with the participants. Conducting formal and strict interviews might not have encouraged frankness in the participants' responses, which could have affected the honesty and truthfulness of their responses. Using semi-structured one-to-one interviews was also necessary because it helped me to maintain a flow of discussion as well as the participants feeling free to ask any questions in order for us to ensure a knowledge sharing session.

3.7.4 Data analysis

According to Saunders et al. (2012), analysis of the qualitative data can be accomplished effectively by following certain steps. These steps are transcribing data, using electronic (audio) data, using textual data including scanned documents, applying the inductive approach, summarising data, categorising data, unitising data, and structuring data by using narrative. I followed these steps to present and analyse the collected

data relating to healthcare experiences of sexual and gender diverse communities for the interpretations of the research questions. Hermeneutics, symbolic interactionism and an interpretive phenomenological approach were used for the data analysis. All these helped to gain better understandings and interpretations about how healthcare experiences of sexual and gender diverse communities help us to understand the continuing influence of patriarchy and colonialism in Bangladesh.

Participants expressed that they trusted my honesty, integrity, and judgment and that I would report their responses accurately, so they were motivated to tell their experiences quite honestly and openly. Data were collected in Bengali for the consideration of flexibility for the participants. Data transcription and synthesising were performed in Bengali as well to maintain the accuracy of the information. It took me about two months to transcribe (verbatim transcripts) the entire audio data on my own. Later, I created English translations of specific excerpts before adding relevant quotations (in Bengali and English) in the final research paper.

I anticipated that I might need to look at specific data or information repeatedly and going back into the whole transcripts and finding the specific information could be very exhausting. Thus, I created a codebook so that I was able to look into the vast amount of data within a minute by looking at the codebook to find specific information or excerpts. A codebook (a separate word document file) was created to make a tally of the generated codes in this research. This codebook was created by reading the transcripts repeatedly, and coded themes were also written in Bengali. I identified a total of 455 points under the category of 47 codes/ideas/sub-themes which came under three major themes. The codebook contained five major columns of information: a) serial number (455 points); b) subject idea or focus; c) page number, name of the document file, and line/sentence/paragraph number; d) sub-themes; and e) codes.

Processing the groups of common ideas or data that are similar in patterns, and then turning them into themes is called ‘coding’. Coding is usually a process of decontextualising transcripts and creating meaningful and useful coded materials; themes or ideas are identified either in an inductive way, which processes the data into codes or in a deductive way, which starts with theory and the produced codes either support or deny the theory (Braun & Clarke, 2006; Hesse-Biber, 2017). Once the codebook was created, the themes eventually emerged.

A thematic method of data analysis was used to create major themes and sub-themes of the research questions during the interpretation of the data (Kumar, 2011). This method was essential to process the data in a way where both explicit and implicit ideas gathered in the data were categorised into major themes and sub-themes (Braun & Clarke, 2006). Sub-themes were compared and revised, and then similar codes were grouped to formulate underlying themes. This method helped me to draw patterns and commonalities deriving from the gathered data.

Despite the relevance of previously mentioned steps of thematic analysis explained by Saunders et al. (2012), I can also relate that my analysis process was somewhat germane to the steps discussed by Braun and Clarke (2006). There are major four steps explained by Braun and Clarke (2006): a) transcription of the audio recordings; b) reading the verbatim transcripts, generating and revising notes; c) creating a codebook that contains codes, sub-themes and sources; and d) comparing, revising and merging similar codes into groups that became major themes of this research. The theoretical framework of information developed by the process of analysis became the underlying themes, which reflected the formation of findings and analysis chapters that follow.

3.7.5 Ethical framework

Meezan and Martin (2009) explain that the research findings cannot be considered as useful and valid unless the research is conducted ethically and responsibly. To ensure that this study was conducted honestly, responsibly, and ethically, I obtained full ethics approval (approval number NOR 18/58) from the Human Ethics Committee (HEC) of Massey University. This approval included respect and dignity of the participants, high trust, voluntary participation, harm avoidance, participant compensation, benefits, justice, and many other important ethical considerations. The ethical approval also examined ethical issues regarding accessing, storing and retrieving data. Ethical issues relating to *Te Tiriti o Waitangi* (The Treaty of Waitangi) are also addressed in the HEC review. Some of the key ethical issues are described below, in addition to how I addressed these issues.

Safety of the researcher and the participants

Participating in this research could mean potential danger for the participants due to the possibility of disclosure. The safety of the participants was ensured by complete confidentiality as I did not report any personal details or any identifiable information about the participants. However, my identity was disclosed to Ostitto and Bijito and I also disclosed my identity to their networks and the participants for trust-building purposes. However, I wrote online blog articles for Ostitto anonymously. I ensured that there was no public exposure in the media about the participants, me, or my research. Working as a volunteer for sexual and gender diverse communities secretly and discreetly reduced the risk of public exposure of the researcher. I address the issue of my own safety more fully in a later section of this chapter called ‘fieldwork journal’. My volunteer engagement was one of the key elements that helped me earn respect and trust from the participants, which is also further described in the ‘fieldwork journal’.

Principles and obligations from the Treaty of Waitangi

Relationships. Both Bangladesh and New Zealand are post-colonial societies. Hence, Māori in New Zealand and sexual and gender diverse communities in Bangladesh could be viewed through a similar lens of oppression of British colonialism. The findings of the research are reported with the merit of transferability in an attempt to make the readers feel as though the findings overlap with their own situation, and they spontaneously transfer the findings to their own context (Tracy, 2010). Therefore, the focus on healthcare experiences of sexual and gender diverse communities can articulate a practical implication of healthcare for queer people among iwi, hapū, whānau, and Māori communities (Hudson et al., 2010). I established and maintained consultation with one local expert (Pita King, a community-based Māori academic) among these communities to take advice from them to improve the sensitivity of my research to the Treaty issues.

Purposefulness. My research studied the role and pathways of healthcare for sexual and gender diverse communities. My research findings are essential for the Māori community to explore healthcare issues for takatāpui people within their community. I analysed the healthcare experiences to explore colonial and patriarchal influences, which can be beneficial for Māori communities to understand how healthcare rights or healthcare experiences of takatāpui people can be affected by colonial and patriarchal expressions.

Cultural and social responsibility. My research examined an issue that is culturally sensitive in terms of Bangladesh’s society. My research outcomes were effective to understand ways to create an inclusive society for every group of marginalised people. It can also represent how a marginalised group of people can be treated with respect and dignity in other communities like iwi, hapū, whānau, and Māori.

Justice and equity. Sexual or gender diverse persons from all societies can benefit from my research outcome. Though my study area is in Bangladesh, the findings can be related to how every group of marginalised people can be benefitted in terms of justice for healthcare in any other communities, especially the Māori community (Hudson et al., 2010).

Autonomous decision making

One of the most useful aspects of ethical considerations was to consider to what extent my research inspired the participants to partake willingly in terms of their values and beliefs. I made sure the participants were empowered to fulfil their cultural needs and ensured their cultural safety while participating. I maintained an autonomous process of decision making for the participants by following four major elements:

a) Emphasis on the participants' capacity to make decisions based on their values and beliefs
b) Providing sufficient information by which participants can decide to participate
c) Participants' decision is based on their total understanding
d) Pressures, bias or manipulation cannot exist so that the decision can be completely voluntary (Massey University, 2018).

Sexual or gender minority persons are considered vulnerable and are threatened with disclosure, so I maintained the element 'd' (above) with a strong commitment. I believe that depriving them of autonomous decision making and not having their voice heard is not good judgement. Other principles that I strictly maintained were: respecting the individual, respecting privacy and confidentiality, voluntary and informed consent, avoiding conflict of interests, and eluding redundant deception.

Ethics in Bangladesh

Although I had full ethics approval from Massey University, I was unable to identify an appropriate authority that could give ethical approval to collect data in Bangladesh. However, I approached one authority that can provide ethical approval only for funded research projects, not for independent academic research. I asked them how they can provide ethical approval for academic research since they do not have any authority to do so but I found the office unresponsive. Also, the amount of money required to submit my ethics approval was exorbitant, and the process seemed to be very time consuming and was not very meaningful. I felt that this might put me and the participants in more danger if I approached them again. Later I concluded that there was no institutional body that can provide ethical clearance for academic research in Bangladesh (Islam & Hajar, 2013). This may be because ethics, as conceived in developed Western countries, maybe a Western concept. Islam and Banda (2011) explain that there might not be any strict and universal standard ethics for academic research in some cultures as people's culture in a certain region and time need to be considered while following ethical standards. Likewise, data collection activities followed the ethical guidelines of the Massey University that emphasise the respect of the culture of the target population and communities.

3.7.6 Bangladeshi culture and language

Due to the stigmatising attitude toward sexual and gender diverse populations, I did not expect that many people in Bangladesh would take my research issue seriously. The socio-cultural construction is influenced by Islam, patriarchy, and colonial values that persist a punitive attitude toward these populations. Additionally, the political system is not very supportive or accepting of these populations, which is expressed by the continuation of Section 377. Hence, I was prepared that my research issue would not be publicly accepted by many people and I experienced mockery on several occasions while sharing my research interests. Greenberg (1988) states that researchers can have anxiety that they would be suspected of being homosexual if they show interest in studying anything related to homosexuality. However, these cultural complexities brought new insight into my research. My passion for this study was very professional from a social work point of view as well as very personal due to my passion for equality, human rights and justice. The barriers I faced due to the socio-cultural practices further boosted my determination to progress with this research.

According to Kaihlanen et al. (2019), it is a benefit to have cultural awareness to ensure efficient fieldwork and data collection processes in research. In Bangladeshi culture, as in many other cultures, food brings people together. Thus, I used the advantage of such cultural awareness by having a one-dish lunch party for the participants before conducting the FGD of my research. This significantly boosted the level of active engagement of the FGD participants to share their opinions.

The Bengali language was used throughout fieldwork, data collection, and data analysis. The learning of basic terms from the Ulti language, spoken in hijra communities, also assisted me to understand the role and implication of having a peculiar language amid stigmatised communities. The actual conduct of the interviews was challenging in terms of the use of language. To clarify, the choice of certain terms or words was very crucial during the interview session. I was well trained by my supervisors and Bijito regarding how to talk in the interview sessions and what kind of terms to use to show respect to the participants. My training helped me to be meticulous in word selection so that even though the participants are stigmatised in society, they did not feel socially excluded during the interviews. For instance, terms such as 'people from our community' and 'sexually and gender diverse people like us' were used instead of 'people from your community' and 'sexual and gender diverse people like you' respectively. The advantage of being a Bengali native speaker helped me to understand and respond to the participants' behaviour easily. This reduced the communication gap with the participants and reflected my shift from outsider to an insider as I was then able to understand what meaning they intended to convey with their responses.

3.7.7 Volunteering for community engagement and observation

I had shared my interest to work as a volunteer for community engagement and Bijito accepted me as a volunteer. This was very important because I had never interacted with sexual and gender diverse communities in Bangladesh before. Thus, integrating into their communities was essential to understand their worldviews toward life, religion and sexuality, amongst other facets of life. Community engagement through volunteering was also essential to create useful networks which led to successful participant recruitments. Furthermore, there are many nuances and modalities in Bangladeshi culture and languages that affect how people see, understand, think, and interpret the world. Metaphor and language, therefore, become very essential instruments of communication, which was also influenced by observation. Despite the benefit of observation through a qualitative approach, volunteering experiences also helped me to observe and learn about non-verbal communications such as smiles, handshakes, eye contact, attire, and how one addresses others. These forms of non-verbal communication determined the degree of engagement and active participation in this research. My volunteering experiences with sexual and gender diverse communities assisted me to adapt and learn non-verbal communications that are predominant, especially among these communities.

3.8 Assessing the research quality

Tracy (2010) states that qualitative research is worthy when the research question is counterintuitive and taken for granted by society, such as healthcare for sexual and gender diverse communities. The common understanding of scientific validity has often emanated from number-based quantitative research and positivist paradigms (Cheek, 2007). Guba and Lincoln (2005) explain that positivist standards of validity, reliability, and generalisability do not fit in qualitative studies. Instead, thick description, multi-vocality, resonance, heuristic significance are the most common practices to increase the validity of qualitative research (Tracy, 2010). The thick description refers to abundant concrete detail and in-depth illustration that articulate culturally situated meanings of the results (Bochner, 2000), which I did throughout the findings and analysis. It also suggests that any single interaction or (healthcare) experience could mean any number of other things when it is disentangled from its context (Geertz, 1973). Hidden meanings and assumptions influence human actions whether or not participants explicitly said so. Hence, the role of implicit knowledge gathered by symbolic interactionism and participant observation (with significant time in the field) is supported by thick descriptions of the findings (Tracy, 2010).

Like thick description, multi-vocality is another strategy that enhanced the practice of ‘showing rather than telling’. This strategy helps to incorporate multiple voices/responses (Lindlof & Taylor, 2002) from multiple groups of people (sexual and gender diverse communities, healthcare providers, and organisational executives). I am aware of sexuality and cultural differences between me and the participants. Accepting this difference increases the credibility of qualitative research (Tracy, 2010). Resonance is another concept of gaining empathic validity of qualitative research that illuminates the researcher’s capability to influence an audience evocatively (Dadds, 2008). This mode of validity is ensured by maintaining evocative writing, aesthetic quality, transferability, and formal generalisation, which I applied throughout the thesis. Tracy (2010) explains that the research findings need to have heuristic significance to raise curiosity among the readers to think about new theories and further scope of the study. She also mentions that ensuring the voluntary nature of participation by the participants also improves the credibility of the data.

Data rigour and a range of theories do not ensure high-quality qualitative research (Tracy, 2010). Qualitative research rigour is as important as art in terms of effort, duration of fieldwork, and the quantity of data. For example, I put many months of effort into negotiations and building trust with community-level organisations, and then I was able to spend extensive time (about six months) in the field for data collection: this helped me to obtain a thick description with about 135,000 words of transcribed data. Hence, the standard of transcription details, transcription accuracy level, and the number of pages of the transcriptions are considered to gauge the credibility of qualitative data (Tracy, 2010). She also adds that self-reflexivity can ensure the validity and credibility of qualitative research by being honest, transparent, and vulnerable throughout the research process. This self-reflexivity is also expressed in this thesis (see section '3.11 Fieldwork journal' at the end of this chapter).

3.9 Validity and reliability

The validity and reliability in qualitative studies substantially rely on the capabilities of the researcher to appropriately design the research with suitable methods (Franklin et al., 2010). The quality of qualitative inquiry is focused to emphasise on the notion of rigour that determines validity and reliability (Liamputtong, 2012). Also, the researcher refers to the truthfulness of the findings by representing that the participants' responses are credible and plausible (Franklin et al., 2010). Similarly, Lincoln and Guba (1985) state that credibility is a concept in research indicating the trustworthiness sustained by the constructions of the realities being studied. To obtain this validity and reliability in research, it is essential to express how credibility and trustworthiness are maintained (Golafshani, 2003; Noble & Smith, 2015). This was upheld by presenting verbatim transcriptions both in the original language (Bengali) in which the interviews were conducted and English translations.

Rigour is also another important factor for research soundness. Credibility, transferability, dependability, and confirmability are the four major elements of rigour in qualitative data (Guba, 1981). Shenton (2004) suggests that one way of fulfilling credibility and transferability is to follow research methods (e.g. interviews and an FGD) that are recognised and previously recognised and employed by other researchers. Additionally, the research has been presented at different seminars and conferences (e.g. 5th and 6th Annual Interscholastic Student HIV Research Symposium, Auckland; 3-Minute Thesis Competitions, Massey University; and CAHRE National Symposium, Auckland). These have helped to obtain peer scrutiny and feedback from many academics and scholars that enhanced the confirmability of this study. In terms of dependability, the concept of the audit trail is necessary because it allows the readers to trace through the researcher's argument and conclude if the research outcomes can be deemed as a platform for further research scopes (Carcary, 2009). The recommendations of further research explained in the conclusion chapter shall allow the readers to apply audit trails. Moreover, for this research, I consulted with community-level organisations (Bijito and Ostitto) for several months, which further impacted on the soundness of the research. This prolonged engagement with community-level agencies was also necessary for the credibility of this research.

Guba and Lincoln (1981) discuss that neutrality and consistency in qualitative data are two important factors to ensure reliability. The incidents shared by participants regarding discriminatory healthcare experiences have a consistent commonality, which is the expression of stigma by healthcare providers. Also, neutrality is maintained by curbing research bias and empowering the participants in the interviews to share whatever they wanted instead of imposing strict questions on them. To deal with bias, I encouraged the participants to be honest and share their experiences in their own words. I further encouraged them to share both negative and positive healthcare experiences. I also made it clear that I respected the values and cultural beliefs of the participants so that they felt culturally safe while sharing their experiences.

Triangulation is also relevant in this research because I employed interviews, an FGD, and KIIs for data collection. Triangulation refers to the use of multiple methods in a qualitative study to gain a shared understanding of the research issue (Patton, 1999). That is also regarded as a qualitative research strategy to test validity through the synergy of data obtained from multiple sources (Carter et al., 2014). The triangulation method explained by Patton (1999) and Denzin (1978) is applied because different methods (e.g. interviews, an FGD, KIIs, field notes, and observation) of data sources are used in this research to ensure a comprehensive understanding of healthcare. I also shared findings reflectively with my supervisors to strengthen the comprehensive understanding of the research issue.

According to Shenton (2004), researchers need to use tactics to help ensure honesty in participants when sharing data. He explains that rapport building is necessary to gain trust and encourage the participants to be frank and truthful regarding their response. In my fieldwork, I maintained an intensive rapport building to create a comfort zone with the participants so that they could be frank enough to discuss the most sensitive aspect of their lives: sexuality. Peer debriefing is also applied in this study because I constantly discussed my research ideas with other PhD students and colleagues who were not involved in this research to influence my analytical and critical thinking throughout the research process.

3.10 Limitations of the research

In doctoral research, perfection is a vague term, particularly for qualitative researchers who employ interpretivism research philosophy to study stigmatised communities. The reason I used a qualitative approach in this research is to understand the multifaceted aspects of healthcare. To elaborate, healthcare is a human right whereas healthcare discrimination is a tool for the oppression of sexual and gender diverse communities in a male-dominant society. Therefore, the interpretations of healthcare from two different facets become debatable. To investigate this debate, a qualitative research approach is a good fit in this research not only to understand what participants said explicitly but to understand the implicit meanings behind their responses. Nonetheless, the fieldwork of this research is the most influential factor because sexual and gender diverse communities are ‘hard-to-reach’ populations: gaining access, building trust and recruiting participants are some of the challenges to implement the research methods (Ellard-Gray et al., 2015). Undercover and successful fieldwork was carried out to negotiate with relevant agencies, build networks, gain access, and recruit participants. Volunteering for sexual and gender diverse communities was one of the most important ways to be a part of these communities and become trustworthy, which eventually helped me to gain key informants and chain referrals for participant recruitment.

In terms of methodology and fieldwork, there could always be some things that could have been done differently. Firstly, a mixed research method could have been useful so that quantitative data could have been collected through surveys of the general population in order to understand the attitude and stigmatisation of the general population toward sexual and gender diverse communities. This would have given a much clearer picture of how people in a society that privileges cis-men and heterosexuality think of marginalised communities who are socially controlled and oppressed. Secondly, surveys or interviews could have been used to study the attitude of healthcare providers to understand the impact of their perceptions toward homosexuality on their healthcare practice or behaviour. Researchers wishing to study issues relating to marginalised communities may consider a mixed research method that not only helps them to understand the overall scenario of society but allows them to use a post-positivist research philosophy to overcome some of the complexities of interpretivism. Future researchers would also have to consider the public exposure of the research because surveys can expose the researcher to the society, which has the potential risks of experiencing violence, stigma, and threats. Furthermore, perhaps future researchers can also apply narrative analysis instead of thematic analysis to explore the research issues from different insights and perceptions.

There are other limitations to this research. First of all, there is a difference between the epistemologies of the researcher and the participants that undoubtedly influenced the data collection. For instance, I struggled to understand how and when stigma starts to affect the participants’ lives. After getting involved with sexual and gender diverse communities, I learnt that the patriarchal attitude that leads to the stigma begins when a person is born. Thus, I realised that during interview sessions I had to listen to and understand the life experiences the participants had had since their childhood. There may be other aspects similar to this which I may have been unable to identify while collecting data due to the differences of epistemologies. The analysis may also be affected due to this gap in the epistemic framework. To clarify, while listening to the audio recordings, transcribing and analysing the data, I often struggled to understand the meaning or justification behind the participants’ responses. This is because how the participants think of certain phenomenon: I may not be able to have a similar perception toward that phenomenon. For example, I would perceive that going to healthcare settings is related to medical treatment, whereas for the participants visiting a healthcare setting may refer to a potential place of insult and humiliation. I struggled constantly to deal with such aspects while analysing the data due to the differences in epistemologies. The volunteering experience, community involvement, and guidance from my supervisors somewhat helped me to deal with this limitation. However, there might have been other facets that I may have been unable to understand while analysing the data due to the differences in the epistemic framework.

It took me a substantial amount of time to transcribe the audio data. I was reluctant to hire a professional who has experience with Bengali transcription of audio data. Because of the safety precautions, I simply could not risk handing over the data to someone else whom I could not trust completely. Thus, I had to do the Bengali transcription (of approximately 135,000 words) and it was a lengthy task because I had never typed Bengali before. The length of time to transcribe the audio data cannot be regarded as a limitation. Although it extended the length of time of this research, one may argue that it significantly strengthened the research. In other words, transcribing the audio data by myself was undeniably essential because listening to the audio recordings helped me to revive and understand the emotion, feelings, and passion behind the participants’ responses, which I could never have obtained had I hired a professional transcriber. Nonetheless, what may be a limitation is the translation of Bengali to English of the excerpts I used in this thesis. The way I mitigated that limitation was by inserting the excerpts in both Bengali and English for the readers so that they could, where possible, draw their conclusions.

The justification and knowledge between one’s beliefs are emphasised by the concept of epistemology (Hardin, 1993). Since I am not a sexual or gender minority person, I have to confess that I sometimes struggled to understand the rationale of self-beliefs of sexual or gender minority persons, which I considered as an epistemological difference in my research. I never experienced the way these stigmatised people experience fear every moment of their lives about disclosing their identity. But to fight against this issue of self-justification, I attempted to learn how the participants live in fear and suffer from acute stigma from family, friends, and society. Some fieldwork incidents were influential in reducing the gaps between the epistemic frame and worldviews between me and the participants. But still, it was not feasible to completely deal with these epistemological gaps since I am not a sexual or gender diverse person. Perhaps a researcher who is a marginalised person would have been a better investigator than me because they would have had or lived with the fear and stigma that the participants experienced throughout their lives. Therefore, I have to admit that it took me a while to understand how oppressive it feels to be a sexual or gender diverse person in a patriarchal society.

This is the first time in my academic career to carry out research with stigmatised people, thus I expected that it was going to be challenging. But I believed that I had the necessary skills as a researcher, and the networks and resources to continue and complete the study. Stangl et al. (2010) discuss that developing rapport is a challenge for gathering information about HIV from marginalised groups — such as gay men — in Bangladesh who face discrimination and stigma. The authors also explain that support from community-level agencies and agreement to not broadcast the interviews or disclose the identity of the participants are the key factors for successful interviews. Therefore, I believe that my integration with Bijito and Ostitto helped me greatly to recruit participants and gather data successfully. Importantly, my supervisors were also key resources to help me manage these research limitations. For example, they played an important role as bona fides during the communication process with the community-level agencies.

The socio-political environment of Bangladesh may lead people to have a negative impression toward me and my research. Before starting my PhD research, I heard people jeering behind me because of my research interest with stigmatised people. But I was strongly committed to this research to manage all these issues and make my research successful and beneficial for sexual and gender diverse communities. Another challenge to studying marginalised communities in South Asia is the lack of equipment for new media dissemination (Stangl et al., 2010). The authors also state that it hampers the participation of people from marginalised groups because of the poor internet connection and lack of information technology. The challenge of information technology and internet bandwidth was addressed by having powerful internet connections and buying the necessary equipment (e.g. audio recorder) from abroad, and I only used them with informed consent. Both private and public exposure of sexual and gender diverse communities is a threat. Therefore, as planned, I conducted the data collection activities with the assistance of relevant community-level agencies to recruit participants who were ensured complete anonymity, privacy, and confidentiality.

The monopoly of the researchers is often shown in social research because they take the authority of data collection and interpretation, and consider participants as passive data providers. Ife (2012) mentions that taking participants in a passive manner appears to be the opposite of the human rights principle, leading to less contribution to the human rights cause. Moreover, he explains that research with rights-based practices must include the population who are being studied in the design, interpretation (member reflections), implementation, and presentation of the research. For example, while writing the research proposal, I discussed the research issue with Ostitto and Bijito, Thus, I had ongoing consultation with sexual and gender diverse populations through these community-level agencies. However, in this research, member reflections or member checks were not applied because it was regarded as risky for both the researcher and the participants. To elaborate, if I had sent a document of transcription or analysis for member reflection, neither I nor the participants would have been able to ensure that it did not get into the wrong hands. Consequently, my supervisors and I decided that we would not take risks that may breach privacy and confidentiality — which could lead to a safety issue — and we chose not to use member checking. Additionally, I had to challenge the orthodoxy of research methodology by employing collaborative inquiry as Bijito (a community-level agency) allowed me to work as a volunteer. Thus, I intended to gain new knowledge and insights by empowering the research population rather than treating them just as research subjects.

This research could have been undertaken from the perspective of patriarchal capitalism, and other theoretical constructs such as class-based oppression, intersectionality, and theory of power. However, the reason I chose to investigate the patriarchal oppression from a human rights framework is that the local agencies in Bangladesh who helped me with data collection and fieldwork activities emphasised the importance of healthcare as a human right for sexual and gender diverse communities, which they believe is an urgent need for these communities in Bangladesh. As a social work researcher, I was led by the experiences of my participants. I, therefore, chose to use human rights as my theoretical framework to expose the nature of patriarchal oppression.

3.11 Fieldwork journal

The fieldwork journal[1] was developed from the field notes and field journal of my fieldwork experiences that I maintained from the beginning of my PhD research. This was ostensibly a

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[1] Portions of this section (3.11 Fieldwork journal) have been published as a book chapter in an edited book. Khan, K. K. (2021). Undercover fieldwork: A queer experience of healthcare in Bangladesh. In M. R. Islam, N. A. Khan, S. H. B. A. B. Ah, H. B. A. Wahab, & M. Hamidi (Eds.), *Field guide for research in community settings: Tools, methods, challenges and strategies*. Edward Elgar Publishing.

learning process for me as a researcher and briefly explaining the fieldwork journal may input additional insights into how this research impacted my worldviews toward certain aspects. It is deemed that investigating issues regarding stigmatised populations can be a difficult journey for academic researchers (Meezan & Martin, 2009). As expected, I went through various challenges during my fieldwork, and this section explains the challenges I faced in the field and the strategies that I followed to overcome them.

I was in New Zealand when I started my communication with community-level agencies (Bijito and Ostitto) in order to get assistance for data collection. I anticipated that gaining access and developing trust with sexual and gender diverse communities would not be an easy task. This is because the fear of violence experienced by sexual and gender diverse communities frequently forces them to be invisible in society. During my first contact, I sent emails and messages to their social media pages. But Ostitto felt suspicious about me and they did not reply to my messages. Also, my name is very peculiar in the Bangladeshi context, so it was understandable that they thought I was a fake person. Then I gave further clarification about my name and provided them with my details. After a month or so, Ostitto wanted to talk to me. We used an anonymous online calling software which used video. They saw my face on the video call although I was not able to see their faces, which was completely understandable. Gradually we started to communicate more, and we were patiently building trust. Ostitto then agreed to help in my PhD research and accepted my request to be a volunteer for their organisation. When I went to undertake fieldwork in Bangladesh, I met representatives of Ostitto in person and they suggested that spreading a flyer in public for participant recruitment was very risky. Although there was no identifiable information given in the flyer, we decided not to use it and Ostitto recommended that chain referral and word-of-mouth communication among their networks could help to recruit participants.

My fieldwork journey was extremely challenging and some of the experiences were thought-provoking. To elaborate, one of my conference presentations regarding my fieldwork experiences caught the attention of other scholars. They raised a concern that challenged my ethical approach. They questioned how ethical it was to include a police officer in my ethical framework to file a general diary when sexual and gender diverse people are often oppressed by the police. Their specific question was: Did the researcher inform the key informants and community-level agencies regarding the involvement of a police officer in this research? Because they argued, if I did not inform them about this, then it was unethical from a methodological point of view. To respond to this argument, such issues were thoroughly consulted with the ethics committee of Massey University before approval. To specifically respond to their question, key informants and community level agencies were informed about the involvement of the trusted police officer, and staff of Ostitto guided me on how to file the general diary systematically so that no identifiable details were reported. Such scholarly argument in a conference presentation indicates how critical and sensitive my fieldwork was.

There were two safety measures that I followed before I started my fieldwork. Firstly, I was not allowed to talk about the events that I participated in with Ostitto during my volunteer work. Nor was I allowed to take pictures, share photos on social media, or check in on social media pages. I admired these safety precautions taken by Ostitto. Secondly, as a part of Massey University's ethical approval, I had to file a general diary in a police station so that I could ask for help in an emergency. A general diary is an entry, or a daily diary entry made when any kind of complaint or anticipated incident is reported and the police enter the details in their records. I disclosed my research to a very trusted friend of mine — a senior police officer — who helped me to file this general diary where no identifiable information was given regarding the participants or community-level organisations. This police friend was constantly in touch with me.

My fieldwork experience was more serendipitous than planned. I experienced some unplanned situations during my fieldwork. Sometimes I had to push the limits of my safety plans to recruit participants. I planned to conduct the interviews in Bijito's office, which is considered to be a safe location. Nonetheless, for one interview, I had to go to the participant's house, which was located in one of the most crowded areas of Dhaka city. While going there I did not feel very safe and I struggled to find my way back from this area even though I lived in Dhaka city. On another occasion I went to conduct a KII at the participant's preferred location, which was another example of how I had to push the boundaries of my safety plans. I did this because I had to return the trust that the participants showed in me. It is important to note that most of the interviews were conducted at Bijito's offices.

One of the biggest challenges, not only in my fieldwork but also in my research, was to deal with epistemological differences between me and the participants since I am not a sexual or gender diverse person. Hence, I struggled to understand the worldviews of the participants. For instance, I can barely imagine the fear that the participants lived with throughout their life. To deal with such a challenge, volunteering is very helpful because it helps the researcher to maintain knowledge transfer with the communities (Akingbola et al., 2013). Throughout my volunteer experience I attempted to understand the beliefs, values, experiences, and philosophies of sexual and gender diverse people by sharing knowledge. I gradually became a part of their community and I no longer felt like an outsider. I sincerely acknowledge the way they accepted me as a researcher who simply did not take sexual and gender diverse people as research subjects, but rather tried to learn and understand their worldviews.

Two major incidents affected my epistemological stances. Once, after an interview session, I felt I was being followed by someone when I was returning home. My first fear was that they might be extremists. I had a very ‘cold feet’ experience in the street and eventually, it turned out that I was wrong. Although there was nobody following me, I realised that day that the fear that I had felt for one day, the participants lived with every day of their lives. Secondly, I had to constantly hide my research project from my friends and relatives because I was not sure how people would react to my passion for this research topic. Thus, I also had to work as a volunteer secretly and discreetly. This made me realise that participants often had to hide their sexual and gender orientation from their family and friends. This helped me understand that the impact of such hideousness can be a huge burden for a person, especially when they have to live with dual identities. Hence, I can claim that these experiences helped me, not completely but partly, to deal with the epistemological differences between me and the participants.

There was also a problem in finding participants who were willing to share their experiences. This is because sexual and gender diverse people usually do not disclose about themselves in healthcare settings (Singh & Durso, 2017): thus it was difficult to find individuals who had negative healthcare experiences due to their sexual and gender orientations. I also found it difficult to recruit healthcare providers to conduct KIIs because many might have thought that my research was about defaming healthcare professionals, which was completely incorrect. However, chain referrals, word-of-mouth communication, and networks among the key informants were essential to deal with the challenge of recruiting participants who are ‘hard to reach’ (Ellard-Gray et al., 2015). Lack of communication was another challenge: for instance, in one interview, the participant did not disclose that she worked as a sex worker. First, the participant acted differently — perhaps she thought I was a customer who had contacted her in a different way. When we started to talk about my research she realised that I was there for data collection. Still, these were my assumptions and I might also have been wrong. This indicates that no matter how much rapport was built, there was still slight lack of communication and understanding.

Working as a volunteer can be deemed unconventional for qualitative researchers. This is because ethnographic researchers often work as volunteers in ethnographic studies (e.g. Garthwaite, 2016; O'Farrell, 2010). Although my research is not ethnographic, I worked as a volunteer for Ostitto in different roles such as an account assistant, volunteer coordinator, helped to organise workshops and events, and assisted in fundraising and awareness campaigns. The impact of my volunteering was essential for network building and participant recruitment (e.g. O'Farrell, 2010). For example, I met an intersex participant during my volunteer work who was the only intersex individual who showed interest in sharing their healthcare experiences. Additionally, my affiliation as a volunteer was immensely important for the participants to have faith in me because they regarded me as one of them, which led to active engagement of the participants during interview sessions.

I have to admit that I faced some interpersonal challenges as a researcher. It was a tough experience for me to be emotionally responsive during the sessions because some interview sessions involved emotional moments. As a social worker, I am empathic, and I am able to imagine myself in the same situations other people have experienced. Despite my efforts of solace, I sometimes failed to look at the participant’s eyes and simply became wordless, though I expressed the empathy I felt to them. Nevertheless, it was hard for me to get through because of those sensitive and emotional experiences. I felt the same kind of emotional situation later when I had to hear the audio recordings repeatedly while transcribing the data. Regarding this, I was asked in a conference presentation if I had received any mental health support after the interview sessions, but unfortunately there are hardly any mental health services available in Bangladesh for such aspects. This has an implication with controlled emotion that enables a social worker or a service provider to express sensitivity to the feelings of the recipients or clients (Weilenmann et al., 2018). This kind of experience helped me to understand the meaning behind the participants’ responses. I believe expressing a purposeful emotional response to the participants’ feelings was efficient learning for me because my fieldwork, an emotional journey, shaped me to become an emotionally component investigator.

I was quite a new researcher and I admit that I might have some limitations to conducting the interviews. Therefore, I applied the approach of ‘learning from mistakes’ by collecting feedback from the participants after each session. This was vastly important to demonstrate self-reflexivity in my research because I was always ready to identify my limitations and overcome them. Tracy (2010) explains that this kind of self-reflexivity through honesty, transparency, and vulnerabilities determines the credibility of the methodology. The feedback from the participants was both negative and positive, and I constantly tried to improve my interviewing skills through the feedback and comments. However, participants often commented that the interview sessions were knowledge-sharing and free-flowing where they did not feel forced to speak. Many qualitative researchers collect feedback to perform member checks by allowing the participants to review the transcripts to enhance data credibility (Thomas, 2017). However, my approach was not exactly member checks or reviewing transcripts as many qualitative researchers do (e.g. Kornbluh, 2015; Lo, 2014) as I only planned to gather suggestions to develop my interviewing skills.

Safety anxieties were common in my fieldwork journey. First of all, I was very anxious about the spare confidential documents such as information sheets, unused flyers, unused consent forms, and interview schedules. I did not want them to fall into the wrong hands and I could not just discard them in a rubbish bin as some of those documents contained identifiable details about me. Thus, I took them to the rooftop of my residence and burnt them. Secondly, as a volunteer of Ostitto, I was writing online blogs anonymously. For this, I logged into their blog website from my laptop by using my home IP address, which is a unique string of numbers separated by full stops that identify each computer using the Internet Protocol (IP) to communicate over a network. I became slightly worried that someone might try to trace me as the author of this blog by tracking the IP address. Therefore, I started to use the TOR Browser every time I had to log in to the blog website. This browser was essential to prevent me from being tracked as it allows the user to use a different IP address from a foreign location. Nevertheless, many would argue how ethical it was to use the TOR Browser for a social work researcher as it is generally used by online hackers. My justification for using this browser was to make sure that my volunteering with Ostitto did not put the participants or me in danger. Lastly, I had to photocopy extra pages of the confidential documents at a photocopying store, and I was worried that some of the documents might be memory-saved in their photocopy machine. I could not do much about this, and this was probably just another safety anxiety that I had. These safety anxieties made me understand that ‘perfection’ was a vague term in my fieldwork as I was constantly learning.

There was also a transportation problem because I did not own a personal vehicle and I had to rely on public transport and internet-operated transport services such as Uber. On several occasions I was unable to arrive at the interview locations on time due to heavy traffic caused by rain, closure of public transport for a public holiday, or internet-operated transport services ceasing due to safety measures before the general election day of Bangladesh. The availability of safe space for interviews was another problem. Bijito offered their offices to conduct the interviews without any financial incentives and I am more than grateful for this voluntary support. I was able to conduct almost all the interviews in Bijito’s offices. However, on a couple of occasions, we could not manage to have interviews in private office-rooms, thus noise was an issue to ensure clear audio recording. To deal with this, I recorded the interview with two devices, just in case, so that I had a back-up audio source of the interview session. This significantly reduced the noise issue, particularly when a private office space was unavailable.

It was also difficult in my fieldwork to create a comfort zone between me and the participants so that they could frankly discuss their sensitive aspects (e.g. sexuality). Creating this comfort zone brought an environment of emotional safety (Edmondson & Lei, 2014), thereby participants could feel safe to express their feelings. It was my responsibility to ensure such a comfort zone. I applied several strategies that were not strictly planned but mostly spontaneous. First of all, to break the comfort zone, I let the participants ask questions. One was very friendly, and we started to have an intimate conversation to test how comfortable I was with her. I answered her questions frankly, which eventually created a very good comfort zone between us. Thus, to have a comfort zone in the interview, I sometimes had to go slightly beyond my comfort zone by sharing intimate information. Cassell (2018) explains that pushing beyond the comfort zone is necessary for qualitative researchers to think about and analyse the issues studied thoroughly.

Secondly, I was not hesitant to share my personal information with the participants to express my trust and faith in them so that I could receive the same trust and faith in return. According to Bell et al. (2019), sharing personal information with participants is a very good approach to build a rapport that leads to a trustworthy relationship between the participants and the researcher. Nevertheless, personal conversations between me and the participants were mostly off the record, not audio-recorded or transcribed. Thirdly, discussing an off-topic aspect (e.g. a hand bracelet the participant was wearing) was essential to subconsciously inform the participants that it was not a strict, formal interview. I tried to ensure that the interviews were conducted informally so that the participants could share their experiences in a way that they could, for example, feel as if they were having a casual conversation with a friend in a coffee shop. Although Adhabi and Anozie (2017) discuss that conducting interviews informally may require unstructured interview guidelines, I used semi-structured interview guidelines for informal interviews, which seems to be another unconventional aspect in qualitative studies. Fourthly, the participants sometimes helped me to build a comfort zone. For example, in the very first interview I was very nervous and constantly sweating for no reason. The participant noticed this and offered me a glass of water, which helped me relax. Hence, I acknowledge the contribution of the participants who equally played their role in this research for successful fieldwork and data collection activities.

My fieldwork journal is written in a confessional way where I did not hesitate to admit my limitations and qualities as a human. Much confessional writing is produced to convince the reader of the human qualities of the researchers or fieldworkers (Geertz, 2011). Overall, my fieldwork consisted of several emotional moments: there was anxiety, fear, crying throughout this journey. All these experiences were somewhat life-changing lessons for me that helped me to understand how a patriarchal socio-cultural system has been oppressing sexual and gender diverse communities. It was a psychological breakthrough for me to admit this fact and expose patri-normativity that is regarded as a culprit to stigmatise sexual and gender diverse people. This is because I come from the same socio-cultural background where I enjoyed the privileges as a man in the same society that privileges men. Hence, it was very challenging for me as a researcher to erase the stigmatising attitude toward sexual and gender diverse communities by learning and understanding their worldviews. Due to my real-life experiences and interactions with the participants, I gradually started to realise how a male-dominated society had influenced my attitudes and conceptions toward various aspects which, ironically, I was not even aware of. Therefore, I posit that engaging, learning, and knowledge-sharing fieldwork is undeniably important not only to understand the factors behind stigma toward the participants who are especially stigmatised in society but to learn how to manage the stigma from a researcher's standpoint.

3.12 Summary

The reason for employing qualitative research methods in this research was to investigate the research issue deeply and understand how participants perceive and experience healthcare. I discussed research philosophy, epistemology, qualitative approach, and other useful methodological implications in this chapter. The description of the research design included participant recruitment, data collection methods, data analysis techniques, and the ethical framework in this research. For community engagement and network building, I worked as a volunteer, which was also described in this chapter. The limitations of the research and my fieldwork journal were also discussed to explain the challenges I faced in my data collection activities and how I dealt with them.

Chapter Four: A Hidden Group of Communities

4.1 Introduction

The findings and analysis of this thesis begin from this chapter. Chapter four to eight (a total of five chapters) are the chapters that include findings and analysis of this thesis. Sexual and gender diverse people in Bangladesh are mostly hidden due to the threats of assassination, stigma and continuous oppression by a society that privileges men. Before we understand how the participants live invisibly under oppression and social control, I define diverse identities of sexual and gender minority communities. I also discuss the local and English terms that are frequently used to identify sexual and gender diverse people. It clarifies how I am using the word hijra as an identity. I then conclude with a brief description of participants so that the reader understands some of the complexities around how participants identified themselves for this project.

4.2 Sexual and gender diverse people in Bangladesh

There are different groups of sexual and gender diverse populations. It was important to participants that I first understood the taxonomy of this diversity. The participants explained that there are people who identify themselves as lesbian, gay, bisexual, intersex, transsexual, transgender (transmen and transwomen), and hijra. The following definitions regarding the taxonomy of sexual and gender diverse identities were drawn from participants in my research.

- Women who are attracted to women are called *somokami nari* (সমকামী নারী) or *somopremi nari* (সমপ্রেমি নারী) in Bengali. *Nari* refers to a woman. The term *somo* (adjective) refers to the 'same' and *kami* (noun) refers to a person who has deep sexual desire. *Kami* is derived from the word *kaam* (noun) which has a Sanskrit origin, meaning extensive desire, sensuality, uncontrolled craving, concupiscence or lasciviousness. Kami is deemed one of the five cardinal sins in Sikhism, a monotheistic religion originated at the end of the 15th century in the Indian Subcontinent's Punjab region (Nesbitt, 2016). Because of this linguistic history, the common understanding is that being *somokami* (homosexual) is all about lust or physical desire. This is one reason why sexual and gender diverse communities are stigmatised. Local Bengali terms have been implicit as the use of the language is intended to stigmatise.

- However, very recently, people who work with sexual and gender diverse communities have started to reflect on the stigmatising nature of these terms. They understand that an emotional attraction or connection also exists when two same-sex people fall in love and it is not only physical. Hence, they began to promote the term *premi* (প্রেমি), which means the person who can ‘love’ (verb: *prem*). The use of *somopremi* (সমপ্রেমি) instead of *somokami* (সমকামী) is a part of the campaign by the Bijito and Ostitto to reduce stereotypes about sexual and gender diverse communities.
- The street word or slang word for lesbian is *chiptibaji* (চিপ্টিবাজি). *Chipti* refers to vagina and *baji* refers to rubbing. Lesbians would usually call themselves ‘lesbian’ because the Bengali terms (e.g. সমপ্রেমি নারী) are not used as much as English terms due to the lack of use of such Bengali terms. However, this street slang, *chiptibaji* is a way of mocking and is therefore not acceptable language. Lesbians would not use this term as it is an abusive word.
- ‘Gay’ refers to men who are attracted to men and in Bengali *somokami purush* (সমকামী পুরুষ) or *somopremi purush* (সমপ্রেমি পুরুষ). The difference between *kami* and *premi* also applies here, and *purush* refers to men. The street slang used to indicate gay male persons is *gaira* (গাইরা) and refers to someone who is engaged in anal sex.
- Bisexuals can be either men or women who are attracted to either men or women. They are known as *uvoykami* (উভয়কামি) or *uvoypremi* (উভয়প্রেমি) in Bengali. *Uvoy* means ‘both’, as in both sexes, and *premi*, as above.
- Intersex refers to a variety of situations in which an individual is born with sexual or reproductive anatomy that does not fit the conventional configuration of male or female. As explained by one staff member of Bijito, sometimes a baby can be born with both male and female organs, while none of the organs is complete. People who are born like this

are known as intersex. They are known as *uvoylingo* (উভয়লিঙ্গ) in Bengali. *Uvoy* refers to 'both' and *lingo* refers to 'sex'. The staff of Bijito also explained that the general public often wants to identify intersex persons as either intersex man or intersex women. However, this is quite complicated to define because they could either socially present or dress like a typical male or female. But in Bangladesh, in most cases, intersex persons are given male names and brought up in the families as men (e.g. Idujon; see below in participant description) because families often prefer to have a son over a daughter.

- The term transsexual is applied to individuals who have gone through gender confirmation surgery and changed their sexual and gender role in society. On the other hand, the persons who have not gone through gender confirmation surgery but changed their gender role and the way they present their gender in society are commonly known as transgender. Transgender people can be transmen and transwomen, known as *rupantorito purush* (রূপান্তরিত নারী) and *rupantorito nari* (রূপান্তরিত পুরুষ) respectively; *rupantorito* refers to someone who is transformed. For example, when a biologically male person changes his gender presentation and social role to female, they become identified as a transwoman (রূপান্তরিত নারী).

Transwomen and intersex are frequently contrasted with another sexual minority group known as hijra (হিজড়া). Ichand, a participant, expressed that there is a misbelief that every intersex person is hijra. The concept of hijra has been studied and defined by many scholars both within and outside the traditional academic canon (e.g. Jayadeva, 2017; Mal, 2018) and the multifarious implications of this concept often tend to be controversial. This is because hijra communities and various scholars have defined this concept in different ways. The awareness and understanding of hijra are often confusing. When I was a child, for instance, my parents used to tell me that we should not be around hijra because hijra could physically harm us. One of my well-educated friends told me that hijra are physically women but do not have the reproductive capacity and cannot give birth. I found that neither my parents nor my friend is right. I cannot blame them for such confusing assumptions about hijra. This is because, Farnen, a hijra participant, explained that society has created an invisible stigma around hijra communities that does not allow people to discover what exactly hijra means.

Hijra is a cultural or a traditional identity, arguably not a sexual or gender identity, explained Farnen. Although a rough estimation of the hijra population puts the population at about 10,000 (Hossain, 2017), there is no demographic research about the overall sexual and gender diverse population in Bangladesh. In Bengali, some slang words for hijra are *chokka* (ছক্কা), *chaiya* (ছাইয়া), or *maigga* (মাইগ্গা), which are abusive words to refer a man who behaves like a woman. However, most people in Bangladesh think of hijra is an orientation, which is the major misconception of hijra, Farnen added. Farnen also explained that hijra can be a profession, or a way of living, or a culture, but not an orientation. In the South Asian context, hijra are transgender and (sometimes self-castrated male) eunuchs. One of the ways hijra can survive is by dancing and singing blessings in order to collect alms or donations and make a living out of it (Chakrapani, 2010). They often also perform at baby blessing events. In India, hijra like to call themselves *kinner* or *kinnar*, mythological beings who excel in dancing and singing (Sharma, 2012). A hijra may choose to live in an intentional community, which is a residential community planned to have a high degree of teamwork and social cohesion. Living in an intentional community is not free and everyone has to work and earn for themselves. In order to do so, the leader or *guru* has to accept hijra as disciples, or hijra accept the *guru* as leader/mentor. Hijra are then expected to collect alms or donations by dancing and singing on the street and for blessing purposes. Once the money is collected, it is divided between the *guru* and the hijra who collected the money. Sometimes, hijra are used by the tax collectors to embarrass delinquent people into paying their taxes — a way of monetising stigma.

Hijra communities in some western parts of India such as Nadia and Kolkata often use a secret language or dialect known as Ulti or Gupti. In the Ulti language, there are many terms used as slang to refer to sexual and gender diverse identities. These terms are not commonly used in Bengali but are frequently used among hijra communities. For example, the active (insertive) male partner of a same-sex relationship is known as *panthi* (পান্থি) and the partner who takes on feminine (receptive) role is known as *kothi* (কথি). The term *ligam* (লিগাম) means penis, *vatli* (ভাটলি) means anal, *dhur* (ধুর) means sexual intercourse, and *vatli dhur* (ভাটলি ধুর) means anal sex or the person who engages in anal sex. Sperm, the male reproductive fluid is known as *sudrani*

(সুদ্রানি). Bisexual persons are often called as *dopaareta* (দোপারেটা) in Ulti. The alms or donations collected by hijra are known as *jholka* (ঝলকা). In general, homosexual behaviour or same-sex behaviour is called as *tona tona dhurpit* (টোনা টোনা ধুরপিট). *Tona* (টোনা) refers to boy, *tona tona* (টোনা টোনা) means two boys, and *dhurpit* (ধুরপিট) means having sex.

Many of the English terms were not previously very well known or familiar amid sexual and gender diverse communities. Consequently, street words or Bengali slang words were used to identify sexual and gender diverse communities. However, gradually, English terms are becoming commonly used these days. I was able to use some of the terms — not all of them — throughout the analysis and discussion chapter. Some of the terms (e.g. *maigga*, *dopaareta*, and *vatli dhur*) are mostly used as slang or in abusive forms, which I was encouraged to avoid using in this thesis. However, I mentioned these slang or abusive words in this section to demonstrate the stigmatising and mocking nature of these terms.

4.3 Description of participants

Before I consider what it is like to be a sexual or gender diverse person in an Islamic male-dominated society, I shall give a brief description of the participants; I used the pronouns that each prefers, along with pseudonyms. I used pseudonyms for participant safety. To make the analysis easier to follow, I used pseudonyms that start with ‘F’ for FGD participants (e.g. Freial), ‘K’ for KII participants (e.g. Karnen), and ‘I’ for interview participants (e.g. Israne).

Focus Group Discussion (FGD)

1. **Freial:** He is a staff member of Bijito and has been working directly with sexual and gender diverse communities for a long time to provide health benefits. He has also been running workshops and training seminars for capacity building and increasing awareness among sexual and gender diverse communities.
2. **Farnen:** Although she is a hijra, she does not live in an intentional community under a *guru*. She worked with various international non-government organisations (INGOs) to promote awareness about stigmatised communities.

3. **Feyan:** He is an art-based activist. He attempts to produce visual arts and multimedia that highlight the understanding of what it is like to be a sexual or gender diverse person.
4. **Famzen:** He is a gay male, a volunteer of Ostitto. He actively participates in different activities organised by Ostitto and has been working with this organisation for a long time.
5. **Fasrub:** He is one of the main representatives of Ostitto in terms of planning, coordinating and arranging campaigns, seminars, and events for awareness building about sexual and gender diverse people.
6. **Feezaz:** She is a hijra entrepreneur and runs her own business where she also employs many other sexual and gender diverse people. She is also a very popular face in hijra communities and often works for their rights.
7. **Famien:** He is a gay male and also a volunteer of Ostitto. He is engaged with different kinds of events and seminars organised by Ostitto. He is also an artist.
8. **Franso:** She is an activist working directly and indirectly with organisations that work for different marginalised communities.

Key Informant Interviews (KIIs)

1. **Karnen:** She is a human rights activist for hijra communities. She participates in seminars in other countries to present the scenario of hijra communities to international stages. She has been working with many agencies that promote awareness regarding sexual and gender diverse communities.
2. **Kelard:** He is a professor at a public university in Bangladesh. He is a cis-heterosexual male. He teaches human rights-related courses. He also participated in workshops to increase awareness about marginalised populations.
3. **Kevlin:** This is a person whom I have known since my childhood, and he is trusted as well. He bears extensive knowledge about Islam. He is a cis-heterosexual male.
4. **Kingshu:** She is a healthcare professional. She is a cis-heterosexual woman. She has been practising as a gynaecologist in a hospital. She bears good knowledge about the professional ethics of healthcare providers.

Interviews

1. **Israne:** He is a transman, in his mid-30s. He was assigned female at birth but now identifies and presents as a male. He takes gender confirmation hormone therapy and wishes to go for gender confirmation surgery in the future to complete his gender realignment. He mostly lives as a male in society and he is a Christian.
2. **Iruyan:** He is a transman. He was assigned female at birth, but now identifies and presents socially as a man. He is very resilient and confident. He is in his mid-40s. He does not think that everybody wants to choose a surgical procedure as the decision of gender confirmation surgery depends on a person's choice and it varies from person to person. He is Muslim.
3. **Imeen:** She is a transwoman, in her early 30s. She was assigned male at birth. She now presents socially as female and works as a sex worker. She does not live with her family. She is Muslim.
4. **Ipreeth:** He is a Muslim gay man. He works as a volunteer to support disadvantaged people. He is in his early 30s.
5. **Idanam:** He is a gay man and he is Muslim. He is in his mid-20s. He lives with his family, but his family does not know that he is gay. He feels quite distanced from his family.
6. **Inrose:** She is a transsexual person, in her early 30s. She was assigned male at birth. She completed gender confirmation surgery and she is physically a female now. She works for a human rights NGO. She previously worked for Bijito. She is Muslim.
7. **Iporane:** She is a hijra and married. Her husband is a Muslim male, although she is Hindu. She runs her own business and trains other hijra to be skilled in different occupations. She is in her early 40s.
8. **Ikhiyam:** She is a hijra, in her mid-20s, and works as a security guard. She used to work as a sex worker. She was assigned male at birth but now identifies and presents socially as female.
9. **Iksera:** This participant is a lesbian. She self-identified as a lesbian just a few years ago. She is in her mid-20s. She is Muslim and lives independently without her family. She works as a volunteer for Bijito to support sexual and gender diverse people.

10. **Ichand:** She is an older lesbian and describes herself as mentally very strong. She is in her late 50s. She was married to a man for a long time because she felt the need to conform to family and social expectations. She works for Bijito and she counsels young people who struggle to understand themselves.
11. **Iruvo:** He is a bisexual male in his mid-30s. He is Muslim and lives with the family. He occasionally works to support sexual and gender diverse communities.
12. **Isalho:** He is a transsexual. He was assigned female at birth, but now identifies and presents socially as male. He is in his mid-20s He recently had breast removal (‘top’) surgery. He is taking gender confirmation hormone therapy and after six months of hormone therapy, he plans to have ‘bottom’ surgery so that he can complete his gender alignment. He is Muslim.
13. **Idujon:** They are an intersex person, in their early 20s. They did not know what they should be addressed as until they came across Bijito. Idujon has recently found out that there are not many people like them. Idujon also learnt the term intersex after being introduced to it by Bijito. They are Muslim.

4.4 Summary

In this chapter, I introduced commonly understood sexual and gender identities. I also presented descriptions of participants as a reference for the reader. Participants are given pseudonyms to ensure their privacy and confidentiality. To make the analysis easier to follow, I used pseudonyms that start with ‘F’ for FGD participants (e.g. Freial), ‘K’ for KII participants (e.g. Karnen), and ‘I’ for interview participants (e.g. Israne). I used pseudonyms for participant safety. Sexual and gender diverse communities are frequently threatened, and I am, therefore, withholding potentially identifying information.

Chapter Five: Post-colonial State and Patriarchy

5.1 Introduction

Sexual and gender diverse people in Bangladesh have been historically oppressed due to the patriarchal social system that has existed since at least the Mughal Empire (16th century CE). Patriarchy was sustained by custom, religion and later by colonialism. I explore the nature of a post-colonial state and the colonial reinforcement on heteronormativity. I also discuss the connection between patriarchy and the oppression of sexual and gender diverse communities, and how this oppression affects healthcare. Bangladesh is a post-colonial state where patriarchy has been sustained throughout history and it maintains the oppression of sexual and gender diverse people. Due to this oppression, participants mostly live hidden lives with dual identities (an identity disclosed to the society, and an identity disclosed only to self and trusted ones). Hence, to receive appropriate healthcare, sexual or gender diverse persons usually must disclose their actual identities to the healthcare provider or system, because the health issue may be related to their gender identity or sexuality. Such disclosure can expose the participants to humiliation and discrimination in the healthcare sector, and this aspect is discussed by analysing the relationship between healthcare and Section 377, a legacy of colonialism. To further consider the impact of colonialism, the role of masculinity in a patriarchal society is analysed to identify how a masculine society perceives sexual and gender diverse identities.

5.2 Post-colonial state

Although the evolution of what is now modern-day Bangladesh was not exclusively informed by patriarchy, a thorough historical consideration of the multifarious influences is beyond the scope of the present project. Nevertheless, before considering Bangladesh as a post-colonial state, it is important to describe the Bengal cultural entity. Bangladesh gained its independence about five decades ago as a sovereign political entity. Before that, it was part of Pakistan (East Pakistan) for almost a quarter of a century; before that part of the British colony, Mughal and other empires (Stewart, 2013). Thus, Bengal as a cultural entity is very ancient. Bengal was mentioned as a distinct area of South Asia in ancient Hindu texts and during the first millennium CE; it used to be governed by Hindu and Buddhist rulers (Sarkar, 2011). After the conquest of Bengal by Ikhtiyaruddin Muhammad Baktiyar Khalji in 1200 CE, many Islamic leaders migrated to this region for their security, and to preserve the culture in Bengal (Adhikary, 2018). As a result, most of the people of Bengal converted to Islam, and gradually the entire nation, civilisation, and culture were transformed by the influence of Islam (Bandopadhyay, 1965/2019). The cultural traditions define the cultural identity of Bengali people who live in today's Bangladesh and in some Indian states such as West Bengal, Assam, and Tripura where Bangla is the primary and official language. Usually, the people who live in Bangladesh and speak Bengali are known as ‘Bangladeshi’ and the people outside of Bangladesh (in India) who speak Bengali are known as ‘Bengali’. The recorded history of Bengal of 1,400 years suggests that it was known to be the richest part of Islamic Medieval India and a major trading nation in the world during the era of the Bengal Sultanate (Minahan, 2012). Due to its distinct language, attire, transport, arts, literature, architecture, foods, rituals and ceremonies, Bengal is considered to be a unique cultural entity.

Since culture is an integral part of Bangladeshi society, it is important to understand the role culture plays in this thesis, especially to develop the argument of health and healthcare for marginalised communities. Culture can be taken as a determinant to investigate colonialism and racism but how these overlap with the marginalisation of sexual and gender identities is insufficiently addressed (Mulé et al., 2009). Ethnic, racial, and sexual and gender diverse minorities face a complex environment while accessing healthcare services (Coalition for Lesbian and Gay Rights in Ontario, 1997; Ryan & Chervin, 2000). The impact of colonialism in the South Asian region shaped the understanding of sexuality, sexual health and healthcare of sexual and gender diverse communities. They also predominantly uphold the pre-existing patriarchal society that precludes sexual and gender minority rights because if the marginalised are given rights then they see the marginalised and the men as equal, which would undermine patriarchy.

A Marxist perspective proposes that post-colonial states are the primary agents to establish capitalism in the post-colonial area and the state is seen as an instrument of class domination (Kumar, 2005). According to Evans (2001), as a post-colonial state, Bangladesh was under the immense pressure of socio-economic growth to move forward with other allied countries. To manage the pressure of socio-economic growth, historically, NGOs have played a significant role

(Roy et al., 2017), which can be seen as an influencing factor toward the development of capitalism in Bangladesh. Along with socio-economic development and a gradual increase in literacy, the state was struggling to sustain democracy due to two successive military regimes, but the rise of democratic ideology and political consciousness of the Bangladeshi people returned the democratic process of electing a government (Evans, 2001). Nevertheless, the current government has been questioned by representatives of international agencies about its practice of democracy and political ideologies due to their contestable election process and their results (The Daily Star, 2019, February 14). From a liberal perspective, a post-colonial state is often described as a system where the state actively intervenes as an agent to progress from colonial exploitation and underdevelopment to a modern socio-economic, cultural and political structure (Kumar, 2005). Therefore, I consider Bangladesh as a post-colonial state or an entity that is under immense pressure to adapt to the modernisation of its socio-cultural and political structure while having to deal with the religiously conservative attitudes among the general population. Such pressure is triggered because Bangladesh is a Muslim majority country where many people tend to justify their reluctance to modernisation through their behaviour based on religious values and taboos.

A society where religious values and taboos are predominant among the general population is described as a religiously conservative society. Some of the common religiously conservative attitudes are objections toward abortion, same-sex behaviour, specific drug use, and sexual activity outside of marriage. In this thesis, I have considered Bangladesh as a religiously conservative society because, in this kind of society, most conservative values and attitudes are grounded in religious beliefs and many people seek to intensify the impact of religion on public life (Petersen, 2005).

Since religious values and taboos have played a substantial role in shaping the general population's behaviour and attitude, these have also played an important role in shaping the political structure of Bangladesh. This is because religion is often deemed as an indicator of identity while political mobilisation affects other indicators such as language and culture (Murshid, 2001). Certain Islamist political parties and groups who demanded the right to be the only interpreters of Islam in Bangladesh claimed to know the ultimate truth regarding religion; such Islamic groups contested certain faiths of Islam such as the finality of the prophethood of

Muhammad and the Quran as the paramount source of divine law (Murshid, 2001). However, it can be argued that the practice and interpretations of Islam have differed in terms of different regions: there are many sects and four major schools of Islamic jurisprudence who all claim their legitimacy (Suhrawardy, 1948). Hence, there is significant potential for conflict when shaping the politics of the nation because the religious orthodoxy attempts to forge a state determined by Islam and the Shariah laws (Murshid, 2001). This is despite the state harbouring a large diasporic Muslim population from other political and cultural locales which cannot be included within this construct (Murshid, 2001). Such construction or conception of the nation and state are somewhat discriminatory to religious minorities whose status would be vulnerable under Shariah laws (Murshid, 2001), and the same applies to the status of sexual and gender diverse communities due to certain contestable Islamic interpretations. This tells us how a post-colonial state has been influenced by religious orthodoxy for its political construction, which has led to discrimination and marginalisation of different minority populations.

5.3 Impact of masculinity in a patriarchal society

Hegemonic masculinity is an expression of a male dominant society (Connell, 2017). Hegemonic masculinity is a practice to regard women as inferior to men, and disregarding any kind of ‘feminine’ emotions such as caring, nurturing, and sensitivity (Uchendu, 2007). Curbing the oppression of women and dismantling the privileges obtained by men through hegemonic masculinity is very difficult to achieve in a patriarchal society (Heasley & Crane, 2012). While examining intra-minority stress related to gay and bisexual men’s mental health, the implications of masculinity are deemed as important factors (Pachankis et al., 2020). This is because male sexual or gender diverse individuals often experience ill health due to the attitude and perception toward manhood and the holistic organisational structure of men’s lives and relationships (Robertson et al., 2016). This implies that ironically it is men who suffer the consequences of socially constructed masculinity.

Public health challenges are intensified by inadequate attention given to the connections between men’s health and masculine norms within public health settings (Baker & Shand, 2017; Hawkes & Buse, 2013). *Masculine Norms and Men’s Health*, a report by Promundo Global in 2019, explains that due to masculine norms men usually have health habits of tobacco use, poor diet, unsafe sex, occupational hazards, drug use, alcohol use, and a limited healthcare-seeking attitude, which are the causes of 70 per cent of men's ailments and more than 50 per cent of all premature male deaths (Ragonese et al., 2018). These health habits are related to masculine social norms that emphasise the idea that manhood is all about risk-taking, stoicism, hypersexuality, and self-sufficiency; these norms mutually influence a particular set of health behaviours that lead to men's poor health status and have an impact on both men and women (Ragonese & Barker, 2019). Since this research studies sexual or gender diverse individuals, we need to consider patriarchal masculinity in terms of its relevance to health aspects of not only men but all sexual and gender identities who participated in this study. Patriarchal norms affected the health status of participants, and these patriarchal norms affected their livelihood in multifarious ways. Before I go into my analysis, it would be beneficial to provide a brief understanding of how patriarchal masculinity is constructed.

The history of patriarchy in the South Asian region goes beyond the British Regime and it is important to consider how masculinity or gender roles affect individual rights or human rights (Anagol & Grey, 2017). To explore masculinity and patriarchy in Bangladesh, we need to understand that masculinity existed during the Mughal Empire and Colonial India and has been sustained by different religious rituals and interpretations. However, the social history of masculinity is arguably paradoxical due to the varied analyses from South Asian scholarships (Sinha, 1999). To elaborate, both social histories of gender relations in colonial India and analysis of the gendered constructions of colonialism and nationalism mostly focused on women due to the oppression and discrimination faced by females. Hence, there remains a relative lack of scholarship on masculinities in colonial India (Sinha, 1999). According to Anderson and Guha (1998), there are also varied concepts of rights and justice that have greatly impacted the understanding of socio-cultural construction including patriarchy in the South Asian countries. Current arguments regarding universal human rights are mostly Eurocentric and do not resemble the socio-cultural practices of the South Asian countries and are thus inappropriate in this region.

Sati impacted on the construction of patriarchy in a very subtle way. *Sati* was originally a voluntary act as a symbol of being an obedient wife to follow the deceased husband to the afterlife (Major, 2006). But over time *sati* gradually became a forced practice if the widow had no children to support her, which indicated an enforced low status of women (Sangari & Vaid, 1981). During the eighteenth century, women were regarded as ‘victims’ of crimes by the administrative policies by considering the custom of *sati* (widow burning) (Mani, 1998). However, the view as ‘victims’ was changed to ‘criminals’ through female infanticide where a newly born female child was killed because being born a female was regarded as a crime. Gradually men were held accountable for looking after female members in the recess of zenanas (Anagol, 2005), thus bringing male dominance or masculinity into families. This reminds us that the historically male dominant society used certain rituals of Hindu religion to subjugate and dispose of women’s bodies.

According to Cain et al. (1979), in Bangladeshi society, patriarchy refers to ‘a set of social relations with a material base that enables men to dominate women’. The authors added that the material base of patriarchy indicates the control of men over income, property and women’s labour under a distribution of resources and power in families where men hold that power to control resources whereas women are dependent on men.

According to Cain et al. (1979), Islam also portrays a normative and ideological force of patriarchy as Islam is very transparent about the division of responsibility and labour, indicating men’s dominance over women. Cain et al. (1979) further explain that Muslim inheritance laws permit a daughter one-half the share obtained by a son, referring to the superiority of men over women. The manifestation of ‘purdah’ or veil — the seclusion of women — arguably confines women but aims to provide security whereas men are normatively obligated to ensure food, shelter and clothing for women. Such interpretations of Islam play a significant role to define patriarchal masculinity in Bangladesh.

Feyan expressed that in contemporary patriarchal society, it is generally believed that women would be oppressed physically, mentally, verbally and sexually, and sexuality is sustained as a taboo to keep these oppressions alive. Farnen reported that the degree of stigma varies depending on the social and economic status of the people, thus feminised men (*kothi*) are frequently pressurised more than cis-gender men to get married. Perhaps, this is because it is about the role of women as subordinate to men, which virtually shows that it is more of a gender issue than sexuality. Men must know their place and women must know theirs and anyone who violates those limits must be forced back into their places and this is why, perhaps, *kothi* are pressured to get married to put them back in their place. The colonial history of masculinity and purposeful use of Islamic interpretations leaves an argument of whether men truly serve Islam or men make Islam serve them to hold dominance over women.

Due to the influence of masculinity, participants explained that *rupantorito nari* are not as accepted in the families as *rupantorito purush*. Imeen was not supported by her family and she had to leave home, but she expressed that if she was a *rupantorito purush,* her family might have accepted her as the society considered that men are the so-called dominant counterparts. This reminds us that the patriarchal mindset of the families is a two-edged sword — despite the occasional acceptance of *rupantorito purush*, *rupantorito nari* are mostly neglected in the families.

Imeen is often called an alien as a form of verbal abuse because of being a transwoman sex worker, a subordinate to women. Imeen stated that "If we are treated as a different species, if we are aliens, then why do people come to us [for sex]?" This statement implies that it is, in fact, the sex that is taken into account, because if a client has contempt for Imeen as a sex worker, the client would have the same contempt for the part of himself that cannot be chaste, and his contempt for Imeen is also his contempt for the sexual part of himself.

Imeen reported that among her surroundings and networks, she never found any transwoman who is accepted by their family. She added that if a woman dresses like a man, people normally consider that she is being modern and following westernised culture and she is most appreciated, but when a man dresses as woman, it is seen as shame, madness, a mental illness, and rejected as a forced modernisation. The reason for such a rejection is that people believe the place of men should not be threatened or changed to be subordinate to women, which is a manifestation of patriarchal masculinity. Such discrimination to transwomen often puts the participants in trouble and Inrose expressed that since transmen are somewhat accepted, they do not usually go through financial problems like transwomen.

Sometimes, the impact of a masculine society may influence the expression of sexuality. For example, Isalho was a female by birth but his parents wanted a son. Thus, they treated him as a son and used to let him wear male attire. Perhaps this was his parents' way of attempting to replace their daughter with a son by raising him in such a way that Isalho did not even understand that he was not representing his assigned gender. Thus, Isalho grew up believing that he was a male but during his adolescence, he realised that he was physically female. However, he explained that due to his parents' way of bringing him up, psychologically he had already transformed into a man. Subsequently, he underwent gender confirmation surgery to confirm his identity as a man. However, to achieve this result of masculine norms on Isalho's expression of sexuality, he had to go through psychological conflict to understand his sexuality, isolation from friends, and feeling of helplessness, which had an adverse effect on his mental health. There is also an interrelation between patriarchal norms and sexual health and behaviour. For instance, Isalho described that most women in Bangladesh think that sexual intercourse is supposed to please only men, not women, therefore, Isalho's female partner is also reluctant to touch him during intimacy because she thought only Isalho can touch her, but she cannot touch him. The way Isalho expressed this indicates that women do not tend to get pleasure out of intimacy and sexual intercourse as they think men are only supposed to be enjoyed in a masculine society.

Idujon explained that they call themselves both male and female or neither male nor female. When they were born with a slightly deformed vagina and testicles, Idujon was identified as a girl in the family. Consequently, ear piercing and nose piercing were done. After a few attempts of (unsuccessful) medical treatments, Idujon was then recognised as a boy, which somehow represents a patriarchal expression in the family. However, deep down, they knew that they were neither girl nor boy, and how society and family identified them was entirely unacceptable to Idujon.

5.4 Relationship between healthcare and Section 377

To understand the ideologies that maintained the exercise of colonial power, one needs to consider the colonial struggles about sexuality. Throughout the 19th and 20th century, some European empires, particularly the British and the Dutch, developed policies on gender and sexuality to control the most intimate domains of both colonisers and colonised (Aldrich, 2003; Mertens & Myrttinen, 2019). As a result, Section 377 was introduced in South Asian societies. The introduction of Section 377 law by the British Regime reinforced the oppression of sexual and gender diverse populations in the South Asian region. As a post-colonial state, Bangladesh is no exception for its unceasing oppression to sexual and gender diverse communities through this law. It is worth noting that Section 377 has implications not just for the acceptance of sexual and gender diverse communities but also for their right to healthcare. It is usually assumed that the right to access to healthcare is for everyone, regardless of a person's individual characteristics. Section 377 criminalised particular behaviours 'against the order of nature', as though the behaviours were so unspeakable they could not be named. The behaviours may have been obvious to the colonisers, but only to the colonisers. It was a short step to criminalise not merely the behaviours but the people who were presumed to enact those behaviours. In this way, the entire classes of people were criminalised. As a result, they are often inhibited from accessing healthcare, which is a violation of the right to health (Kapoor & Pathare, 2019). The participants identified a relationship between Section 377 and healthcare experiences. Freial expressed that Section 377 still penalises homosexuality and for this sexual and gender diverse communities are scared of disclosing their sexual and gender orientation to healthcare providers.

Freial added that Bijito supports healthcare for sexual and gender diverse people and about 85 per cent of their clients visit Bijito because they can disclose who they are without any danger. Freial also explained that one of his clients went to a government hospital due to his anal problem but the physician refused to see him and asked the staff to call a police officer to arrest the client. Similarly, Iksera reported that she is scared to disclose information about herself to the physician as she thinks they might call the police.

There was also another problem — the challenge of getting a proper diagnosis and treatment as the participants did not wish to disclose information about themselves due to Section 377. For example, for an anal problem, a sexual or gender diverse person may hide the actual cause and tell the physician that they have constipation. Freial added that because of this, they can receive a faulty diagnosis and treatment from the healthcare providers. Thus, Farnen reported that sometimes sexual and gender diverse people fail to receive proper medical treatment and their health deteriorates over time; they often end up having anal cancer or an anal fissure.

5.5 Colonial reinforcement on heteronormativity

The introduction of Section 377 not only maintained the oppression of sexual and gender diverse communities but effectively established the idea or notion of heteronormativity.

Heteronormativity is the notion that being heterosexual is the default sexual orientation from the anticipation of gender binary: it idealises that marital or sexual relationships can only happen between intervals of the opposite sex (Marchia & Sommer, 2019). Heteronormativity also refers to the assumption that heterosexuality — attraction to the opposite sex, and the social and legal rights and institutions that go with it, such as marriage and child-rearing — is inevitable, natural or desirable (Montgomery & Stewart, 2012, p. 164). The concept of heteronormativity constructs sexual and gender diverse communities as marginalised and vulnerable (Henrickson & Fouché, 2017, p. 38).

Although equality in healthcare emphasises that all patients need to be treated equally, the notion of equality is a heteronormative concept in this context, thus homosexual healthcare receivers are usually treated as heterosexual (Röndahl, 2011). Similarly, Chervin et al. (2003) explain that heterosexism at an institutional level, particularly in health settings, does not necessarily manifest homophobia but displays a subtle yet equally harmful depiction of a ‘don’t ask, don’t tell’ policy. This policy implies that the service receiver would no longer be asked about their sexual and gender orientation (Fielding, 1996). Treating everyone equally also means treating everyone as heterosexual, making homosexual people invisible (Chervin et al., 2003). According to Enson (2015), heteronormativity is found to be detrimental in health settings because it can form bias and prejudice created from socially constructed taboos that are embedded in our mindset which we are not always aware of.

In many cases, some participants expressed that they hid their identities and the healthcare providers assumed that they were heterosexual patients, manifesting a heteronormative attitude of making sexual and gender diverse people invisible. This attitude indicates that healthcare providers are most probably heterosexual, and they represent heterosexual values. Also, perhaps the training of healthcare providers does not adequately teach them to be equitable or non-stigmatising in healthcare delivery. Thus, sexual and gender diverse communities may experience discriminatory healthcare delivery, which is an impact of heteronormativity maintained by the British Regime. Ichand stated that heteronormative behaviour, stigma toward sexual and gender diverse people, and discrimination in healthcare delivery are major consequences of Section 377.

5.6 Summary

Bangladesh, a post-colonial state, has been using religion and values derived from the British Regime to perpetuate the oppression and social control over sexual and gender diverse communities. I discussed the post-colonial societal structure, and how colonialism reinforced the notion of heteronormativity that is used to justify the oppression of marginalised people. I explored the relationship between healthcare and Section 377 and the role of masculinity in society to further understand how healthcare experiences have been impacted by patriarchal and colonial values. I considered and analysed all these aspects in this chapter to indicate that historically the use of religion, colonialism and patriarchy leads to collective oppression of sexual and gender diverse populations. The participants were often victims of a patriarchal social system, and they drew a connection between Section 377 and their healthcare experiences. Apart from the impact of patriarchy and colonialism, participants also lived in a suffocating environment due to the existing heteronormative values in society.

Chapter Six: Living as an Invisible in an Oppressive Society

6.1 Introduction

The collective oppression of sexual or gender diverse people in a society that privileges men has many facets and consequences that are analysed in this chapter. The aim of this chapter is twofold: to describe what it is like to be a sexual or gender diverse person in an Islamic patriarchal society, and to describe the healthcare needs of the participants. To identify different impacts of oppression, I analyse invisible communities and fear of disclosure, expression of self-identification, relationship experiences, risks and consequences of nondisclosure, disclosure and virtue signalling, attitudes of the family, and financial, educational, and occupational struggles. Further, I explore public harassment, rape, sexual harassment and invisible male rape, and police violence to discuss different forms of oppression against marginalised populations. I explore all these facets to understand oppression, its consequences, and social control over the participants in a society that privileges men. I also argue and demonstrate how health and healthcare overlap with each facet discussed in this chapter. I then explore the lives of the participants from their understandings and worldviews, and how the participants survive in the context of patriarchal masculinity.

6.2 Invisible communities and fear of disclosure

It is essential to consider how participants maintained dual identities which somewhat make them hidden and invisible in society due to the fear of disclosure. In this section, I analyse the reasons for sexual and gender diverse people to be hidden and live invisibly and the potential risks associated with participants' disclosure. The impact of the fear of disclosure on mental health, the legal barrier of disclosure, and the impact of stigma on other family members after disclosure are also analysed from participants' experiences. This section also discusses why the government may be willing to keep sexual and gender diverse communities invisible by not acknowledging their existence.

Many studies have been conducted to investigate the difficulties associated with disclosing self-identification or ‘coming out’ of a sexual or gender diverse person. Telford (2003), for instance, explains that during the expression of self-identification, a person may feel pressure not to come out due to their ethnic and racial backgrounds, religious affiliation, or financial condition; the fear of being excluded from financial support from the family prevents many young people from ‘coming out’. Similarly, a sexual or gender diverse person usually, in the Bangladeshi context, would not disclose themselves and would live throughout their life maintaining dual identities: one is socially conforming, and the other hidden from the public gaze.

The sexual and gender diverse population is known as an ‘invisible population’, a term used by Margaret Cruikshank, a feminist scholar. Before the 1970s homosexuality was poorly understood, especially in the United States, except for the view that it is immoral and deviant behaviour (Gelo, 2008). In the South Asian cultural view, sexual and gender diverse people usually conceal their sexual and gender orientation due to stigma and oppression in the form of physical and mental harassment, isolation from loved ones, and potential rights deprivation. Feyan said that “there are many shadow reports[2] conducted mentioning that sexual and gender diverse communities exist in Bangladesh.”

Feyan added that “many INGOs have conducted shadow reports to count the sexual and gender diverse population; these reports have concluded that sexual and gender diverse communities exist although they are rarely publicly visible.” The lack of formal documentation suggests that perhaps the government wants sexual and gender diverse communities to be socially excluded from the mainstream society by such denial of their existence. Choosing not to acknowledge these communities can lead to discrimination and exclusion from services, particularly during crisis moments like a pre-disaster period when sexual or gender diverse people are forced to disclose themselves in order to receive rehabilitation services (e.g. Yamashita et al., 2017). For instance, it is argued that during the lockdown and crisis moments under COVID-19, hijra, *kothi*, and transgender people are considered some of the most vulnerable groups of people in Bangladesh; this is because many members of these communities live hand to mouth, and their

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[2] Shadow reports are a source of information for NGOs and INGOs to provide substitute information to governments.

sources of income (e.g. collecting alms (*jholka*), partaking in religious rituals, and sex work) are restricted, or cease completely under the lockdown situation (Tan & Knight, 2020).

Some participants also made a connection between stigma and their lack of disclosure; the stigma is very acute, and they are made to look like criminals, thus they are usually unwilling to disclose. Ipreeth said that "it almost feels like a curse to be a sexual or gender diverse person in Bangladesh." This is because he feels like he will not be able to live long with such an invisible life as he cannot do whatever he wants, cannot speak out, and cannot have the partners he wants to live with.

There is a relationship between poor mental health and lack of disclosure (Wilson & Cariola, 2019). Disclosure has an impact on emotions; participants were often scared to share their feelings with their loved ones. As articulated by participant Idanam, "the fear of humiliation and shame frequently forces us to hide our feelings toward others." This is a psychological impact of not disclosing to others. For instance, some of the participants' friends will not abandon them as long as they do not find out about who they are. However, once friends find out, the relationships often fall apart, which leads to loneliness, isolation, and frustration. Therefore, most participants were also afraid to disclose themselves to their friends and close ones.

The fear of being exposed to humiliation and neglect means that participants usually made themselves invisible. For instance, disclosing one's sexual orientation to healthcare professionals may often lead to negative behaviour from these professionals (Gelo, 2008). Therefore, the participants often concealed their sexual orientation from healthcare providers.

Some participants may go or might have gone through a physical transition. For example, transwomen (*rupantorito nari*) or transmen (*rupantorito purush*) participants may choose surgeries or physical transition by taking gender confirmation hormone therapies. Disclosure in society can create different barriers in a transperson's life that may preclude or inhibit their physical transition. Therefore, transperson participants preferred to be hidden and invisible so that they can at least survive. It indicates the degree of resilience and determination that transperson participants had. Even if the participants wanted to disclose their identities, they had to assess their surroundings painstakingly. As articulated by some participants, they were always worried about how much they disclose either through words or appearance. Some participants, nonetheless, also believed that if they do not disclose themselves and talk about transgender issues in public, society may not be supportive of sexual and gender diverse people in the future. A significant problem is that the amount of risk disclosure entails is unknown, which was the biggest fear for the participants.

Then, there is a legal barrier to disclosing sexual orientation. Idanam stated:

> যদি মনে করেন আপনি নিজেকে সেল্ফ ডিক্লারেশন করেন তখন দেখা যাবে এটা তো আইনগতভাবেও ঠিক হবে না কারণ যেহেতু এখনো সেকশন ৩৭৭ রয়েছে আমাদের দেশে তখন এভাবে নিজেকে এভাবে পরিচয় দিয়ে যদি আপনি প্রকাশ করতে চান তখন এই স্টেটমেন্ট টা কাজে লাগিয়ে তখন ওরা আমাকে আইনি জালে জড়িয়ে ফেলবে। তো আমি এভাবে নিজেকে আত্মপ্রকাশ করলে ওটা একটা স্টেটমেন্ট হয়ে যাবে বা একটা দলিল এর মত প্রমাণস্বরূপ হয়ে যাবে তখন এটাকে কেউ কাজে লাগিয়ে আমার বিরুদ্ধে কোন অ্যাকশন নিতে পারে। আমি যদি কখনো কারো কাছে প্রকাশ করি আমার ব্যাপারে তখন দেখা যাবে সেইটা সেইটা অপব্যবহার করে আমার সাথে অনেক ধরনের কিছু করতে পারবে। অথবা দেখা যাবে আমাকে সে আইনগতভাবে ভয় দেখাবে অথবা আমার থেকে আর্থিক সুবিধা নেয়ার একটা সুযোগ নিবে তাই এই এই ঝুঁকি গুলো রয়েছে আসলে নিজেকে আত্মপ্রকাশ করার।

> *If you think about declaring yourself then it will not be legal because Section 377 is still applicable in our country. If I want to disclose myself in this way, then they will use this statement and they will put me in a legal net. Therefore, if I disclose myself like that, it will become a statement or a document, and then anyone can use it and take actions against me. If I ever reveal this to anyone, then they can put me in a lot of trouble by blackmailing me. Alternatively, they may legally intimidate me to take financial advantage from me, so these are the risks of self-disclosure.* (Idanam)

Iksera explained that despite the threat of violence and death, many people also consider that being homosexual is a mental health illness. Thus, some participants said that after disclosure, family members often try to send the sexual or gender diverse individuals to mental hospitals.

This is one reason why the participants did not usually intend to disclose themselves: they can end up being sent to mental hospitals or prison. Iksera said:

> *পাবনায় যে পাগলা গারদ আছে ওইখানে আসলে অনেককে নিয়ে যায় এরকম কিছু হলে কিন্তু এটা হয় বেশিরভাগ ছেলেদের ক্ষেত্রে। কিন্তু আমি তো একটি মেয়ে, তাই অনেকেই বলবে বা অনেকে এরকম একটা মিথ বিশ্বাস করে এবং বলবে যে ‘ও যেহেতু কোন ছেলের স্বাদ পায়নি তাহলে ওকে একবার ছেলের স্বাদ দিয়ে দেখ।’ এটাকে অনেকে মনে করে কার একটি কারেক্টিব পদক্ষেপ বা মনে করবে এটা একটা সংশোধন মূলক কাজ তো এরকম কিছু বিশ্বাস আমরা দেখেছি আমাদের সমাজে।*
>
> *There is a mental hospital in Pabna where most boys would be sent if there were cases like me. However, I am a girl, so many will believe the myth that says that ‘since she has not slept with a boy then give her a taste of boy once’. Many people think of this as a tactical step or think of it as a corrective action. We have seen some beliefs like this in our society.* (Iksera)

Some participants expressed that the consequence of disclosure can directly affect other family members. Sometimes family members might be accepting of a sexual or gender diverse individual. In such a scenario, a sexual or gender diverse person often fears disclosing themselves to others because society may start to disrespect and humiliate their families. Consequently, family members would struggle to continue their education, business or work and it would become impossible to live in society. People may generalise their hate from the individual to their family and such inclusive intolerance is one of the causes of stigma (Stangor & Crandall, 2000). It is deemed as an attempt to socially exclude a family just because one person in that family discloses their sexual orientation (Breshears & Braithwaite, 2014). Isalho stated:

> *জঙ্গি হামলা বা কোন মৌলবাদী হামলা দেখিয়ে আমাকে হয়তো মেরে ফেলবে। কিন্তু সবচেয়ে বেশি এফেক্টেড হবে আমার ফ্যামিলি এবং আমার মা এর অনেক কথা শুনতে হবে।*
>
> *They might kill me by making it look like a terrorist attack or a radical attack. However, my family and my mother will be the most affected due to mockery from society.* (Isalho)

Hiding oneself from society may also lead to physical issues. For instance, Idujon expressed:

> *ব্রেস্ট লুকানোর জন্য কুঁজো হয়ে হাঁটতে হাঁটতে আমার মেরুদন্ডে ব্যথা হয়ে গেল। তো তখন আমি বুঝতে পারিনি যে আসলে আমার মেরুদন্ডের হাড় বাঁকা হয়ে যাচ্ছে এবং দেখা যেত আমি ব্যথায় ঘুমাতে পারতাম না।*
>
> *Walking with a bending forward posture to hide my breasts made my spine ache. Then I did not realise that my spinal cord was twisting, and I started to have trouble sleeping due to the pain.* (Idujon)

Even if somebody asks Idujon why they seem physically different, Idujon would reply that they have some other physical issues (e.g. hormonal imbalance) so that they do not have to tell the truth.

Such hiding and invisibility can be a barrier for participants to communicate and build networks, although the participants sometimes use signs and body language to communicate so that the people around them cannot identify them. Some physical gestures or body language are used for hidden communication between sexual or gender diverse people. Perhaps some of those gestures are commonly used among sexual and gender diverse communities, but what makes these gestures important in Bangladeshi society is that without such gestures, invisible communities like sexual and gender diverse communities would struggle to identify community members and communicate with each other.

There are some other disadvantages of the disclosure. Some people may take advantage of their disclosure and try to get financial benefit by blackmailing them. Thus, Idanam believed that he somewhat become bait or a tool for others to gain financial benefits. Some participants also explained that people do not want to rent out houses to sexual and gender diverse people, or they ask for such high rent that sexual and gender diverse people cannot afford the place. Thus, they often end up living in slum areas or dirty places where their health starts to deteriorate. Some participants also reported that even if someone among the sexual and gender minority communities has a well-paid job, they often fail to access good accommodation and transportation services due to their self-disclosure in society.

Education, sports and cultural activities become almost impossible for most participants if they disclose themselves in society. Iruvo expressed that his mother beat him once as his tutor told her that he was attracted to both men and women. Physical abuse was one of the ways the participants were treated when they did not agree to present in ways their families and teachers approved. All these barriers of disclosure pushed most participants to led a life with dual identities. Consequently, participants often struggled to decide which identity to disclose in front of healthcare providers, which affected their healthcare experiences.

6.3 Expression of self-identification

In this section I analyse how expressions of self-identity are multifarious from each participant's point of view, suggesting the ways people disclose themselves are not consistent. Disclosure is different at different ages, as are the conflicts experienced by the participant as a result of the disclosure. The complexities of disclosure encouraged participants to maintain dual identities, which impacts on their healthcare experiences.

Self-identification or 'coming out' is a constant daily struggle for sexual and gender diverse people (Wang et al., 2009). Early theorists and scholars defined this expression of self-identification as one discrete or single event, not as a continuous process (Hunter, 2007); however contemporary theory suggests something quite different. Traditionally disclosure was understood by essentialist theorists as the first acknowledgement of one's self as a sexual or gender diverse person or a recognition of one's 'true' self (e.g. Cronin, 1974). This widely held view of the discrete event was dominant in early psychoanalysis of 'homosexuality', leading to the belief that a homosexual person was thought to result from a single traumatic pattern or event of family interaction (Socarides, 1978). In contrast, contemporary understandings argue that the expression of self-identification is a dynamic event, and there are both psychological and socio-cultural factors affecting disclosure (Hunter, 2007).

To analyse self-identification disclosures, it is essential to understand the major incidents that are taken as progress or turning points in self-identification, such as the person's feelings when they first understood they were different or felt attractions to the same sex (Rust, 2003). It is important to understand what is unique about the Bangladeshi experience of disclosure to self and others.

Self-identification of the participants has been influenced by the use of different terms. For example, many participants expressed that English terms such as gay, bisexual, lesbian, and transgender were not familiar in the past. Thus, many would use local terms — that can be often slang or abusive words — to identify them because they struggled to express their sexual orientations with specific terms. However, gradually, once these English terms started to become familiar, expression of self-identification arguably become easier for the participants. Participants mostly heard these terms from Ostitto and Bijito. They also became aware of the terms from friends and relatives who live abroad. This also implies that there is an adoption of Western notions of identity, and these Western-style identities being grafted on to South Asian cultural constructions is probably not very welcomed by the government and religious communities, thus stigma continues to rise.

Isalho explained that he became aware of being different when he was only nine years old and he used to like his best friend who was a female. Once he realised that he did not want to conform to his assigned birth-gender (female), he started to suffer psychologically. He hoped for gender confirmation surgery so that he could identify himself as a man. Similarly, Ichand explained that she self-identified when she was eleven years old although she did not express it to anyone else. She added that once people grow up, their feelings grow as well, which may raise self-conflicts. With this increasing degree of conflict, they start to realise the difference about themselves. Understanding oneself as different, even when there are not words, may begin at the toddler age. Iruyan explained that he heard from his parents that he was very reluctant and would start crying while putting on girls’ dresses when he was one or two years old. It somehow indicates how resistant he was to not conform with his assigned gender even though he was a child.

Expressing self-identification is something that happens naturally and cannot be forced. Israne explained:

> *আমি তো অনেক ছোটো থেকেই ধরেন... আমার তো চিন্তা ধারাই ওই রকম ছিল একজন ছেলে হিসেবে... [সামান্য ইতস্তিত]। মেয়েদের একটা সময় আছে যে পিরিয়ডের সময়, তখন হয়তো তারা বুঝতে পারে যে না আমি আসলে ওটা না, আমি একজন মেয়ে। তারপরও কিন্তু দেখা যায় যে মন আসে না, বুঝে না,*

> আমার মনটা আসলে একটা ছেলের মতোই। একটা ছেলে হিসেবেই থাকতে চায় এবং এটা কিন্তু একটা ন্যাচারাল ব্যাপার। এটা জোরপূর্বক না এটা ন্যাচারালি আসছে আমার মন থেকেই এটা।
>
> *I understood it from a very young age ... I thought I was like a boy ... [I was slightly shy]. During menstruation, girls maybe realise who they are; I also felt that I was a girl. Even then, it appears that I was not convinced, could not understand, my mind has been like a boy, it wants to be a boy, and this is a natural thing. It is not forced; it is coming naturally from inside.* (Israne)

Adolescence is often a common period of life for sexual and gender diverse people's self-identification expressions. Ipreeth said that he realised his sexual orientation during puberty, and it was not an easy experience for him. For hijra participants, the expression of self-identification was somewhat similar. Ikhiyam discussed that although she was biologically a male, she had always presented herself as a girl since her childhood. She was always attracted to female attire, make-up, and jewellery.

Disclosure of self-identification could be a continuous or lengthy process. For example, Iksera explained that she does not recall exactly when it all started. When she began to experience mixed feelings and thoughts, she started to spend time alone. She realised that she did not have to fear as much as other women, and she did not have to talk in a low tone like other women.

While self-identification is a complicated and continuous matter, some participants identified themselves during their adult life once their childhood is over. Iksera described another incident as an adult that made her realise her sexual orientation. She tried to socialise and form a relationship with a man. When she kissed this man, she felt disgusted. This was when she realised that she was not attracted to men.

After the participants identified themselves, or 'came out', as adults, they tended to segregate themselves from society because of the mockery and bullying. During segregation from society, some participants sought for spiritual and religious guidance to deal with their conflicts. This suggests that there is a relationship between the religious affiliations of the participants and disclosure (Telford, 2003). Inrose said:

> *তখন বয়স তো মনে করেন ১০ বা ১১ বছর ছিল। আসলে আমি তখন থেকেই বুঝতে পারি যে আমি অন্যদের থেকে একটু আলাদা আমি একটু ডিফারেন্ট। এবং আমি যেহেতু মুসলমান পরিবারে জন্মগ্রহণ করেছি আমি আমার মনের কথা আর কাউকে না বলতে পারলেও আমি কিন্তু একজনকে বলতে পারি সে হলেন আল্লাহ। আমি নামাজ পড়ে আল্লাহর কাছে বলতাম যে আল্লাহ তুমি আমাকে যে অবস্থায় জন্মগ্রহণ করিয়েছো তুমি দয়া করে আমাকে পরিবর্তন করে দাও এবং আমাকে নারী বানিয়ে দাও কারণ আমার নারী জেন্ডার ভাল লাগে তাদের মতো হতে ইচ্ছে করে।*
>
> *I think I was ten or eleven years old. In fact, from then on, I realised that I am not like others and I am a little different. Moreover, since I was born into a Muslim family, I could not speak to anyone else. However, in my mind, I could speak to someone — ALLAH. I prayed and said to Allah that 'You made me, please transform me and make me a woman because I like being a woman and this gender is what I want'.* (Inrose)

Many participants also emphasised that being different from others is not just physical, it is equally emotional. As Iporane expressed, "It does not matter whether I have female organs or not; the only thing that counts is that I am mentally a woman." Ironically, people in a conservative society mostly find this mentality difficult to accept because people in a patriarchal society do not seem to accept when a woman does not want to represent her socially assigned gender. Therefore, expression of self-identification to the society is even more critical. Israne said that if a transman wants to put on male clothing or have a male haircut as a part of self-recognition, he would be questioned by those surrounding him. However, some participants tended to be resilient and tried not to care about what society thinks of them.

Self-identification has been viewed as a strong sense of recognising one's true self in this research. A strong sense of recognition can also mean the wish to change to prepare for disclosure in society. For instance, Isalho said:

> *আমার মা একদিন বলতেছিলেন যে কেন শুধু শুধু নিজেকে এত কষ্ট দিচ্ছিস এবং যেমন ছিলি তেমনি থাকতি। তখন আমি আমার মাকে বললাম তাহলে দেখো আমি কতো ডেসপারেট আমার নিজেকে চেঞ্জ*

> *করার জন্য, এত কষ্ট করার পরও আমি এটা করেছি, তার মানে আমার আগের অবস্থা আমাকে কত কষ্ট দিত। আমরা কতটুকু যন্ত্রণা বা কতটুকু ব্যাথা পাই যে আমরা এত ডেসপারেট হয়ে যাই নিজেকে এভাবে শারীরিকভাবে চেঞ্জ করার জন্য। সবাইতো সবার শরীরকে ভালোবাসে আর কষ্ট তো আসলে আমাকেই পোহাতে হচ্ছে এই অপারেশনের পর।*
>
> *Once, my mother said that you hurt yourself so much, but you could have stayed as you were. Then I told my mother how desperate I was to change myself, even though I had suffered so much, showed how much more painful it was for me to accept my old self. No matter how much pain or suffering we have, we have become desperate to physically transform ourselves. Everyone loves their body, and I am the only one who is experiencing pain after this operation.* (Isalho)

Isalho reminds us that even though gender confirmation surgery can sometimes be physically risky, many gender diverse people are still willing to have it done, as they want to self-identify themselves with their true self. The pain and suffering of this surgery are nothing in comparison to the pain of enduring the old self that they were not meant to be.

Not everyone had a similar experience, of course, to point out how multifarious self-identification expressions can be. For instance, Imeen described that she was always attracted to men, and preferred to have to a women’s lifestyle. Once she had watched a video of ‘Shemale’, referring to a transwoman working in the sex trade (Arune, 2006), she decided that she wanted to be like a ‘Shemale’. She then secretly started to wear her sisters’ make-up and clothing and fantasised that she would be like ‘Shemale’ one day.

6.4 Risks and consequences of nondisclosure

Nondisclosure by sexual and gender diverse people is not an uncommon event in healthcare settings (Dovidio et al., 2000). The reason for such nondisclosure is that the anticipated consequences are unknown, and disclosing can also bring experiences with an unwelcoming environment for sexual and gender diverse people in the healthcare sector (Beehler, 2001), resulting in a decrease in the level of willingness to visit a healthcare setting in the future

(Johnson & Nemeth, 2014). Hence, it is essential to analyse the potential risks and consequences experienced by the participants that discouraged them from disclosing their identities to healthcare professionals. If sexual and gender diverse people do not disclose themselves, they may not experience discriminatory behaviour but may receive inappropriate care because the healthcare provider may treat and diagnose them by assuming that they are heterosexual patients (Beehler, 2001; Utamsingh et al., 2016).

In most cases where participants experienced negative behaviour and discrimination from healthcare providers, they made a rational choice of disclosure by using a utilitarian approach, which refers to a model developed to assess the outcome of a certain decision or action (Mulgan, 2020). Rational choice theory urges that every human being analyses personal cost and benefit before deciding to perform a certain task (Sen, 1990). In healthcare, the quality and the proximity of the care, socio-economic condition, and cost of treatment are deemed to be important when patients make healthcare decisions (Owumi & Raji, 2013). In this research, many participants assessed the rational consequences of their decision of disclosure in healthcare settings, and whether the overall advantages outweighed the disadvantages; they made a rational choice to disclose or not. They were somewhat aware of the consequences, but their choice was rationally based on their health needs.

Due to the mockery and stigma after disclosure, many participants radically changed their appearance and public gender expression. Isalho said before his gender confirmation surgery:

> *আমি চেষ্টা করেছিলাম মেয়েদের মত করে চলাফেরা করার বা মেয়েদের মত জামাকাপড় পরার । তারপরে চুল একটু বড় করতে শুরু করলাম। এবং আমি এটাও চেষ্টা করছিলাম যে আমি একটা ছেলের সাথে রিলেশনশিপেও গেছিলাম। কিন্তু আসলে এটা হচ্ছিল না কারণ আমি তো ওভাবে চেষ্টা করেও পারছিলাম না। একটা ছেলের সাথে ওর সম্পর্ক করার চেষ্টা করেছি কিন্তু এটা আমার দ্বারা সম্ভব হয়নি।*
>
> *I tried to behave like a girl or dress like a girl. Then I started to grow my hair longer. And I also tried to form a relationship with a boy. But it did not really happen because I could not even try it. I tried to form a relationship with a boy but that was impossible for me.* (Isalho)

Nobody can easily force themselves to change although that is what Isalho attempted. He also explained that he struggled because of his transition to maintain his friendship with a very good male friend. He is worried that if his friend came to know about his gender confirmation surgery, his friendship could end. Isalho was also risking his business activities due to this transition as he knew that business partners would not accept it. Even with all these barriers and consequences, he rationally decided to go for this transition as it was not bearable for him to conform to his socially assigned female gender.

The risk of being homeless is a major consequence of disclosure for sexual and gender diverse communities (Macias-Konstantopoulos & Bar-Halpern, 2016). Also, the consequences of disclosure to healthcare professionals may hinder the process of receiving healthcare and this issue has been studied by many other scholars (Rossman et al., 2017). Nondisclosure not only affects the healthcare experience but the socio-cultural and financial aspects of most participants' lives that made them hide their identities while visiting a healthcare setting mean that again they had to make a rational decision whether to disclose or not who they are.

6.5 Disclosure and 'virtue signalling'

The issue of disclosure by others is a common scenario that many participants experienced. In some cases, either a so-called best friend or tutor would disclose the participants in front of their family, which created a fear of betrayal. Families who rejected participants after disclosure were somehow betraying them. Denouncing a person or publicly expressing opinions intended to demonstrate one's moral correctness is defined as 'virtue signalling' (Hamilton, 2019), and some participants were frequently victims of 'virtue signalling' not only by family and friends but also by healthcare providers.

There is a relationship between 'virtue signalling' and the conception of homosexuality discussed from the social constructionist perspective. This can give a further understanding of how historical and religious attitudes toward homosexuality can motivate people to use 'virtue signalling'. According to Greenberg (1988), social constructionists claimed that each culture is different in its way of perceiving homosexuality: for instance, gender-crosser or transgender (e.g. hijra in the South Asian region) practising homosexual behaviour are deemed as a unique feature in many cultures. During the thirteenth century, Christianity was used by wealthier and upper-class people to justify penalising homosexuality in many western parts of the world (Greenberg, 1988). Many religious people from communities assumed that God would support their economic and political goals if the majority of people are virtuous (Weinstein, 1970), and they were willing to use coercion to obtain collective virtue: a major element of virtue was sexual behaviour (Greenberg, 1988). Hence, social constructionism proposes that the virtuous need to construct the notion of 'non-virtuous' in particular ways in order to assert and confirm their own virtue. Goodich (1982) and Greenberg (1988) claim that the religious campaigns against homosexuality during the thirteenth century were nothing but a class-based effort to reform society. Greenberg (1988) discusses that the repression of sodomy was reasoned by the early Christian interpretation of the story of Sodom; however, the factors that led these repressive campaigns were those of class hatred. Pre-modern literature argued that sodomy could be performed with a man, though a virtuous person would abstain even if they are tempted to engage in it (Greenberg, 1988). This again reminds us that many would simply deem/label/denounce sodomy as a non-virtuous act just to claim that they are virtuous.

While exploring moral virtues for medical practitioners, Kotzee et al. (2017) explain that fairness, good judgement, and kindness are essential to determine whether a physician is a moral person. However, healthcare providers can have different kinds of judgements pertaining to homosexuality due to their ethnic, social, and religious background. For example, a physician may feel that denouncing a homosexual patient is a part of their moral obligation. But in fact what they may be doing is 'virtue signalling' to their colleagues about the homosexual behaviour of the patient, without realising that their role is not to change minds with their moral principles; they are simply trying to put themselves in the spotlight (Levy, 2019) and align themselves with the moral norms of their colleagues and peers.

Critics of 'virtue signalling' argued that the people who are 'virtue-signalling' are showing nothing but outrage toward a particular belief (Jordan & Rand, 2019, March 30), and in the participants' cases this outrage is demonstrated by the attitudes toward *tona tona dhurpit*. Perhaps the purpose of such 'virtue signalling' is to justify the superiority over the participants, whereas such a feeling of superiority is mostly a false sense of power, explains Shariatmadari (2016, January 20).

6.6 Relationship experiences

The relationship experiences of the participants were arguably rewarding but difficult for some participants to continue due to the pressure and negative attitude of the society. Even if participants felt connected to someone, they had to break up because there was little community support for same-sex relationships – and when these relationships were publicly disclosed, they were rarely accepted. Yet there are examples of long-lasting relationships: Israne had been in a relationship with a woman for eight years. However, he had to go through a tough relationship experience when he was younger. During his 9th standard in school, he was in a relationship with a girl who was a year junior to him. A teacher at the school found out about their relationship and Israne's girlfriend was punished with a school transfer certificate. After that, they had lost contact, but a few years later when they were in contact again, she was already in a relationship with another man, although Israne still had feelings for her. He could never tell her again that he loved her, and eventually, she married another man and moved abroad. Iruyan said that he also had another relationship that did not end well, and not having a long-lasting relationship made him feel isolated and lonely throughout his life.

Marriage is a social expectation in Bangladesh and every family directly or indirectly pressurises their children into getting married. Iruyan was pressured by family members to get married but he insisted that he did not want to. However, Ichand, a *somopremi nari*, had to sacrifice her love to a woman at a young age and marry a man due to family pressure. Ichand reported that lesbians are in a situation where they are unable to protest forced marriage, whereas in many cases *somopremi purush* can protest forced marriage, referring to patriarchal masculinity where women are bound to comply. Nevertheless, after almost three decades, she was divorced, and she and her first love were back together. The example of Ichand is very important because she suffered from depression due to her relationship experiences, which inspired her in later life to switch her career to work for mental support for sexual and gender diverse people.

When a *rupantorito nari* forms a relationship with a man, he may not feel any obligation to get married because society would not accept it. For instance, Imeen had a boyfriend and for four years she spent a lot of money on him that she had earned by sex work. Eventually, he left her. Therefore, Imeen thought that people liked to stay with her just because they did not need to commit to getting married. Sometimes men may take advantage of ‘sleeping’ with a *rupantorito nari* just because they know a marriage between a man and a *rupantorito nari* is rarely accepted.

Not everyone has been successful in forming a relationship. Idanam used to have feelings for his best friend but could not express his feeling because he did not know how his friend would react. He was scared that his friend might disclose him to his family or society, thus he never dared to express that he liked him. Meanwhile, his friend started to avoid him. It was so unbearable for Idanam; he felt he was going through psychological trauma and depression. He once even thought about committing suicide and left a note for his friend. Nevertheless, over time he moved on. He expressed that innocent feelings of love are being buried because society is not willing to accept same-sex relationships.

Sometimes having a relationship is not always what it seems. For instance, relationships within these communities are mostly invisible. Inrose said:

> *আমরা তো আমাদের শরীর এবং মন কে মানিয়ে নেই। আমরা একটা সম্পর্ক থাকলেও দেখা যায় যে আমি কিন্তু তারপরও অনেকটা একাকীত্বে ভুগি কারণ তার সাথে তো আর আমি রাস্তায় একসাথে স্বাচ্ছন্দে ঘোরাফেরা বা হাত ধরে হাঁটা চলা করতে পারিনা।*
>
> *We do adapt to our body and mind. Even though we are in a relationship, I often suffer from loneliness because I cannot walk with him outside comfortably or cannot walk with him holding hands.* (Inrose)

Even though some participants were in relationships, they were mostly as invisible as their identities and these relationships rarely resulted in marriage. However, one hijra participant, Iporane, married a heterosexual man who is Muslim. She was able to legally marry him because she was a woman in her civil documents such as her national identity card (NID) and passport. Iporane used to belong to the Hindu religion but to get married she had to convert to Islam by an official affidavit so that she could marry the person she loved. She did this because she considered love and self-identification to be far more essential than religion.

Although Iruvo previously had a female partner, he is afraid to live with his current male partner. Iruvo's first relationship was very difficult. This relationship experience was with a man. His friends discovered this, and they beat his partner almost to death. They also threatened both of them to stay apart and eventually his partner left the country. Iruvo's partner invited him to leave the country with him but Iruvo loves his family so much he could not leave. Iruvo chose to stay with family rather than his same-sex partner so that he would not be beaten.

Since sexual and gender communities are hidden, they usually depend on online communication sites to meet people (Rashid, Standing, et al., 2011). In this way, they can also meet people from different parts of the world. Isalho's current partner is a bisexual female who is from a different country, as was his previous partner. Isalho articulated that their families have recently accepted their relationship and they both want to be together soon. Idujon also communicated with a man over the phone. However, they never met in person and they had to stop communicating as Idujon never mentioned their sexual identity to him. The relationship experiences of the participants were also diverse, but there was one thing that was common in most of their relationship experiences – they were hidden and secret. As a result, breaking trust became somewhat easier which tended to bring isolation, depression and loneliness to participants' lives.

Relationships of sexual and gender diverse people can affect their health, and the effects of stigma also have a severe impact on mental health and intimate relationships (Thornicroft, 2006). A mental health problem can affect existing relationships: for example, if a person is dejected, they can lose interest in intimacy and their partner may think that the other partner does not love them anymore (Pacitti & Thornicroft, 2009), so there is an interrelationship between relationship experiences and mental health of the participants. According to Crowe (2004), awareness must be increased among helping professionals (e.g. healthcare providers) so they can help people who suffer from mental health problems to understand the need for a stable relationship. Hence, this section analyses participants' relationship experiences and how these experiences, sometimes affect their mental health.

6.7 Attitude from the family

According to Needham and Austin (2010), attitudes from the family can range from acceptance to rejection, and these attitudes and the responses associated with them can influence the family relationship and mental health status. The attitude of family members toward young sexual and gender diverse people greatly impacts life course trajectories by identifying the availability of sources of support (Schmitz & Tyler, 2018). Family dynamics and the parental relationship may have both positive and negative impacts on the mental health of young sexual and gender diverse people (Carastathis et al., 2017). Support and a positive attitude from the family in comparison with non-familial support such as friends are considered an important element for the positive psychological health of sexual and gender diverse people (McConnell et al., 2015). According to Needham and Austin (2010), support and closeness from family members, particularly parents, can be a strong source of resilience for sexual and gender diverse people in promoting their health and well-being. When a sexual or gender diverse person experiences negative behaviour from the family, they tend to lose their whole world and live with the anxiety of mistrust, and family rejection and a negative family relationship have an impact on the person's psychosocial situation and mental health (Parra et al., 2018; C. Ryan et al., 2009). This section of the analysis describes how the participants experienced attitude from the family to understand whether these attitudes cause mental and emotional health problem or promote well-being.

Sometimes, parents, despite being educated, do not accept the fact that one of their family members does not want to conform to their assigned gender. Consequently, many participants were forced by their parents to leave the house. For example, Imeen disclosed to her family members but they scolded her; she tried to explain that she was emotionally a woman and never wanted to be a man. After a long struggle, she left home when she was about eighteen years old and identified herself in society as a *rupantorito nari*. It must have taken a lot of bravery for Imeen to take such a step because unacceptance from family members often leads to serious consequences, perhaps even suicide. While she had trusted her family members, she did not get trust in return. Once the most trusted people did not support her after the disclosure, she did not have anywhere else to go and the whole world became, as she said, a "living hell" for her. Since she had disclosed publicly, she could not get any other work and was forced to be a sex worker.

None of Ikhiyam's family members, including her parents, wanted to listen to or understand her situation. Sometimes, families may have realised the participant's sexual orientation and did not force them out of the home but were not ready to accept them from the heart. For instance, Idanam discussed that even though he resides with the family, he is not living with them emotionally. Such partial acceptance in the family is critical because it tends to seriously affect the sense of belonging in the family and affects mental health. Another example of partial acceptance is expressed by Inrose: her family somewhat accepted her after her gender confirmation surgery, but they would not accept her if she marries a man and lives with him because they think that she already humiliated her family enough in front of the society. However, transwomen participants in particular said they hid their gender confirmation hormone therapies from their families because they were not certain how family members would react to the idea of their not conforming to assigned male roles.

Family attitudes reflected both support and neglect for the participants. Karnen expressed that the family was one of the most important sources of support for people to be resilient. Sometimes, the support from a mother was noticeable, whereas siblings and other members of the family were not as supportive as the mother. Karnen stated:

> *আমার মা আমাকে যথেষ্ট সাপোর্ট দিয়েছেন এবং আমি ছোটবেলা থেকেই আমার মায়ের খুব একটা সাপোর্ট পেয়েছি। কিন্তু আমার মা তো এখন মারা গেছেন তাই এখন আর আমার পরিবারের সাথে থাকা হয় না। আমার পরিবার থেকে আমি মা ছাড়া তেমন একটা সাপোর্ট পাইনি, আমার ভাই যেমন খুব কষ্ট পেতো আমাকে নিয়ে আমাকে মাঝে মধ্যে থাপ্পর মারত যে আমি এমন কেন। আমি এটা খারাপ ভাবে নিতাম না কারণ আমি জানতাম ও তো কষ্ট পাচ্ছে আমার যে এত যন্ত্রণা দ্বিধাদ্বন্দ্ব এগুলা দেখে ওর এত খারাপ লাগত এজন্য ও আমাকে রাগে থাপ্পড় মারতো। এবং এজন্য আমি ওকে কখনো দোষ দেইনি কারন আমিও ওর দিকটা বুঝতাম।*

> *My mother gave me a lot of support and she supported me since I was a child. But since my mother passed away, I no longer live with my family. I have not received any support from my family except my mother; my brother was so upset with me and sometimes he*

> *would slap me because of how I am. I did not take it negatively because I knew he was suffering as well by seeing me living with such identity conflicts, which made him hurt and he had slapped me in anger. And that is why I never blamed him because I also understood what he was going through.* (Karnen)

Being psychologically resilient was the key for most participants to survive. To build resilience, support from family was very important. Despite their mother being supportive in some cases, siblings tended to behave aggressively. Karnen's statement reminds us that even though she was slapped by her brother, she was not angry, rather she tried to understand what made her brother do it. Most participants needed not only to tolerate physical abuse but also to find meaning and justify those abuses so that they could continue to live with the family, though such justifications were not necessarily correct all the time. The reason behind this participant's endurance against such abuse was not to be kicked out of the home.

Idujon discussed that their family members had been supportive throughout their life. Their parents spent a substantial amount of money and sold the property to pay for their gender confirmation surgery, though Idujon's parents were unable to get the surgery for Idujon. But Idujon's parents and siblings had always been beside them. A relative once tried to humiliate Idujon but it was their mother who protested. Despite having support from the family, Idujon's brother's marriage was called off due to Idujon's existence in the family. Idujon's sister had to get married when she was about eleven years old — a child marriage. This was because when she would grow up, nobody would have wanted to marry a daughter of the same family where Idujon belonged. These issues never let Idujon's family members, including siblings, go against them. However, the wider society did not encourage the familial support given to Idujon and wanted to stigmatise and socially exclude the whole family just because of Idujon's situation. Eventually, Idujon's father went abroad and their mother fell sick, everybody else around them started to neglect them, and Idujon had to leave home.

Ichand reported that to deal with negative attitudes from the family or society and its impact on mental health, we first must understand how it works like a chain from the family members to the government. She said that "if we want to change the mindset of a government, we need to change the mindset of society; and to do that, first, we need to change the mindset of the family." Hence, it all starts with the family. She also mentioned that sexual and gender diverse people sometimes run away from home out of frustration, even without trying to talk to see whether the family understands. Nevertheless, she stated that "we cannot blame sexual and gender minority people for doing so because the reaction of disclosure to the family is mostly unknown, which is the biggest fear." She expressed that if "we can try to counsel them, then a family might understand." She even counsels many parents when they come to talk to her about their child who does not want to conform to the socially assigned gender. Ichand attempted to educate them and help them realise that this situation is completely normal, and they should look after their children so that they do not psychologically suffer due to their sexual and gender orientation.

6.8 Viewpoints about sexuality, identities, and life

The participants understanding of sexual preferences and sexuality has a connection with sexual health, which is defined by World Health Organization (2006) as a state of emotional, physical, and social well-being in relation to sexuality. Sexual health needs a respectful and positive approach to sexual relationships and the possibility of having safe and pleasurable sexual experiences; sexual health can be obtained by respecting, fulfilling and protecting sexual rights of an individual (World Health Organization, 2006). According to Wellings (2012), sexual health can be seen as a broad spectrum that aims to protect the persons by preventing the negative impact of sexual health such as sexual violence, sexually transmitted infections (STIs), and unplanned pregnancy. Hence, the participants' perception toward sexuality has a relationship with their sexual health, which I analyse in this section. Moreover, the major positive outcome of sexual health entails personal relations and enhancement of life (Wellings, 2012). This segment of analysis also includes participants' understanding of life, altruism, and sexual identities that are somewhat germane to explore the connection between sexual health and enhancement of life.

Challenging life experiences and being different from others made participants learn about stigma and exclusion. Therefore, participants' viewpoints of life can be manifold. Viewpoints of life include the participants' disposition toward different aspects of life that have direct or indirect relevance to sexual and mental health and healthcare experiences of the participants that I analyse throughout this section.

The emotion behind falling in love was the most important perception explained by most participants. Feyan explained that he thought people sometimes put too much emphasis on physical attraction and fail to understand the psychological connection between people. Isalho said that “sex is often a fantasy, and how we want to do it, or who we want to do it with, totally depends on a person and their sexual preferences.” He added that it is an individual matter how a person wants to enjoy physical intimacy: this is a personal right where nobody should interfere, and if someone fails to express their sexual preferences, it often leads to severe mental health problems such as frustration and isolation, and can adversely affect sexual health.

Like physical intimacy, disclosing a person’s sexual identity should be considered as a person’s right. However, how a person wants to represent their sexual identity or identities may vary. This is important because not only can this affect the sexual health of the participants, but it may create a hindrance to the individual right to disclose, and preclude the participants from receiving proper healthcare (e.g. Utamsingh et al., 2016).

Many participants said that the nature or preference of sexual behaviour can vary in terms of context, time, region, and person. Iporane, for example, discussed that she knew a woman in her mid-50s who is sexually attracted to younger men who are in their late 20s. This woman was not attracted to younger men until she was fifty years old. Iporane’s main argument is that while accepting the fact that the nature of sexual behaviour may vary in different circumstances, we need to understand that there can also be socio-cultural factors such as health, sexual knowledge, the taboo on sexuality, religious beliefs and lifestyle patterns, which somehow may encourage a person to change their sexual behaviour. Such an expression of dynamic sexual preferences or behaviour is a potential way of ensuring one’s sexual health, which tends to impact on a person’s mental health.

The perception of sexual identities is also affected by using the Internet and technology. Iruvo stated that the new generations are advanced because they learn about sexuality and sexual identities from the Internet. He expressed that if he had Internet access when he was younger, he would not have suffered from depression and isolation trying to understand his (*uvoypremi*-bisexual) sexual identity. Like *uvoypremi* identities, intersex or *uvoylingo* persons (e.g. Idujon) can also be attracted to both sexes. Understanding self-sexual identities is the first step to positive sexual health.

6.9 Public harassment

Harassment is a troublesome issue for sexual and gender diverse people. Harassment could include workplace harassment, public harassment or health sector harassment. Due to different kinds of harassment, sexual or gender diverse persons frequently experience prejudice, stigma and discrimination (Sheridan et al., 2017). According to minority stress theory, negative health outcomes are the major consequences associated with the stigma, prejudice and discrimination of sexual and gender diverse people (Meyer, 2003). Harassment and discrimination are linked to detrimental impacts on the overall health and well-being of sexual and gender diverse people (Brenner et al., 2010; Brewster et al., 2012). To draw a connection between mental health and harassment, Smith and Ingram (2004) discuss that harassment, particularly at the workplace, may cause depression and psychological distress among sexual and gender diverse people.

Not only most participants struggled in almost every sphere of life, they were also humiliated and harassed in different sectors due to their identities. For example, Idanam reported that he and his friend were attacked in a public park. Although they chased and caught the attackers, the public and police did not help; instead, Idanam's friend was beaten in front of everyone and nobody came forward to help them. He added that the police were perhaps linked with those attackers. Since the attackers realised that they were gay men, they must have informed the police. Subsequently, the police were reluctant to help them. He added that this kind of planned crime takes place with sexual and gender diverse people while law enforcement agencies are not willing to help. Such incidents traumatised Idanam and his friend, and they were often scared of going into public spaces, thus they could end up being isolated.

Not only the police but also lawyers can and do take part in the process of humiliation. Iruvo recounted that one of his family lawyers heard him speaking *Ulti*, উল্টি, their community language. The lawyer then kept asking Iruvo whether he was a sexual or gender diverse person, but Iruvo refused to disclose. The lawyer was indirectly asking Iruvo to have a physical relationship with him but Iruvo was consistent with his answers that he was not a sexual or gender diverse person. This constant harassment by the lawyer created severe mental distress for Iruvo and he apparently could not ask anyone for help. Iruvo stated:

> *আমি যদি তার কাছে স্বীকার করতাম, উনি আমার এই ব্যাপারে আমার ফ্যামিলির কাছে বলে দিতে পারেন এবং বলে দিয়ে যদি সে আমাকে ব্ল্যাকমেইল করা শুরু করে তখন আমি কি করতাম? এইজন্য আমি ওনার কাছে স্বীকার করিনি এবং উনার কাছে আমি অনেক ধরনের হ্যারেজমেন্ট এর শিকার হয়েছি কারণ উনি আমাকে প্রায়ই ফোন দিতেন এবং এসব ধরনের আজে-বাজে কথা বলতেন। এবং উনার কারণে আমি আমার মোবাইল নাম্বার চেঞ্জ করেছি।*
>
> *Had I disclosed myself to him, he could have told my family about it or started blackmailing me by the leverage of disclosing me to my family, and what could I do then? That is why I did not admit to him and suffered significant harassment by him because he would often call me and talk about such nonsense. And because of that, I had to change my mobile number.* (Iruvo)

Idujon — who is not hidden in society anymore — was verbally harassed in the street. Idujon responded to this harassment, which resulted in a fight with the offenders, and a legal complaint was subsequently filed against Idujon. At the judicial procedure, the judge listened to what Idujon had to say and chose not to make a verdict. The judge sent the case for settlement to the local political leader who was a Member of the Parliament (MP). Eventually, the MP decided in favour of Idujon and the MP made the offenders apologise to Idujon in front of everyone. Despite going through all this distress, Idujon held their nerve and did not break emotionally. This indicates that Idujon’s psychological persistence was rewarded and they felt that despite all the manipulative attempts by the offenders to corrupt the legal and judicial system, Idujon held their strong determination for justice, which was the key to their persistence. The MP could not ignore Idujon’s determination for justice, which probably made the MP make this decision in the face of stigma toward the sexual and gender diverse population.

6.10 Rape, sexual harassment, and invisible male rape

The United States Centers for Disease Control and Prevention mentions that sexual and gender diverse people experience sexual violence and harassment at similar or higher rates than the heterosexual population (Centers for Disease Control and Prevention, n.d.). Nonetheless, as a community, people rarely raise their voice against sexual harassment of marginalised people (Human Rights Campaign, n.d.). The health outcomes of such sexual violence and harassment on sexual and gender diverse people have not been sufficiently addressed by UN policy agenda and research (Kiss et al., 2020). Also, Kiss et al. (2020) state that sexual violence and harassment can have long-lasting and severe mental health consequences.

Many participants often experienced sexual abuse, harassment, and rape. Iruvo discussed that seducing someone or forcing someone to admit their sexual orientation in order to have free sexual relationships is nothing but an attempt of sexual abuse. Sexual harassment at work is frequently experienced by some participants. Despite all the precautions of hiding their sexual and gender identity, colleagues at work sometimes became aware of their identities. In such cases, the participants were sometimes exposed to sexual harassment. Iruvo was frequently pressurised to have sexual relationships with his boss’s brother, who was attracted to men. When Iruvo refused, he was verbally abused at his workplace and was often threatened to be disclosed to others. Eventually, he was fired just because he refused to have a physical relationship with his boss’s brother. Being pressurised into unwanted sexual behaviour may have an adverse effect on the sexual health of a person.

Some participants, particularly hijra, were frequently victims of sexual abuse and rape. Karnen said that, sometimes, police force hijra sex workers to have free sex with them, without asking for their consent. This kind of forced sexual behaviour creates an adverse effect on both the sexual and mental health of a person. Iruvo added that people who humiliate sexual and gender diverse people often think that they can have a physical relationship without any sort of commitment; perhaps they consider it as unpaid sex, and they often take sexual and gender diverse people as sex workers: such a judgement is completely unacceptable.

Gay men also endure sexual abuse. The male participants expressed that male rapes are unnoticed and uncounted. There might be a reason why male-rape cases are not listed. Freial said:

> *এখানে ছোট একটা সমস্যা রয়েছে। পুরুষ ধর্ষণের মামলা করতে গেলে মামলা আর করা হয় না। কারন হল সেকশন ৩৭৭ হল এমন একটি আইন যেখানে যিনি ধর্ষনের শিকার হলেন তাকেও অপরাধি [সমকামী আচরনের অংশ] হিসেবে ধরে নির্দিষ্ট সময়ের জন্য হাজতে থাকতে হবে। যদিও সে ধর্ষিত হয়েছেন, কিন্তু তাকে সমকামী আচরনের অংশ হিসেবে বিবেচনায় নিয়ে তাকেও শাস্তি ভোগ করতে হয়। এরপরে তাকে প্রমান করতে হবে যে তার অনিচ্ছায় এই আচরন করা হয়েছে বা সাক্ষী লাগবে আরও অনেক ঝামেলা, এসব কারনে এই মামলা আর রজু করা হয়ে উঠে না। একমাত্র ব্রিটিশরাই জানে তারা কেন এরকম ফালতু আইন করেছিল।*
>
> *There is a subtle issue here. When men want to file rape cases, they are not taken. This is because Section 377 is a law where a person who is a victim of rape is also deemed a criminal [part of homosexual behaviour] and he has to remain in custody for a certain period. Although he was raped, he was also punished for being considered to have participated in homosexual conduct. Then he would have to prove that his conduct was reluctant, or the witnesses would have to face many more troubles. For these reasons, the case is not usually filed. Only the British know why they formulated such a nonsense law.* (Freial)

There is a connection drawn by the participants between Section 377 and male rapes. The flaw is actually in the law created during the British Regime. Iporane reported that even if a male is raped, he cannot file a case to the police because it also makes him an offender under this law. Male rapes cases are rarely believed by the judicial systems (Capers, 2011), and reporting male rapes can put the victims at considerable risk in regions where homosexuality is not legally accepted (Vojdik, 2014). As Karnen discussed, a person may have their preferences and choices when choosing a client in the sex trade and it is important to get consent even if one is willing to have sex with a sex worker. Everyone has the right to choose, and, as a sex worker, they should also have the right to choose their clients, but if someone forces sex on a sex worker it is definitely rape. She added that in this way police have been raping both male and female sex workers, and the health impacts of such sexual abuse are rarely addressed.

Corrective rape is one of the major consequences of varied understandings toward homosexuality, and such rapes are often encouraged by families. Although the World Health Organisation (WHO) removed homosexuality from its International Classification of Diseases (ICD) in 1992 (Mysorekar, 2019, August 01), many consider that being homosexual is a psychological disease. Family members often believe that if a *somopremi nari*, for example, can be forced to have physical intimacy with a man, she may be treated to become heterosexual. If that happens, it would be definitely a rape, or in other words, a so-called corrective rape (e.g. Koraan & Geduld, 2015). However, those who are responsible for this so-called corrective rape would attempt to justify this rape as a method of treating a *somopremi nari*. Koraan and Geduld (2015) explain that corrective rape often represents brutality and violent behaviour by the rapist and can qualify as a hate crime; it is ridiculous to justify a hate crime with controversial religious interpretations and patriarchal behaviour of the family members.

6.11 Financial, educational and occupational struggles

Healthcare, from a socialist theoretical perspective, urges that quality of life can be hampered by discriminatory healthcare (Dlugacz, 2017). In this theory, the disproportionate prevalence of ill health among financially disadvantaged people can be attributed to unsafe work (e.g. sex work), occupational injuries, unemployment, and work stress (Shannon & Young, 2004). In other words, socio-economic factors such as education, employment, and earning sources are deemed as important factors for analysis that are closely linked to further understand healthcare from a socialist theoretical point of view.

Unaffordability of healthcare was a common scenario for the participants who are marginalised and have been discriminated against in terms of education and employment. Since the participants are marginalised, they went through different personal struggles such as financial problems, educational barriers, and employment barriers. The reason I analyse these struggles of the participants is because many sexual and gender diverse people choose not to visit government hospitals as they assume there is more risk of humiliation and discrimination in a government healthcare setting in comparison to a private healthcare setting. Thus, the participants would prefer to visit private hospitals or clinics that are slightly more expensive than government hospitals to avoid the probable unwelcoming situation. For a sexual or gender diverse person, I assume from the participants' responses that educational opportunities are hindered, which leads to the problem of gaining employment and eventually leads to financial struggles. Given this scenario, healthcare — either at government or private settings — becomes quite unaffordable for the participants. Therefore, I analyse how educational, occupational, and financial struggles appear in participants’ lives and how they affect their healthcare experiences.

The participants were frequently deprived of education. Karnen, a human rights activist, stated that every human being should have basic needs such as food, clothing, education, medical care and accommodation. These needs are also defined as “the basic necessities of life” (Article 15) in the Constitution of Bangladesh (Government of the People’s Republic of Bangladesh, n.d.-a). However, she stated that because of being a hijra, she could not go to school and receive a proper formal education. It implies that sexual and gender diverse people cannot get proper education just because of who they are, which brings more misery for their survival in terms of getting jobs and earning money.

Despite family support, Idujon was unable to go to school due to the fear of bullying and mockery they could have experienced as their breasts grew. This identifies one of the many ways that stigma against the participants can affect their education. However, Imeen tried to continue her education, but when she disclosed her sexual orientation to her family, she had to leave home and there was no family support for her. She tried to work but she did not have enough qualifications. Somehow, she managed to find a job, but due to her sexual identity she was asked to wear male clothing at work, and she refused. Asking for such a change at work can be seen as one form of workplace bullying that Imeen was not willing to endure. Even at the workplace, she was being asked to conform to a socially assigned gender, but she did not compromise and represented her realigned gender. Thus, she could not continue at her job. Eventually, she had to start working as a sex worker.

The participants mostly had to live on their own as they rarely got opportunities to work or were unable to continue to work (e.g. Imeen) in any employment sector. Even if someone possibly finds work, the salary is too little to survive. For instance, Inrose was educated and working in an agency outside of the capital and the monthly salary was only BDT 8,000 (US$94). She, therefore, struggled to find the resources to commute to the capital when she had meetings with various authorities for her name change in civil documents. Participants who were not educated enough suffered the most. Despite good support from their family, Idujon had no other choice but to leave home as their father went abroad for work, and the mother fell sick. While living without family and inadequate educational qualifications, Idujon could not find any work. They have been getting sewing training in a tailoring shop and this may help them to earn money for themselves.

Hijra and *rupantorito nari* participants were frequently forced to do sex work for their survival, which is arguably considered as unsafe due to potential risk of STIs. Imeen articulated that there are other risks involved in sex work. Firstly, she works at night when most food places are closed, so she has to spend the night without food, which is harmful to her health. She cannot have a bag with her to carry food because people or clients may think that she is hiding something dangerous inside. Secondly, if she carries a bag with food, people may think she has earned a lot and she would become a target to thieves. Hence, she hides her money inside her blouse. However, sometimes her clients notice money inside her blouse, and they think she earns a lot, and they become reluctant to pay the amount of money they agreed on. She cannot argue with the clients because she thinks it is negative for her image in the sex trade and may affect her earnings. As sex work is viewed negatively, exploitation becomes inevitable for sex workers, and hardly anybody is willing to raise a voice for them. The participants who are sex workers were neglected by their families and society and stigmatised by their work. This is a two-level dilemma, where these participants were stuck in a position of neither being able to leave sex work nor protest when they are being exploited. However, sometimes, hijra can receive financial support from the intentional community where they live with other hijra.

Another problem is encountered when changing the names and sex in civil documents such as national identification, passport and educational certificates from assigned birth gender and name to the current lived gender and name. This is important because without changing the names in these documents, it becomes almost impossible to get a government job or a permanent position in any occupation. Changes of name and gender can be possible sometimes for hijra participants.

For instance, Iporane presented herself as a woman when authorities came to record her name in the voter list for the first time. Since then, she bears a female name and female gender in her NID, so consequently in her passport and banking documents too.

However, changing names on educational certificates and already-completed documents is much more difficult. Although Inrose attempted to change her name in educational documents, she failed. She went through many complicated procedures, including a health check, in order to convince the appropriate bureaucrats to support her application of name change to the Educational Board. Still, all her effort went in vain because the Education Board did not approve her request. At this point, Inrose's NID includes her female name but her educational certificates have a male name. Because of this mismatch, she cannot get a government job or a full-time position on government-related projects. At a seminar at Ostitto, a story was revealed by one of the panel speakers about the same problem. This speaker was invited to a formal discussion where representatives of the government were saying that hijra people are getting jobs these days, particularly in government projects. Then the panel speaker asked whether these jobs were permanent, and, in reply, the representatives mentioned that since they had a mismatch of name and gender between civil and educational documents, they could not be offered a full-time position. Another panel speaker said that the government should be held accountable for solving this problem and there has been an ongoing debate between these communities and government to allow them to change name names in educational documents.

Name change issues create problems not only for employment but for gender confirmation surgery as well. Some participants are scared to undergo this surgery because it might hinder them from getting a job later on since they will not be able to change their name in educational documents. Iruyan said that "if it is possible to change my name or my gender in the document, then I can try for surgical procedures at any time." If Iruyan cannot change his name in educational documents after gender confirmation surgery, he will be still identified as a female in his educational certificates. This makes it almost impossible for him to get a good job. The participants are very much aware of this. Such concern often discouraged the participants from going for gender confirmation surgery.

Despite the problem in changing the name, another barrier is the absence of the term ‘third gender’ or ‘other gender’ in certain circumstances. Ichand expressed that, for example, the Constitution of Bangladesh states that any woman or man can submit a nomination for election, but hijra do not fall into either category. As of now, no amendment has been made in the Constitution to identify the third gender. One may argue that hijra can still partake in elections unofficially and there has been an example of this. A third gender person won in the Upazila election (local government election) in Jhenaidah district in 2019 for the first time in the history of Bangladesh (Khandokar, 2019). Earlier this year, the Election Commission (EC) of Bangladesh announced that transgender people can contest in the election for seats that are reserved for women (Islam, 2019). However, it was mentioned by the EC that those who do not identify themselves in the gender section as ‘female’ in the voter-forms will not be eligible (Dhaka Tribune, 2019). This reminds us that even though hijra may be able to participate in the election without identifying or stating their gender orientation, it indicates that whoever does not conform to the patri-normative values will not be eligible to fit within the system.

Ichand expressed that whenever representatives of Bijito are invited for a discussion with the government, issues such as problem in changing name and absence of term ‘third gender’ and sex in educational documents has been raised and the government seems reluctant to do anything about these issues due to the fear of losing support from the majority of the population. However, even with all these difficulties, the participants can still work in private sectors. Some participants work to support their community members. For example, both Ichand and Iksera used to work in other sectors, but they changed their careers and started to work for sexual and gender diverse communities. Both of them explained that because of their sexual and gender identities, they have been inspired to work for people who are like them.

6.12 Lack of awareness

Since the participants often lacked education and family support, they sometimes struggled with a lack of awareness about themselves. The participants often lacked understandings about diverse sexual and gender identities including their own identities. As a result, understanding of sexuality and sexual health was found relatively underdeveloped among the participants. A lack of awareness regarding safe and hygienic sexual identities and behaviour often leads to different kinds of health risks (Adhikari et al., 2009; Pinyopornpanish et al., 2017).

Sometimes, the participants struggled and found themselves in a situation where they were oppressed or abused due to their lack of awareness about themselves and the possibility of unexpected disclosure. Therefore, Inrose believed it is very important for sexual and gender diverse communities to understand when, where, and how to disclose. Ironically, like cis-heterosexual people, some participants also had a lack of awareness about the hijra tradition. For example, Idujon stated:

> *জানি না বাংলায় [ইন্টারসেক্স কে] কি বলবো আমি এবং আমি নিজেও আগে জানতাম না যে আমাকে ইন্টারসেক্স বলা হয়। মাত্র কয়েকদিন আগেই জানলাম। হিজড়া কমিউনিটির যারা লোকজন আছে আমি না তাদের ব্যাপারেও ঠিক জানিনা আসলে তারা যে কিরকম।*
>
> *I do not know how to say [intersex] in Bengali and previously I did not even know I was called intersex. I only came to know a few days ago. I do not even know much about the people who belong in hijra community, or exactly how they are.* (Idujon)

A lack of educational opportunities and exposure to an environment to discuss sexual and gender diverse identities might be one reason for the lack of awareness among the participants. If I take Idujon as an example, since they barely knew about own gender and sexual orientation, then it might have been difficult for them to understand their sexual health and health facets related to their sexual health and behaviour. Franso reported that she previously had a misunderstanding about hijra when she was a child and was told that hijra do not have any reproductive capacity but later she realised that she was wrong. Due to the many barriers, participants identified above, they even often struggled to define their own sexual and gender orientation, which made it even more difficult to perceive their sexuality, sexual health, and surroundings. It is worth mentioning that the persons who hardly understand their sexuality and sexual health may also fail to receive proper healthcare due to the lack of self-awareness of their health.

6.13 Internal conflicts in communities

The concept of unity may not be as strong as is needed for enhancement of life for a minority population if there are internal conflicts in a minority community. For instance, internal conflicts among different groups of sexual and gender identities are considered as a barrier for uniting sexual and gender diverse communities, which has an impact on their rights, either for their right to acceptance or right to healthcare.

The lack of understanding and awareness about sexual and gender diverse identities may cause or might have caused some internal conflicts among the participants. Consequently, hijra participants were the most neglected among the participants. To begin with, as expressed by Ichand, masculinity is a major factor that contributes to conflicts among transgender communities. She thought *rupantorito purush* may belittle *rupantorito nari* or hijra for their behaviour. This is because, perhaps, *rupantorito purush* often think that they transformed themselves into the dominant counterpart (men) in society and they tend to start neglecting *rupantorito nari* because they voluntarily gave up the dominant gender-assigned roles by transforming themselves into women. Perpetrators of neglect and sexual harassment against men frequently try to impose control and domination through their acts (Javaid, 2016; Loncar et al., 2010). This can be deemed as an impact of a patriarchal society where people take the masculine gender as the dominant one over the feminine and other gender roles. Ichand added probably, transmen have always been treated with neglect by family and society before their transition; as a result, when transmen start to identify themselves as men, they impose the same neglect that they had experienced.

As expressed by Freial, “it is necessary for all the sexual and gender diverse groups to work together for the betterment of sexual and gender minority communities, or else it may be difficult to maintain movements or campaigns for our rights to acceptance and healthcare.” However, if sexual and gender diverse people do not understand their identities properly and lack of knowledge about each other, then it might also be difficult to work as a community. Therefore, such conflicts inside these communities affect their campaigns and community activities.

6.14 (This section embargoed)

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6.15 Summary

Sexual or gender diverse persons are neither well understood nor accepted. The participants rarely received any kind of support from their families, which could lead to adverse mental health outcomes. The participants’ experiences with police, along with sexual abuse, public harassment, and stigma, indicate how oppressive it is to be a sexual or gender minority person in a patriarchal society, as well as identify the health impacts of these issues. In this chapter I also discussed the attitude of the public, society and family and how the police (the protector) become the predator, implications of ‘virtue signalling’ and the homoerotic undercurrent of exposing the desire of same-sex behaviour to each other. The reasons why all these facets are analysed in this chapter are to justify how health is affected by the above-mentioned themes, and why healthcare is as important as the other rights of marginalised people.

Chapter Seven: Implications of Healthcare with Society, Law, Government and NGOs

7.1 Introduction

The implications of healthcare and society, law, NGO initiatives and government policies are analysed in this chapter to identify how health and healthcare are perceived from different institutional levels. I initially discuss the taboo on sexuality, religious stances of the participants, and lack of understanding about sexual and gender diverse identities by considering these aspects as barriers to understanding health and healthcare as a human right. The NGO initiatives of healthcare and the inclusion of healthcare in the government's 7th Five Year Plan are discussed later in this chapter. Finally, I consider how stigma and marginalisation, and social values can impact on healthcare experiences of the participants.

7.2 Taboo on sexuality

According to Fershtman et al. (2011), a taboo is an unimaginable action, and performing an action or even thinking about undertaking an action that is not permissible can trigger social sanction; either conforming to or violating taboo depends on individual choices and affects one's identity. Taboo also refers to the prohibition of something based on a cultural sense or religious interpretations that is extremely repulsive or inhibited for the members of a certain community (Bennett & Harden, 2019). The taboo on sexuality can have an impact on healthcare, particularly in palliative care in general (Nyatanga, 2012), and I analyse how this taboo is associated with the health and healthcare of the participants. Sexual health is constructed from socio-economic and cultural factors including tradition and religion affecting the gender roles and sexual practices in a country (Roudi-Fahimi & El-Feki, 2011). Taboos regarding sexuality - and even talking about sexuality - are dominant in Arab regions (El-Feki, 2013; Zahlan et al., 2019), but there is a widespread affirmation of hetero-cis normative sexuality and dominant patriarchy. In many Muslim majority countries like Bangladesh, there is also a taboo around both talking about sexuality, and premarital sex. Lack of knowledge regarding sexual behaviour and sexual health is one of the many impacts of the taboo surrounding sexuality (Reed et al., 2016). Such a lack of knowledge is considered the major reason for sexual disorder and sexual dysfunction in Arab territories (Muammar et al., 2015) and Muslim majority regions. Men in Muslim majority countries are more likely to conceal sexual disorders due to the taboo regarding sexuality (Zahlan et al., 2019). Therefore, the tension between health and taboos on sexuality needs to be further analysed, not only from the perspective of Muslim majority countries but also from sexual and gender diverse people's experiences.

Freial expressed that social taboos can influence individual values: healthcare for sexual and gender diverse communities can place individuals in vulnerable situations due to values impacted by social taboos. For example, he added that the values of healthcare providers are frequently affected by social taboos, thus affecting healthcare for sexual and gender diverse communities. Given this scenario, if participants have to visit a healthcare provider, the participants need to hide their sexuality or and gender differences which can directly affect the quality of healthcare. In other words, the participants rarely received proper medical treatment, which may increase the risk of sexually transmitted infection and deteriorate their health.

According to Graugaard (2017), sexuality does not only mean physiological processes such as lubrication, orgasm, erection and intercourse but involves social and psychological aspects such as affection, feelings and sensuality. A person's health condition and the medical treatment they receive can affect their sexuality: for example, the effect of illness related to sexuality includes low sexual ability, fatigue, incompetence and depression (Traumer et al., 2019). There is a relationship between sexuality and healthcare whereby the taboo on sexuality can hinder the understanding of health aspects of the participants. The social construction of sexuality may have influenced participants to think heteronormatively. They were socio-culturally taught by the family and society that being sexually or gender diverse is not accepted so they rarely express issues regarding sexual health and health risks associated with their sexual behaviour.

To understand the taboo of sexuality, we need to understand how society is constructed and how it navigates the people to think about sexuality. Fasrub explained that despite Section 377, the social rituals and taboos on sexuality play an essential part to discriminate sexual and gender diverse communities. He explained that many police also rarely understand Section 377 due to the lack of open discussion on sexuality. Feyan stated:

> *আমার মা ছোটবেলা থেকে কিভাবে যৌনতার বিষয়গুলো এড়িয়ে চলা যায় সেগুলো শিক্ষা দিতেন। সেখানে পায়ুপথের মিলনের ব্যপারটা যে একজনের সাথে আলোচনা করার মত যে নূন্যতম সহনশীলতা তৈরি করা, সেটা আমাদের দেশে নেই।*
>
> *My mother taught me how to avoid the discussion of sexuality as a child. In this scenario, there needs to be some sort of tolerance to discuss anal intercourse; we do not have these discussions in Bangladesh.* (Feyan)

Feyan added that sexuality is taken as a social sin. He also worked abroad for HIV campaigns where he noticed that in Thailand and the Philippines people are more culturally tolerant about sexuality matters, and the earnings of sex workers are accepted by the parents to support household expenses, but if one is involved in the sex trade in Bangladesh they will be rejected by the family. He believed that due to this taboo on sexuality, an adult person can struggle to express their sexuality in their conjugal life, which creates psychological conflict with their partner.

The taboo on sexuality can affect the relationship between women leaders and female sex workers. Feezaz explained that she knew women community leaders who she worked with were not very supportive of female sex workers as they thought that sex work is not a legitimate occupation and they did not think female sex workers belong in any sort of rights movement. She discussed that if women leaders were not under the taboo of sexuality, they would realise that hardly anyone becomes a sex worker by choice. Thus, the lack of awareness about sexuality influences the attitude of people. For example, Isalho said if the term ‘sex’ is involved anywhere, people usually think it is something bad. He added that some English terms do not have exact Bengali terms, such as transsexual, and it is not easy to have a Bengali term to say this; thus, the term ‘sexual’ in ‘transsexual’ makes many people think that is something bad, without even knowing what the word really means.

Farnen explained that many healthcare institutes provide social education and awareness for physicians. This education includes family planning, breastfeeding, and the Expanded Programme on Immunization (EPI) which mostly focus on maternal health or social medicine, but she added that it does not involve any lessons regarding gender and sexuality, or sexual health. Therefore, taboos and misunderstandings about sexuality can spread in the healthcare sector. Such taboos and misconceptions about sexuality can limit the knowledge of the healthcare providers about the effects of sexuality on the health of the participants.

7.3 Religious stances

There is a conflict between sexual and gender diverse identity and religion emerging from a Judeo-Christian background (Guittar, 2013; Hamblin & Gross, 2014). It is found that in many cases, sexual and gender diverse people consider religion to be more of a difficulty than support (Henrickson, 2007). Furthermore, sexual and gender diverse people rarely find religious association as a benefit during suicidal thoughts and attempts (Lytle et al., 2018). However, limited studies have been conducted on this conflict amid Muslim populations; some studies have been conducted with Muslim populations from Pakistan, Bangladesh, India, Iran, and Iraq who are living abroad, especially in Western countries (Gany & Subhi, 2018). According to Hamblin and Gross (2014), religion has a negative impact on the psychological health and well-being of homosexual individuals. Hence, it is essential to understand the tension between religion and sexual and gender diverse identities in a Muslim majority country, particularly to understand the psychological consequences of religious and spiritual beliefs. To evaluate this aspect, I analyse where these dominant beliefs of the participants came from.

It is also important to note that many healthcare professionals are not well-trained about religion and its spiritual elements affecting health (Castaldelli-Maia & Bhugra, 2014). While exploring the connection between mental health and religion among young sexual and gender diverse people, McCann et al. (2020) identify that sometimes mental health practitioners are not very aware of or sensitive to patients' religious and spiritual issues — this is important because religious activities can help to deal with negative outcomes of mental health such as substance abuse, unsafe sex, and prostitution. Prairie et al. (2018) explain that the religious belief of the physicians may impact on their decisions whether to treat patients who are sexual and gender diverse.

Understanding religious stances is essential because healthcare providers sometimes asked participants to get spiritual support by either praying or fasting, hence the spiritual and religious belief of the participants is investigated in this section. In addition to this, participants believed that sometimes the religious beliefs of the healthcare providers influenced the decision on providing healthcare to sexual and gender diverse people.

The participants were Hindu, Muslim, and Christian and they were mostly believers, irrespective of their religious orientations. Imeen articulated that every religion mostly contains similar kind of message, but it is the people who make conflicts; some people try to misuse religion to advance their own interests and this is where the conflict starts. Imeen is a faithful believer. Perhaps faith in religion is one way to be psychologically resilient and survive in a conservative society where the participants get little support from people around them.

Sometimes, religion is used as a kind of spiritual medicine to treat homosexuality. A psychologist once told Iksera that if she can pray and fast then she might be able to avoid homosexual desire. As suggested, she continued praying and fasting for a while, but it did not change anything. Participants sometimes put their faith in religion just because they were told that they are not ‘normal’, and they believed what they were told.

There is also a conflict among the participants between homosexuality and religious beliefs. Feezaz expressed that religion always gets in the way of homosexual behaviour and it sometimes made her hesitate whether to disclose their homosexual behaviour to others because others might judge that she is committing a sin, or she would be derided, not just with words but also with looks and behaviour. Such conflicting thoughts are the consequences of a patriarchal society that has been using religion to reinforce male-dominant values and marginalise sexual and gender diverse populations.

Karnen stated that she considers sex and religion as two different facets and she does not want to conflict these two. It could be that she attempted to justify it to herself why she does not let Islam interfere in her sexuality. Similarly, Ipreeth did not want to conflate sexuality and religion and he expressed that these two aspects were different. Iporane belonged to the Hindu religion and is married to a Muslim man, which indicates that not all participants let religion interfere in their relationship and sexual and gender orientation. Ipreeth recounted that being homosexual is as natural as being born into a Muslim family, and he did not have any choice in choosing either his religion or his sexuality; they were given to him at birth, thus, he had a strong faith in Islam and he did not think that due to his sexuality his faith in Islam can be disrupted. Ipreeth said that "I am a Muslim at the same time as I am gay, and I want to live with these [two] entities." Perhaps such thought about religion is a self-justification for Ipreeth since he is worried many interpretations of Islam that do not support homosexuality.

The religious stances of the participants toward sex and sexuality indicate that although they probably thought sex is deemed as bad because it is pleasurable, sex for reproduction is necessary. But sex that does not lead to reproduction such as fornication, pornography, same-sex practices, masturbation and artificial contraception is regarded as sin in the view of the Roman Catholic theology of sexuality (The Holy See, n.d.). Similarly, the view of Orthodox Judaism implies that homosexual behaviour should be prohibited (Lamm, 1974). From the Islamic views on oral sex, in particular, arguments expressed by Islamic scholars and the popular Egyptian cleric Yusuf al-Qaradawi stated that there is no restriction to performing oral sex between husband and wife, but while performing oral sex, if sucking leads to releasing semen then it is *'makruh'* (blameworthy), and Yusuf's view is very popular because there is no clear command or evidence in Hadith and the Quran prohibiting this act (Keating, 2012, April 23). However, the most common censure against Yusuf's view is that mouth and tongue are used for recitation of the Quran and for the remembrance of Allah, hence oral sex should not be performed (al-Hudha, 2001). Such religious perceptions toward sex may have created a conflict where sex only for reproduction is accepted, as opposed to sex for pleasure.

Karnen reported that if people marginalise sexual and gender diverse communities by the excuse of religion, they should also know that every religion emphasises helping disadvantaged and deprived groups of people. Similarly, Kelard, an academic and expert on human rights, explained that not only Islamic values but every religion specifically mention about helping and protecting minority communities. However, he added, a conservative country does not pay much attention to supporting sexual and gender diverse population. Kevlin, an expert on Islam stated that this is because Islam is often misunderstood and misinterpreted, which contribute to the stigma and hatred toward sexual and gender diverse people.

Ipreeth expressed that Islam is often misinterpreted by many religious leaders which affect the psychology of the general public; consequently, sexual and gender diverse people become more stigmatised. Kevlin recounted that even though Islam is sometimes misinterpreted and many religious prejudices exist in society, no religion teaches us to have hatred inside us. However, religious communities are trying to incorporate measures to include hijra in religious events. For example, Kevlin said that there is a separate space reserved for hijra in *Bishwa Ijtema*, a yearly and global peaceful gathering of Muslims in Bangladesh. Also, a *madrasa* (a school for Islamic education and guidance) has been established in Bangladesh that is dedicated to the third gender communities (Shovon, 2020). Such measures indicate that initiatives are gradually being taken by a few religious communities so that hijra can be accepted in society. However, it is a matter of further investigation to see how a religious educational institution is going to treat people who are mostly stigmatised through religious sentiments.

The learnings from Islamic histories can be inspiring but the harsh reality and experiences of the participants tell us a different story. Kevlin said that this is because the actual Islamic values followed by the Quran and Hadith and many so-called religious values are not quite the same. For instance, he added that “many of us understand the Islamic values but are not ready to follow, thus Islamic values are not expressed properly in this country; we call ourselves a Muslim country, but many people are unable to practise Islam properly.”

7.4 Stigma and social attitude

Stigma, particularly from healthcare providers, is an important aspect for this research to understand how a stigmatised group of the population experience healthcare. Before we move on with the analysis of stigma and its relevance to the healthcare experiences of the participants, it is essential to understand the concept of stigma. Stigma, in theory, is an attribute of discrediting a person that makes the stigmatised person feel belittled due to three usual conditions such as physical deformities, identities (sex, race, and religion), and blemishes of individual characteristics such as mental disorder or employment (Goffman, 1963). The concept of stigma is not static, but it is taken as a social construction connected to the values related to certain social identities: in other words, a process involving two basic elements such as the recognition of a differentiating mark, and the consequent evaluation of the bearer (Dovidio et al., 2000). Hence, the perception and understanding of stigma can be relative depending on attributes that may change in terms of region, time and culture (Arboleda-Flórez, 2008).

While understanding why stigma is formed or the purpose of stigma, it is arguable that stigma toward minorities communities (e.g. sexual and gender diverse communities) is formed to exert social control, to set boundaries about what is acceptable and unacceptable behaviour. Theoretically, it is argued that social sharing of information or beliefs or taboos is one of the major purposes of stigma because this stigma sharing gradually tends to become a segment of the society that forms, overlooks and sustains stigmatising behaviours (Stangor & Crandall, 2000). Perhaps the sharing of contempt toward sexual and gender diverse people is one reason behind this stigmatising behaviour, which ultimately serves the purpose of maintaining social control of this population. This section of the analysis is essential because I analyse how stigma and negative social attitudes impact on health and access to healthcare of the participants.

Stigma influences drug abuse (Lehavot & Simoni, 2011), unsafe sexual behaviour (Jeffries et al., 2013; Nakamura & Zea, 2010), and health-seeking behaviour (Bradford et al., 2013) among sexual and gender diverse communities. The minority stress model emphasises that stigma can affect the determination of the health of sexual or gender diverse individuals (Hendricks & Testa, 2012; Meyer, 2003). Many studies have identified that experience of stigma amid sexual and gender diverse communities is a significant barrier for accessing healthcare; the degree of health-seeking behaviour of these communities tends to reduce with a higher degree of stigma (Whitehead et al., 2016).

Several participants expressed that sexual and gender diverse people are stigmatised, and most people have a negative attitude to this stigmatised population. Famien expressed that even the government disregards sexual and gender diverse people as they have to maintain political power by gaining support from the majority of the population in society. Therefore, Freial noted that people and society take advantage of this governmental negligence to increase the degree of stigma and marginalisation. The degree of stigma can be acute sometimes and has resulted in two assassinations of community activists (Xulhaz Mannan and Mahbub Rabbi Tonoy).

Famien believed that perhaps most people in Bangladesh are not that hostile to sexual and gender diverse people and his best friend, who is very religious, is supportive of him. This friend accepted him as a gay individual while he was reluctant to talk about it with Famien as he thought talking about it can somehow create fragility in his religious faith. To clarify this fragility: while Famien’s friend accepted him the way he is — a gay person — it created a conflict in his faith in Islam as he believed in certain contestable interpretations of Islam regarding homosexuality, thus he would rather not talk about it. It reminds us that people may sometimes be conflicted with personal beliefs and religious beliefs regarding the acceptance of sexual and gender diverse communities, and when such conflict occurs, they rarely want to discuss it; consequently, the occurrences of stigma continue to rise.

Fasrub did not completely agree that marginalised people (e.g. indigenous or physically disabled population) are controlled by deprivation of healthcare. However, Freial argued that many other marginalised groups of people such as physically disabled or indigenous populations are not as hated as sexual and gender diverse people, Freial said:

> অন্যান্য যত সংখ্যালঘু জনগোষ্ঠী আমাদের দেশে রয়েছে তাদের মধ্যে আমরাই [লিঙ্গ ও যৌন সংখ্যালঘু] সবচেয়ে বেশি ঘৃণিত ও কলংকিত। একারনে অন্যান্য সংখ্যালঘু জনগোষ্ঠীর বঞ্চনার প্রকৃতি আর আমাদের বঞ্চনা প্রকৃতি এক হবে না। অন্যরা হয়তবা বেশি বৈষম্যের শিকার হতে পারে কিন্তু আমরা সবচেয়ে বেশি কলংকিত/ হত দরিদ্র মানুষরাও বঞ্চিত কিন্তু তারা আমাদের মত এত অপবাদের শিকার হয়না। বরঞ্চ দরিদ্রদের প্রতি মানুষ সহানূভুতি দেখায় আর আমাদেরকে কলংকিত করে।

> *We [the sexual and gender minority] are the most hated and stigmatised among the minority groups in our country. Therefore, the nature of the deprivation between other marginalised populations and us will not be the same. Other minority populations may be more discriminated, but we are the most stigmatised. Poor people are also deprived, but they are not verbally abused like us. On the contrary, people empathise with the poor but stigmatise us.* (Freial)

This statement indicates that the participants were hated and stigmatised because it was their association with sex that makes it so unspeakable. Iporane said that “everyone seems to be laughing behind hijra, and our identities have become nothing but contempt for them; not only the general public but police and other professionals also think we are a joke.” In general, Kelard explained that very few people have started to accept sexual and gender diverse communities.

Karnen explained that people need to understand that expressing sexual and gender orientation is something that an individual should decide, not society. To clarify, the freedom of expression (of sexual and gender orientation) is an individual right (Howie, 2018), and every human has the right to decide whether they want to represent the socially assigned identity or not. Karnen added that all this awareness and understanding about sexual and gender diverse people needs to be aimed at bringing respect for sexual and gender diverse people. In the Constitution of Bangladesh, Article 39 emphasises the freedom of thought, conscience, speech, and expression as a fundamental right (Government of the People's Republic of Bangladesh, n.d.-b). This mainly emphasises on the expression of one's opinion and speech rather than expressing one's sexual or gender orientation.

7.5 Structural oppression

Structural oppression refers to a situation where institutions such as government, educational institutions, law enforcement agencies, and health settings are structured in a way that prevents an individual of a particular (minority) group from receiving equitable treatment as a whole (Hancock et al., 2012). The data suggest discrimination and an unsupportive attitude are expressed at the structural levels toward the participants. Sexual and gender diverse communities may not yet be at a stage of legal recognition where liberation and freedom are possible. They are still in hiding — uncounted, using a private language, and concealing their spaces. The time is not yet right — as it has been in India for many years — for significant legal and social change. However, the authorities — both political and religious — know that change is coming, and so have increased their oppression and silence. By looking at the way diverse communities are responding we can see the effect of stigma and oppression. This does not seem like unconscious oppression by society and the state. They see what is happening in neighbouring countries (e.g. India and Pakistan) and they do not want to see the same situation in Bangladesh so they have increased their deliberate oppression in order to maintain social control and social privilege. It implies that they are afraid of the change they see coming. People confident of their power do not need to oppress — the structures and systems will do that for them. But when assassinations occur, that is a signal that there is a perceived threat to privilege.

Feyan described that many officers of the law enforcement agencies and healthcare settings are not ready to accept sexual and gender diverse identities. Structural oppression at institutional levels such as law enforcement agencies and government bodies that expose sexual and gender diverse people to discrimination, particularly in the healthcare sector. The healthcare institutions attempt to maintain social control through the stigma that brings an adverse effect on the mental and sexual health of these communities. The use of these institutions as a mean of structural oppression is further reinforced by the reluctance to take actions so that they can maintain the oppression.

7.6 Lack of awareness of the general public

There is a complete lack of discourse on homosexuality in the national space of Bangladesh (Rashid, Standing, et al., 2011), indicating a lack of understanding and awareness about sexual and gender diverse identities. To clarify the degree of unawareness regarding sexual and gender diverse people, Isalho stated that the society makes people believe that giving birth to a hijra is a sin but will our society ever understand that a child can never be a hijra or no child can actually be born as a hijra?

Isalho added that the general public is mostly unaware of hijra culture and they hold on to their misbelief about hijra communities. Feyan said that it has become a tendency to assume or anticipate something before knowing the truth, and this has become a part of the culture; the law of nature and religion are also misused to sustain this lack of awareness about sexual and gender diverse communities. Feyan further stated:

> *প্রকৃতির আইন ও ধর্মকে পুঁজি করে তারা সমপ্রেমি আচরনের বিরদ্ধে জোড় দেয়। এসব নিষেধাজ্ঞার পুঁজি দিয়ে তারা অপমান, অপদস্ত, লাঞ্ছনাকে তারা বৈধ করতে চাইছে। এর ফলশ্রুতেই সেবা পাবার যে অধিকার সেটা থেকে আমাদের বঞ্চিত করার চেষ্টা করা হচ্ছে।*
>
> *By capitalising on the laws of nature and religion, people insist against the practice of homosexuality. By capitalising on these laws, people are attempting to legalise humiliation, insult, and discrimination. Subsequently, they have been trying to deprive us of the right to have care.* (Feyan)

It would be contentious to justify the general public’s lack of awareness about sexual and gender diverse identities when the country has somewhat improved educational and information resources: in particular, the rate of literacy is higher than it was before independence (Paul & Saha, 2017). While describing the lack of public awareness about sexual and gender identities, it might seem like I am claim superiority over others because I know something that they do not. Rather, I discuss such to indicate that, as explained by DeNicola (2017), ascriptions of ignorance or lack of awareness can be used to denounce and further marginalise minority groups of populations. If a minority community is not well understood by the majority of the population then it becomes easier for the government and society to control them. It is obvious that if the majority of the population is unaware of the oppression sexual and gender minorities are facing, they will not raise their voice against the oppression.

Even though I assumed that the general public must know and understand sexual and gender diverse communities better than they do, it may seem unfair to expect such awareness when the general public thinks they know what they need to know. Paulo Freire, a Brazilian educator discusses a similar kind of notion (conscientisation) where people do not know what they do not know. Freire argues that conscientisation is a process of gaining critical awareness of a person’s social contexts through action and reflection, and the process of changing the reality requires actions (Freire & Ramos, 1970). The general public needs to develop consciousness in order for them to change their awareness and attitude toward marginalised communities. Such development of consciousness does not happen spontaneously unless actions are taken. Someone needs to make people aware of both what they do not know and why is it necessary for them to know more than they do about sexual and gender diverse communities. However, there is a potential threat in doing so because if someone acts, then they can be assassinated.

Interestingly, Ichand said that understanding about homosexuality is gradually increasing and people have started to talk about it in different spheres of society but there is also a subtle threat of such awareness. Ichand added that since people have begun to understand what homosexuality is, unlike in the past, people tend to notice when two same-sex persons walk holding hands, and this can expose sexual and gender diverse communities to the public. This indicates that increased understanding of sexual and gender diverse identities may have some negatives impacts of being publicly disclosed.

7.7 Politics of 7th Five Year Plan

Freial said that “the National Health Policy of Bangladesh is outdated, and it is not properly aligned with the needs of people.” This is important because the 7th Five Year Plan (2016-2020) states that transgender populations are arguably in need of ‘health insurance’ just as much as others (Planning Commission, 2015). However, the National Health Policy has not been updated to this statement in this Five Year Plan. It is also questioned by the participants what government means by ‘health insurance’ because sexual and gender diverse communities require equal healthcare as others do, and the government needs to define what exactly they mean by ‘health insurance’. Nevertheless, participants of the FGD expressed that this is the first time the government has mentioned sexual minority groups and their situation and needs in an official document, which they believed is a good sign. But is it indeed? Oddly enough, the term ‘health insurance’ is rarely used for any other minority groups of the population. Some may argue that the term may have been incorrectly used in the Five Year Plan without proper clarification. But in a government document, such a significant term cannot be just used randomly without appropriate consultation. Health insurance is not as common in Bangladesh as in many developed countries; people usually need to have health insurance if they are willing to go abroad, other than that people barely have health insurance. Probably the government had a hidden motive of promising something to sexual and gender diverse communities that simply do not exist in health settings.

Iporane expressed that there has hardly been any implementation of government health insurance programs. She reported that this inclusion is stated in this plan to attract foreign donors and even if the government has received additional funds for such health insurance programs for sexual and gender minority people, nobody knows where the funds have gone; ultimately sexual and gender diverse communities remain as disadvantaged as they were in the past, and nothing has changed. This not only reflects her suspicion about the government but also the expectation that the government is looking outside the country for additional aid to provide care for undesirable populations within the country.

Government representatives invited Freial as a staff member of Bijito to a meeting while the 7th Five Year Plan was being drafted. Freial and others asked why sexual and gender diverse people were not mentioned in this plan. He and other representatives in the meeting proposed the names of the sexual and gender diverse identities but the government representatives refused to keep them in this plan. This is very important because it implies that someone is reaching out to them and acknowledging their existence. Even though the meeting outcomes were not what Freial expected, the fact that he was invited by the government is hugely important. Since Section 377 is still current, the government representatives replied that they cannot state all the sexual and gender diverse identities. However, Freial argued, “if the government had not known about us, why have they been supplying us condoms and lubricants since 1996?” He believed in terms of these supplies, the government justifies that they want to prevent HIV, thus they avoid the existence of all the sexual and gender diverse identities.

In order to reduce the number of HIV infections from one intravenous drug user (IDU) to another, syringe exchange programs (SEPs) were commenced by CARE Bangladesh (an international health and aid agency) in 1998 (Cahill & Schaefer, 2009). This indicates the government began to worry about an HIV epidemic during the late 1990s and even started to distribute condoms for sex workers two years before introducing SEP. However, “SEP programs in Bangladesh ultimately stop short of officially supporting policies” (Cahill & Schaefer, 2009). Probably the lack of supporting policies for SEP programs is one of the reasons why the government has to depend on international funding agencies (e.g. CARE Bangladesh) to run these programs. If the government amends the policies in favour of programs that help undesirable and stigmatised populations then the social control and oppression may be hindered. As a result, the government probably invites INGOs to provide services for stigmatised populations without changing the policies and guidelines around them.

Freial added that since the National Health Policy still does not state anything regarding the health needs and healthcare of sexual and gender diverse communities, there is an urgent need for research public discussion to encourage the government. This seems like governmental duplicity, where there is an incongruity between the National Health Policy and the 7th Five Year Plan. In other words, what the government is saying about the National Health Policy does not align with the 7th Five Year Plan. And such duplicity can also be seen in other issues such as gender violence or drug users’ treatment.

Azim et al. (2005) discuss that the advocacy and intervention programs of CARE Bangladesh were helpful in reducing the number of HIV infections among IDUs through the harm reduction programs. Also, Islam et al. (2015) state that the Narcotics Control Act (1990) of Bangladesh emphasises mandatory treatment for drug users; this law, however, gave law enforcement agents an opportunity to harass drug users and sellers. The National HIV/AIDS Strategic Plan and the National AIDS Policy developed harm reduction activities for IDUs where law reform is an urgent need so that the intervention activities with drug users can be facilitated appropriately (Islam et al., 2015). The need for law reform suggests that there may be inconsistencies between the Strategic Plan and AIDS Policy — another example of government duplicity — that need to be addressed. According to Reid (2003), governmental duplicity can expose minorities — based on class and race — to discrimination. Perhaps such duplicity is maintained by the government to hold on to the discrimination and control over sexual and gender diverse communities.

7.8 Government attitudes and political interests

Bangladesh is known as one of the most corrupt countries in the world as per the corruption perception index as estimated by the Transparency International, and Governance index estimated by the World Bank (McDevitt, 2015; Transparency International, 2020). This can bring into question the fairness of the election processes. Bangladesh is a rising democratic country, though democracy in this country differs to some extent from others. From 1971 to 1990, general elections were barely free and fair as they were largely rigged by the incumbent parties (Khan, 2018). However, from 1991 to 2008 non-partisan governments acted as caretaker governments during the general elections, whereas the current government usually acts as a caretaker government in many other democracies. It is believed that voters enjoyed the liberty to express their political choices through the elections between 1991 and 2008 because in each election the incumbent party failed to be re-elected during its tenure (Khan, 2018). But the incumbent government did not maintain a non-partisan caretaker government for two successive terms in 2014 and 2018 (Quadir, 2018, November 18). This influenced the opposition to boycott the general election and the election result as well as the democratic approach being arguably questioned by many international agencies.

Due to the lack of official data regarding elections and voting patterns, it is very difficult to report the socio-demographics (gender ratio, age ratio and income ratio) of the people who turn out to vote. However, Khan (2018) argues that the impact of vote buying and selling practices (exchanging vote for cash) is very low because poor people may be self-motivated to vote in order to vote out the incumbent government which has the responsibility and logistic capacity to reduce poverty. On the other hand, one may argue that vote buying and selling practices can also attract voters who are financially poor to sell their votes. Despite having no official data regarding the gender ratio of the voters, one cannot deny that women voting can be influenced by their male guardians' preferences (Khan, 2018).

An unstable government usually attempts to oppress marginalised and stigmatised communities because it is easy to oppress them and this oppression is arguably accepted by the most conservative populations and stigmatised people cannot fight back. For instance, along with other groups of minorities, sexual and gender diverse minorities experience stigma (Lassa & Li, 2016); America is perpetuating oppression toward its indigenous people (Gonzalez et al., 2014); and in many parts of Africa, similar forms of oppression are being perpetrated upon the marginalised population under the regimes of unstable governments (Hamilton, 2019). Usually, it is seen that secular government systems are somewhat supportive of sexual and gender diverse communities and their rights (Clark, 1994), and the current government is also known as a relatively secular government who believes in social equality. Some might argue that the present government system is not very stable so they want to exert social control on the sector of the population who cannot fight back. I analyse how governmental attitude and its manipulation with different terms related to sexual and gender identities are being used for social control over marginalised populations. I analyse this aspect because such an attitude from the government can have an impact on the health and healthcare of the participants, which is also discussed.

Freial reported that the attitude of the government toward the existence of sexual and gender diverse people affects the holistic condition of sexual and gender diverse communities including community welfare or healthcare. Ichand said:

> *সরকার সেক্সুয়ালিটি নিয়ে কথাই বলতে চায় না এবং বিশ্বাস করে যে আমাদের এই [লিঙ্গ ও যৌন সংখ্যালঘু] জনগোষ্ঠী বাংলাদেশে নেই। জেন্ডার এর সাথে যে সেক্সুয়ালিটি কথাটা চলে আসে এটা তারা কখনো স্বীকার করে না কিন্তু তারা কিন্তু ঠিকই এই ব্যাপারটা জানে।*
>
> *The government is reluctant to discuss sexuality and they believe that there are no [gender and sexual minority] populations in Bangladesh. Despite knowing about sexuality and gender interrelated concepts they never acknowledge it.* (Ichand)

Freial said that the National Surveillance (HIV/AIDS in Bangladesh) in 1996 reported to the United Nations and the government that homosexual individuals exist in this country. Ichand recounted that a very few reports mention MSM (men who have sex with men), but MSM is a behaviour, not a sexual and gender orientation, thus the government is manipulating with these terms so that they do not need to state ‘gay’ or ‘lesbian’ in any report. This shows that the government is avoiding specific terms related to sexual and gender diverse identities because as far as HIV and other STIs are concerned, it is the behaviours that are risky, not the identities. Thus, the government is using this as leverage to avoid mentioning or stating terms such as ‘gay’, ‘lesbian’ or ‘homosexual’ in their documents.

Freial said that Bijito also proposed an elaborative definition of hijra to the Ministry of Social Welfare but they rejected it and defined hijra the way government officials perceived it. He was once invited to work as a researcher in a ‘complex study’ funded by the government and the World Bank. He drafted the definition of different sexual and gender diverse identities along with a designed approach on how to provide healthcare and useful recommendations. Unfortunately, all these definitions, recommendations and ideas were not included in the final version of the report of this study. Therefore, he expressed that there was a substantial lack of coordination, reluctance to help, and stigma shown by the government.

Iporane was invited as a representative of the hijra community to a meeting with the election commission’s team responsible for creating a voter list database to discuss the voting process of hijra individuals. She was informed that pilot studies were being conducted to count the number of hijra in different districts. This team was willing to work with Iporane and her hijra friends to create a verified hijra voter list so that nobody can forge any information. She added that such coordination from the government is often missing when it comes to the matter of acknowledging transpersons, gay, bisexual, and lesbian individuals.

Some participants thought that the government is also somewhat forced to disregard sexual and gender diverse people. For example, Iksera said, “perhaps the government does not acknowledge us [gender and sexual minorities] for some reasons, perhaps because we are a Muslim country and most of the people are Muslim, thus acknowledging us might create anarchy.”

Once, Ichand was in a meeting with government officials where she often mentioned the term ‘transgender’ and insisted on the relevance of sexuality and gender to the other committee members. Throughout, a government official was whispering to her that she should have said ‘hijra’ instead of ‘transgender’ and the official told her that stating the term ‘transgender’ can bring the concept of sexuality into the discussion, which was not encouraged in this meeting. This again reminds us how government does not allow the public discussion of sexuality and people with different sexual and gender characteristics. As a result, the concepts and interventions about sexual health and health needs of these communities remain underdeveloped.

Political interests and gains may preclude the political parties from recognising sexual and gender diverse communities. To clarify, Famien expressed that if the government recognises the sexual and gender diverse communities, then the majority of people might protest and public support for the government would be at risk. He added that INGOs such as Cooperative for Assistance and Relief Everywhere (CARE), and International Centre for Diarrheal Disease Research, Bangladesh (ICDDRB) have been given the responsibility to provide healthcare needs for sexual and gender diverse communities so that the government can avoid stating all the sexual and gender diverse identities in policies and laws, in case it puts their public support in danger. The funding comes from sources external to Bangladesh; the government solely depends on INGOs and external funding sources so that they do not need to amend national policies and guidelines. Ichand said that it somehow builds a connection between governmental denial of sexual and gender diverse population and their accessibility to healthcare because it is easy to exclude people from the health system if they are not accepted or officially identified in the country.

Freial discussed that sometimes political parties utilise religious prejudice to gain certain political interests by using religion as an excuse. He added that in many cases socially liberal thoughts (e.g. homosexuality) have been condemned by conservative and religious political parties, but it is worth investigating what the actual motive of these political parties is for such protests. Usually, conservative groups use religious traditions to create barriers for sexual and gender diverse populations' rights movements (Wilson & Gianella-Malca, 2019). Freial added that the groups who are considered as non-supportive of sexual and gender diverse people, use legislative systems and litigation to hinder the formulation or discussion about the laws to protects the rights of sexual and gender diverse people. Participants frequently expressed that the government does not want to lose the support and votes of the majority of the people by appearing to sanction homosexual behaviour. However, there might be more political interests for the government. For instance, in general, there has been political unrest for the last ten years and arguably there is political instability that may have pushed the government to maintain strong social control, so the government remains in power. In many societies, one of the first groups to be oppressed and stigmatised (after criminals and so-called drug abusers) is sexual and gender diverse populations. By doing so, the government demonstrates it is competent to maintain law and order and is aligned with the will of people. The stability of a government depends on its ability to stigmatise marginalised populations in order to maintain social control. This indicates that it is not only society that is reluctant for change but also the government, which is not prepared to allow change.

Patriarchy is, of course, rooted so deeply that neither society nor the government is fully aware that we are socially trained and taught to think of everything in a patriarchal way even though we are not aware of it. Hence, giving marginalised people equal rights and opportunities would make them equal to men, which challenges male dominance. It should be noted that the government uncritically reproduces patriarchy and privilege in its laws and regulations, and this contributes to the subjugation and oppression of sexual or gender diverse persons who represent a challenge to the dominant worldview.

7.9 Difference between changes in Bangladesh and Pakistan

The recognition of the third gender in Pakistan took place in 2009, while Bangladesh recognised hijra communities as a third gender in 2014. The law in Pakistan has been amended further to allow eunuchs, intersex and transmen and transwomen to self-identify gender in official forms (Barker, 2018, July 23). While discussing this with Ichand, she explained that despite being similar patriarchal, socially and religiously conservative societies, there is a subtle difference between these changes in laws in Bangladesh and Pakistan. Ichand discussed that although the government of Pakistan recognises transgender communities, the general public is not very supportive of this recognition, while in Bangladesh the majority of people are relatively supportive of sexual and gender diverse people despite the government being reluctant to recognise them. Ichand's opinion is contradictory and not evidently correct. The general public in Bangladesh is mostly unsupportive of sexual and gender diverse communities. Ichand probably holds this assumption because she expects people to be different from neighbouring countries in terms of treating undesirable populations.

Riaz (2010) discusses that historically religion has played an important role in the politics of immature South Asian democratic societies. Khan (2018) reports that Hindus have traditionally supported the Awami League, the dominant secular and current ruling party: about 9.6 per cent of the overall population of Bangladesh are Hindus, indicating that Hindu voters can have an impact in turning electoral outcomes in favour of the Awami League. It can be considered that the current government (Awami League — the ruling party) is in support of secularism (Samuels, 2016, November 15), meaning that this government is somewhat liberal compared to the current government of Pakistan. Bangladesh was founded as a secular country in 1971 after independence, and the court judgement in 2010 restored secularism as one of the main doctrines of the Constitution. This restoration was needed because during the military regimes the secular aspects of the country's Constitution had been greatly eroded (Ganguly, 2019, January 07). Nevertheless, four years ago a Bangladesh court decided to uphold Islam as the religion of the state (Bergman, 2016, March 29). Dr Abdur Razzak, a leading member of Awami League party proposed to drop Islam as the state religion. He reported that Bangladesh is a country of communal harmony where people from every religion reside, thus Islam should not be established as the state religion in the Constitution (Samuels, 2016, November 15).

The general election in 2014 was boycotted by the major opposition party (Bangladesh Nationalist Party — BNP — relatively a conservative party) in most districts (Chowdhury et al., 2014, January 06), leaving many people reluctant to vote. The election in 2019 was challenged and the results were rejected by opposition leaders such as Dr Kamal Hossain (Leading member of Jatiya Oikya Front/National Unity Front) due to allegations of corruption (British Boardcasting Corporation, 2018, December 31). Given this scenario, it can be said that the election process was undermined due to an undemocratic strategy where people were actively discouraged from voting in order to destabilise or delegitimise the government. Ichand's analysis is that because of this strategy, the opinions of the overall population were not manifested in the recent election; people are not very conservative, and they tend to believe in communal harmony. In this way, Ichand rationalises the current government's lack of support for sexual and gender diverse populations.

The issue of the questionable and arguably one-sided election process is likely to be the difference between Pakistan and Bangladesh. In other words, a fair election system may have helped Pakistan to have a fair and liberal government who are in support of the welfare of the marginalised population. But the government of Bangladesh has been failing to maintain an acceptable electoral process, which indicates a lack of trust between the public and the government. Thus, even if the majority of the general populations were to accept sexual and gender diverse communities, the government does not seem ready to manifest the same attitude through laws and policy guidelines. Nonetheless, the recognition of hijra as a third gender population took place during the period of Awami League, hence it is argued that this recognition was a sugar-coating to gain control over sexual and gender diverse communities en-masse. Even if the opposition party (BNP) were to rule, sexual and gender diverse communities would probably not have a better situation as BNP is known as a conservative or a right-wing party.

Ichand said that the situation of Islam in Pakistan might not be similar to Bangladesh because of the different ways of practising Islam, and consequently the mindset of the people in Pakistan, perhaps, is more religiously conservative, not allowing them to accept sexual and gender diverse communities. She added that "the practice of Islam has changed in this country as many people do not practise Islam these days, which can arguably provoke liberalism or secularism." A senior minister of the current government stated that "the force of secularism is within the people of Bangladesh; there is no such thing as a minority in our country" (Samuels, 2016, November 15).

This statement indicates that everyone is the same because nobody is considered as minority implying that the government will use the changes in Islamic practices to enforce conformity, even if the government is secular.

7.10 Health support of NGOs (Bijito, ICDDRB, and CARE)

In this section, I analyse health supports provided by the NGOs for sexual and gender diverse people. Analysing this aspect is very important to describe how government lets NGOs manage healthcare support for sexual and gender diverse communities to arguably deny the existence of these communities as well as avoid the responsibility to provide healthcare.

Apart from the applications of government policies and laws, there are initiatives run by NGOs for sexual and gender diverse people. As Freial explained, Bijito (funded by international funding agencies) has been providing health support for sexual and gender diverse people but they also have shortcomings such as lack of medicine, medical tests and instruments. Kelard added that due to security and social pressure, the work of Bijito is mostly secret; therefore, INGOs such as ICDDRB and CARE have been attempting to deliver healthcare for sexual and gender diverse people. These INGOs mostly deliver STI related treatments for sexual and gender diverse people; however, the services of a few NGOs have been shut down due to funding problems.

The data indicate another treatment given by the NGOs is DOT (Directly Observed Therapy), which refers to an effective way to prevent tuberculosis, STIs (sexually transmitted infections), and other highly communicable diseases. There is also a sister organisation (they requested not to be named) of Bijito that used to provide healthcare support but these days, due to lack of funding, the support from this sister organisation has become limited. Except for DOT treatment, they are not able to provide any other healthcare. Such limits in healthcare support concern hijra participants and the hijra participants assumed Bijito might be focusing on gay and lesbian communities instead of hijra. To clarify this, Ichand, a staff member of Bijito, responded that such an assumption is not true, and Ichand added:

> *আগের থেকে ডোনেশন কমে গেছে, এইচআইভি প্রতিরোধের জন্য যে রকম আগে প্রজেক্ট বা ফান্ড আসতো সেটা আসলে এখন আর নেই। গ্লোবাল ফান্ডের আগে দুইটা প্রজেক্ট ছিল কিন্তু এখন গ্লোবাল*

> *ফান্ডের মাত্র একটা প্রজেক্ট চলছে এইচআইভি প্রতিরোধের জন্য। আমাদের স্যাস্থসেবা আসলে আস্তে আস্তে কমে যেতে লাগলো এই প্রজেক্ট কমে যাওয়ায় বা ফান্ড কমে যাওয়ার জন্য।*
>
> *Donations have decreased, the projects or funding that we used to get in the past for HIV prevention are no longer available. There were two projects operated by the Global Fund but now there is only one Global Fund project for HIV prevention. Our healthcare services started to be limited as the project shut down or the funds decreased.* (Ichand)

She added that the activities of Bijito are aimed at all sexual and gender diverse people, thus the funds are not allocated to any particular groups of sexual and gender diverse community.

NGOs also play an important role in network building among younger sexual and gender diverse people for the promotion of their mental health status. The staff at Bijito try to reach out to the young people who struggle to express their sexual and gender orientation and counsel them. Ichand explained that during adolescence it is quite common for people to lack knowledge and understanding about sexual and mental health and the role of Bijito is to help them create awareness about sexual and mental health. Bijito often relies on word-of-mouth or one-to-one communication so that an individual can be reached out to by a trusted person by ensuring privacy and confidentiality. For example, Idujon had to leave home due to their sexual and gender orientation and later they were contacted by Bijito. Consequently, Idujon involved themselves with sexual and gender diverse communities and they came to understand who they are and what they are called. Idujon explained that being involved with sexual and gender diverse communities helped them in many ways: for instance, they received sewing training from the hijra community so they can start earning for themselves.

Ostitto also operates different seminars and events for awareness building about sexual and gender diverse identities and their health aspects via publications, art exhibits and cultural programs. Ostitto runs crowdfunding campaigns by which they can promote further awareness of building initiatives. Some of the activities of Bijito and Ostitto are jointly managed by foreign organisations that enable a better network building platform.

Another role of Bijito is to provide counselling for sexual and gender diverse. As Iruvo explained, Bijito attempts to provide counselling to people who struggle psychologically and physically during the transition of their sexual and gender orientation. However, some participants expressed that they received hardly any counselling when they needed it the most, which implies that mental health is almost disregarded.

To support Bijito, there is a broad range of international funding partners that include the World Bank, UNESCO, UNDP, and UNICEF. For CARE Bangladesh, the common funding sources include the Australian High Commission, Dutch Ministry of Foreign Affairs, European Commission, Embassy of Kingdom of Netherlands, Aktion Deutschland Hilft, USAID, JICA, Office of U.S. Foreign Disaster, the Swiss Agency for Development and Cooperation. It is evident that support and funds provided for sexual and gender diverse communities are sourced from international agencies. The funding stream is quite different; this is because for other undesirable and marginalised populations such as Rohingya (a refugee community who were forced to leave Myanmar), support and funds have come from both national (government services) and international sources (Lewis, 2019). On the other hand, for sexual and gender diverse populations, the government only relies on international agencies.

Despite the political interests of helping Rohingya, the cultural and religious identity of Bangladesh has played a significant role in the ideas of community and responding to those in need; the Muslim identity of the Rohingya population inspired political leaders, local volunteers, NGOs and many other people to provide help and support (Sajjad, 2020). Since sexual and gender diverse identities do not align with certain (contestable) Islamic interpretations, local NGOs, political leaders and the government are probably reluctant to invest in their support. Consequently, sole dependency on external funds and international donor agencies arises. This is what makes the funding stream quite unique for sexual and gender diverse populations, where the government is not willing to risk any of their internal funds and resources for their own citizens while investing more on refugee populations.

7.11 The role of peer educators

Due to the lack of health support and stigmatising healthcare behaviour, some participants obtained health awareness and relevant support from peer educators who are the field-level staff of different NGOs. I analyse whether health awareness and support given by the peer educators push the participants to lose trust in visiting healthcare providers. I also analyse who peer educators are, and how they contribute to health education, awareness and other necessary health interventions.

One of the most prominent services provided by Bijito and other NGOs is to provide health education and condoms for sex workers. Freial expressed that there are a few sex workers who belong to sexual and gender diverse communities, and peer educators work in public places or particular public spots to distribute condoms for sex workers. Karnen reported that these public spots are often called Drop-in Centres (DIC) where CARE, Bijito and other NGOs place peer educators and a supervisor to help distribute the condoms. The purpose of this initiative is to prevent HIV and there are many Drop-in Centres all over the capital city, Dhaka. DIC provides STI treatments, and the participants can also have blood tests done there.

Ipreeth discussed that the role of peer educators is very useful, and his health awareness has increased from what he learnt from peer educators. Many participants explained that peer educators are very helpful because they provide condoms free of charge and it is convenient to collect condoms from peer educators as they have specific locations to distribute them. Ipreeth was informed that peer educators are mostly sexual or gender diverse individuals and if they can work as peer educators it helps to build better networking among the sexual and gender diverse people. Peer educators can educate about health, HIV prevention, and STI prevention which promotes capacity building and awareness about sexual health. Ipreeth further stated that “the information I received about healthcare or STIs from them [peer educators] I could not easily find or ask for by going to a hospital or seeing a physician.”

This is because Ipreeth believed that if he looks for such information from a hospital, his sexual and gender orientation or his partner might be disclosed and this would create trouble for him. Apart from this advantage of peer educators, police often create problems in their work. Police sometimes interrogate them in the street about why they carry condoms and lubricants in their bags. Despite this harassment, the peer educators are determined to provide health education and condoms and they always look for more locations where sex workers require health awareness, condoms and lubricants.

Freial reported that many (unpaid) volunteers work with Bijito and some of the volunteers become very much efficient in terms of their roles, engagement, and experiences so they are considered for more responsibility. These volunteers are then recruited by Bijito as peer educators by following a proper recruitment process. The peer educators are mostly sexual or gender diverse individuals and, in most cases, they have limited formal education. To achieve this, Bijito trains and educates the peer educators regarding sexual health, behaviour change and communication (BCC) and other relevant issues so that they can educate others. Once they are trained as peer educators, they become paid staff of Bijito.

Freial further added that sometimes peer educators are questioned by police, but usually a peer educator would carry a letter or a card that is supported by ICDDRB or the Directorate General of Health Services, which is a government Directorate under the Ministry of Health and Family Welfare. This card or letter is also supplied to the major police stations around the locations where peer educators are based so that police do not harass or arrest and detain them. Peer educates are effective part of the ‘hidden’ underground resistance to social control. However, during my fieldwork, there had been recent incidents of physical assault to some hijra community members which had caused severe community concerns and they were in a situation of ‘hide and seek’. Thus, even though it was intended, I was unable to recruit a peer educator for an interview.

7.12 Relocating HTC units to the government hospitals

HIV Testing and Counselling (HTC) units or centres provide voluntary testing and counselling and provider-initiated testing and counselling (Kennedy et al., 2013). ICDDRB established the first HTC unit in 2002 and the number of these units increased due to the support of different NGOs (Urmi et al., 2015). Access to HTC is not sufficient in Bangladesh due to the limited numbers of HTC units as well as a stigma against people living with HIV (United Nations International Children's Emergency Fund, 2016). Many participants expressed that the government has moved many HTC units from NGOs to government hospitals and this has created a concern for disclosure. Participants mentioned that one disadvantage of relocating many HTC units into government hospitals is that visiting a government hospital for HIV testing can increase the risk of public humiliation and insult. As a justification for this shift, Karnen explained that the World Bank considers Bangladesh as a middle-income country (World Bank, 2019, October 15), thus funds from foreign donors are gradually decreasing and NGO services (e.g. HIV testing) for sexual and gender diverse people are reducing.

Freial reported that HTC units and HIV-related services have become more limited than in the past, and gradually these services are being shifted to government hospitals. Probably the government has been gradually moving many HTC units so that it does not attract the attention of the media or the public. Given the fact that sexual or gender diverse individuals generally experience more insults and humiliation in government hospitals than private settings, the government wanted to maintain the social control and oppression by forcing them to go to government hospitals for HIV testing and services. One may argue that the reduction of foreign donations could be one of the reasons for HIV services gradually being limited. However, Karnen's assumption cannot be disregarded — being described as a middle-income country and decreasing foreign donations are merely a possible 'sugar-coating' approach adopted by the government to maintain the social control and oppression.

Due to previous incidents of insults and discrimination, Iporane stated that visiting a government health setting is more dangerous than visiting a private health setting. The relocation of many HTC units from NGOs to government hospitals has created a sense of fear among the participants, thus affecting their overall health-seeking behaviour.

Many people in Bangladesh misunderstand the causes of HIV (Sheikh et al., 2017), and stigmatise people with HIV. Some participants reported that the attitude toward HIV is also an issue and people sometimes think that only gay, transpersons and hijra can have HIV. Karnen expressed that many people may think that HIV only exists in sexual and gender diverse communities and they rarely understand that there are other causes of HIV infection rather than sexual transmission. As a result, the stigma toward people living with HIV has become very difficult to manage due to the misconceptions of the general public. This also discouraged participants from visiting government hospitals for HIV testing.

The number of people living with HIV was increasing every year when Feyan started to work as an HIV counsellor in 1990 and he expressed that it is beyond imagination how much this number has increased. According to Amin (2019, December 01), a total of 7,374 individuals are living with HIV in Bangladesh as of 2019. However, Amin (2019, December 01) estimates that the actual the number of people living with HIV is roughly 14,000, which is arguably not an alarming number in terms of the size of the population. To clarify, United Nations International Children's Emergency Fund (n.d.) reports that HIV only affects 0.1 per cent of the overall population, referring to a low prevalence of AIDS, although the data indicate that new cases of infection are increasing. However, the wide range of estimates of people living with HIV indicates the lack of access to testing, either because testing is unavailable, or people are unwilling to have it.

The socio-economic status of being a middle-income country may be seen as a positive milestone except for the implications for healthcare impacts of sexual and gender diverse communities. By continuing healthcare discrimination and allowing healthcare providers to perpetuate social stigma, the government is mismanaging the situation and it is unable to engage in community preventive health activities due to its stigmatising practices. This could lead to higher costs for the government because treatment is always more expensive than prevention. Not only are sex workers and substance abusers very vulnerable to HIV infection (United Nations International Children's Emergency Fund, n.d.), but the entire population may have to pay the price in STIs and HIV because at-risk persons may avoid seeking clinical care. Thus, it can be pragmatic to provide healthcare for sexual and gender diverse people separately — as many other countries do — in order to avoid government and mainstream services; this is being secretly attempted by the health services of NGOs that are funded by international agencies.

Ichand expressed that the number of HIV infected people increases every year, and this should be a concern; the government cannot just disregard this fact and say that HIV is not a big health issue because of its consequences on public health. Ichand reported that about one hundred Rohingya individuals have been detected with HIV; many agencies are worried that the number of HIV infection per annum may increase further. Therefore, HIV has remained a big concern for public health and there is no point of taking HIV for granted. She further explained that HIV testing in government hospitals is dangerous for sexual and gender diverse people because they do not know how healthcare providers and other staff will react to them, but the scenario of HIV testing was different as NGOs staff are relatively supportive of sexual and gender diverse communities.

7.13 Message to community, society, and younger generation

While talking to participants I received different messages from them about sexual and gender diverse communities and society. This section compiles the messages delivered by the participants. It is my privilege to share their messages so that their voices can be heard. I also analyse how these messages are important from health and healthcare aspects because most of their messages have a direct or indirect implication on health and healthcare aspects.

Iporane expressed that no matter what happens, sexual and gender diverse people have to be mentally strong so that depression and hopelessness do not take over. She took herself as an example; when she left home there were two options for her: she could become a sex worker or start collecting alms for the hijra community in the street. But she did neither and attempted to work and start her own business. She added that sexual and gender diverse people need to be patient because ensuring rights for marginalised communities has never been easy and it would take time, thus patience is the key to survive and maintain sound mental health.

There is a subtle message from Iruvo that emphasised the attitude of society. He explained that “we never force anyone to have sex with us, we also need consent from either side to maintain sexual health. However, if we get in a relationship with a cis-heterosexual man, we are always blamed, not the cis-heterosexual man, even though we did not force anyone.” He also asked, sometimes, “cis-heterosexual men or police would force us to have sex; why are we blamed for such cases? Just because they are the majority and we are the minority?” Iruvo shared his message that people in society need to understand sexual health is something that everyone needs to think about and forcing someone to have sex brings adverse sexual health impacts.

Iksera expressed a message for sexual and gender diverse people, particularly those who are younger. She urged that no one should abandon their education, because in the future, they may need to support themselves if they are disclosed in society, and education is a way to get a job and survive. She added that it is important to keep oneself resistant and determined by education at a younger age so that no wrong steps (e.g. substance abuse and unsafe sexual behaviour) are taken at an early age, because these steps may break a person psychologically and emotionally.

Many participants reported that the use of the Internet can be beneficial for the younger generations to read blogs and articles to understand sexual and gender diverse identities whenever they feel conflicted in order to avoid frustration and isolation because these can severely damage their health. However, much of the online material and content regarding sexual and gender diversity, sexual health, and most of the websites of many NGOs are in English, not in Bengali. This may be difficult for young people because not all of them may be able to read and speak English fluently. However, there are some blogs and magazines that are published in Bengali by NGOs that work for sexual and gender diverse populations. Apart from this, younger people can also get in touch with organisations that work for sexual and gender diverse communities such as Bijito and Ostitto so that they can build community networking and receive mental support.

7.14 Summary

It is important to consider how health and healthcare are perceived at different institutional levels so that they can be investigated as a lens to understand the overall oppression of sexual and gender diverse communities. In this chapter, I discussed the relevance of law, society, and taboo on sexuality with the understanding of health and healthcare. I examined the roles of NGO initiatives and government policies to understand how healthcare for sexual and gender diverse communities are planned and delivered. At the end of this chapter, I presented the hopes and messages of the participants to the society and community members to highlight how things can be different in the future for the betterment of health status among sexual and gender diverse people.

Chapter Eight: Healthcare, a Human Right or a Tool for Oppression?

8.1 Introduction

The chapter begins with an understanding of how health and healthcare is theorised as a human right from a social justice point of view. By analysing the healthcare experiences of the participants, we can understand whether healthcare can be regarded as a human right. Before I describe the participants' healthcare experiences, I discuss the interrelation between health, justice, and patriarchy, and some common health issues for which the participants usually sought healthcare. Then I analyse the discriminatory healthcare experiences of the participants to investigate whether this discrimination is used as a tool for the oppression that is mostly influenced by patriarchy and colonialism. An analysis is then given on rights-based movements and their barriers. Further, analyses of other healthcare issues such as medical social work, ethical standards of healthcare professionals and health and well-being are discussed.

8.2 Health, justice, and patriarchy

A theory of justice is regarded as an important mechanism in this research to justify healthcare as a right and how it can be used as a lens to look at the overall socio-economic oppression of sexual and gender minorities. This is because justice models can rationalise how health and healthcare relate to socio-economic factors (influenced by patriarchy) through a justice framework. In many cases, participants experienced healthcare discrimination when they made a rational choice of disclosure by using a utilitarian approach, which created a bridge between health and justice models.

A theory of justice is deemed highly influential as it follows the notions of Rousseau, Locke, and Kant along with the theory of social contract (Daniels, 2001). Notably, the concepts of health and the right to healthcare are changed by a theory of justice. This theory proposes that health is not a gift from nature but a dynamic state that is affected by a person's socio-cultural, economic, psychological and environmental factors (Braveman & Gottlieb, 2014; Hernandez & Blazer, 2006). It further emphasises that health and illness are affected by social factors such as stress, social exclusion, working condition, early-life conditions, nutrition, social support, and addiction (Ekmekci, 2017).

Since health is understood in the context of a person's socio-economic, cultural, and psychological factors, it is important to consider the same factors for sexual or gender diverse individuals' health. The nature of oppression experienced by these individuals in a male-dominated society significantly affects the same socio-economic factors that define their health. This creates a strong connection between social factors of health and patriarchy to determine the influences a male-dominated society has on their socio-economic and cultural lives. This somewhat made the paradigm of health a subject of social justice (Daniels, 2008) due to the impact of patriarchy on social factors such as social exclusion to maintain the oppression of sexual and gender diverse populations.

Health is perceived in a theory of justice through a normal functioning approach, as discussed by Daniels (2001). It is argued the moral necessity of health is concerned with the usual protection and functioning opportunities of an individual. Daniels constituted his ethical defence based on justice theory and fairness, which refers to a fair system to protect normal functional opportunities (Ekmekci, 2017). To add emphasis to the right to health under a fair system, Daniels (2001) reasons that health holds a higher ethical value in comparison to other social services, and supported that an equal and fair opportunity is a major social good that aims to reduce adverse effects of the social or natural gift. He redefined that social factors behind health are undeniably important to ensure a normal and fair opportunity for everyone (Daniels, 2008). However, a fair opportunity to provide healthcare to sexual and gender diverse populations would arguably create equality that would weaken a male-dominated social system. According to Ekmekci (2017), Daniels' arguments determined that social determinants of health have a higher ethical value than other social services or goods; thus, fulfilling the health needs of a person became a requirement to objectify a theory of justice.

The ethical reasoning of Daniels (2008) indicates that a) if healthcare and social factors of health promote health status, b) if health is needed for normal functioning, c) if normal functioning leads to the protection of normal opportunity, then equal and fair opportunities are protected by healthcare and social factors of health. The approach of Norman Daniels is indifferent to a person’s ethnic, religious, socio-economic, and gender identity; the origin of such indifference is derived from the theoretical position of a theory of justice (Ekmekci, 2017).

Theory of justice generally refers to equally distributed social services by various institutions. It also demands an original position for those institutions to determine the principles of justice (Daniels, 2001). This theory discusses two prior requirements to sustain this original position. Firstly, everyone is placed behind a curtain of ignorance that conceals personal knowledge about their characteristics, abilities, socio-economic backgrounds, ethnicity, age, gender identity, health status, intelligence, educational level and their understanding of good. Secondly, the opposite scenario is where the individuals in this original position are aware of all those situations and can make rational choices. The rationality leads to reasonableness whereas ignorance leads to the neutrality of the decisions made by the individuals (Ekmekci, 2017).

The participants sometimes made rational decision to disclose their sexual and gender orientation when it came to the matter of health by hoping that health settings and medical institutions would treat them due to their principles of justice. However, the participants mostly experienced discrimination and humiliation instead of getting equal and fair opportunities for healthcare. Hence, it is notable that there has been an inconsistency of justice models in the context of marginalised populations of a society that privileges men. Some participants assessed the potential risks of disclosure, but health settings were somehow unable to hold their original position for equally distributed services. This is because providing fair healthcare to sexual and gender diverse populations would make these populations as equal as men, which threatens patriarchy.

8.3 Common health issues

It is worth noting that the provision of justice theory to provide fair and equally distributed (healthcare) service can determine whether healthcare is a right. Before we analyse if healthcare is fairly and equally distributed as a right to everyone, we need to understand some common health issues that the participants experienced. Due to patriarchal influence and colonial oppression, participants suffered from various socio-economic, cultural, and psychological issues that led to health problems that the majority of the population may not usually experience. These health issues were mental health, gender confirmation hormone therapy, and gender confirmation surgery.

8.3.1 Mental health and mental healthcare

According to World Health Organization (2019), mental health is related to the psychological and mental state of a person; good mental health refers to the promotion of mental well-being, prevention of mental ailments, and the promotion of human rights and care for individuals who suffer from mental disorders. Currently, the level of awareness of mental health is very low, particularly in rural areas (Uddin et al., 2019). Healthcare professions involved in mental health sectors are psychiatrists, psychologists, social workers, mental health nurses, and counsellors (World Health Organization, 2017). Psychiatrists who are medical doctors are appointed to mental health services and one example of this is Pabna Mental Health Hospital, the only mental health hospital in Bangladesh (World Health Organization, 2007). Psychiatrists would usually have a Bachelor of Medicine and Surgery (MBBS), not necessarily with specialised training in the treatment of mental disorders. Social work is not completely recognised as a practised profession, and psychiatric social workers who have educational qualifications in social work are rarely appointed in government hospitals except a very few including Pabna Mental Hospital (Government of People's Republic of Bangladesh, 2020). The persons who have an educational qualification in psychology (Bachelor or Master’s in Psychology) can work as a psychologist or professional counsellor, mostly working for non-government health settings or sometimes practising independently. Mental health nurses generally have a qualification in nursing.

Iporane explained that there is a lack of professional counselling because the concept of social work, mental health and well-being are not properly recognised. She added that the participants were often scared to see a psychologist or counsellor due to the fear of humiliation, insult, and public disclosure.

It is important to note that Bangladesh passed a new Mental health Act in 2018 by replacing its previous Lunacy Act, 1912 (Hossain et al., 2019). Despite the high burden of mental health issues, only BDT 2.4 (USD 0.028) is allotted for mental health expenditure per person (World Health Organization, 2017), indicating that not only are mental health services insufficient but also that it is severely underfunded.

According to Hossain et al. (2019), the main limitation of the new Mental Health Act is the lack of consideration toward the substantial economic needs of the mental health sector; confidentiality, accountability, and human rights facets are not addressed by this Act. This is essential in terms of this research because some participants reported suffering from anxiety, isolation, and depression due to the stigma toward sexual and gender diverse populations, and if there is no regulation of ensuring privacy and confidentiality of the person then it leaves them at great risk of being exposed to the public.

Mental health functions are not well organised: the country does not have a robust and specific policy for mental health to complement the strengths of new Mental Health Act (Hossain et al., 2019), hence it is difficult to say what type of model or insight is incorporated in the mental health services. However, it is noticeable that most mental health patients are prescribed with psychotropic medicines such as mood stabiliser, antiepileptic, anxiolytic, antipsychotic and antidepressant medications (World Health Organization, 2007). This implies that there is hardly any application of non-medical therapies to treat mental health patients.

Many participants said they often suffer from mental depression and frustration but reported that they are unable to see a physician about their issues. For example, Famien reported that his friend who identifies as gay had been suffering from erectile dysfunction which had resulted in tension with his partner. He was scared of seeing a physician about this problem as he thought the physician might find out about his sexual orientation, thus his relationship with his partner deteriorated.

The mental state during adolescence is something that was mentioned frequently by the participants. For instance, Famien remarked that when a boy notices that other boys around him are growing up in a different way from him, he tends to alienate himself and is often verbally abused due to his calmness and non-conforming behaviour. Therefore, he encounters many barriers and his focus on education is disrupted. This frustration affects his mental state. Imeen said “I used to think was I sick or crazy, or was I mentally unstable? Back then I could not even discuss with anyone that other boys were attracted to girls, but I was not.”

Idanam explained that such isolation can often make a person feel lonely and distanced from family members, and this can result in tears, depression and suicidal tendencies during this conflicted period of life. Some participants were forced by their families to get married and this put an extreme degree of mental stress and generated suicidality. Franso said:

> *আমার পরিচিত এক [সমকামী] ছেলেকে জোড় করে বিয়ে দেয়ার চেষ্টা করা হয়েছে। তার এঙ্গেজমেন্ট করানো হয়, তারপর সে তার পরিবারের কাছে সময় চায় কিন্তু সময় তাকে দেয়া হয়নি। তাই সে পরিবারের কাছে চিঠি লিখে সব কিছু জানায় এবং সে বিষ পান করে আত্মহত্যা করে। তার জন্য যে মানসিক স্বাস্থ্যসেবার দরকার ছিল সেটা আমাদের দেশে নেই, থাকলে হয়ত তার জীবন বাচানো যেত।*
>
> *A [gay] man I knew was being forced to get married. He was engaged, then he asked for a delay from his family, but he was given none. Therefore, he wrote a letter to the family and explained everything, and he drank poison and committed suicide. If we did have the mental healthcare he needed in our country, perhaps his life could have been saved.* (Franso)

Iksera and Idujon attempted to commit suicide quite a few times. Iksera took 300 powerful sleeping pills when she was struggling to understand herself, and Idujon attempted to take their life by hanging themselves as they believed that they were a curse to their family. Isalho ended up taking drugs due to his depression, but his involvement with Bijito helped him to recover.

Karnen said while mental health should be prioritised, there is rarely any discussion about this aspect in health settings. She further explained that counselling and mental health support is essential for people who live with HIV and suffer from mental stress and psychological conflicts; however, the government hospitals have yet to consider providing any form of counselling or psychosocial support for people.

A sister organisation of Bijito and a few other NGOs have been able to deliver mental health support and counselling for sexual and gender diverse people, and some participants explained that they always received mental health support from the staff of Bijito. Israne explained that he feels a sense of belonging to the community due to his engagement with Bijito. Imeen said, “I receive support from them [Bijito]; they have a counsellor who always tries to help us and tries to give us psychological counselling.”

Once Imeen was very upset and was missing her mother. She called her mother, but she was not answering Imeen's calls. Bijito's counsellor called and convinced her mother to speak with Imeen, which gave her great relief. She reported that she likes to talk with the counsellor because she can express anything she wants, and the counsellor listens and cares for her. She also reported that she needed to break through her isolation with some sort of mental support, which is rarely available for sexual and gender diverse people.

One might argue that since mental health services are underdeveloped for everyone, why should they be available for sexual and gender diverse communities. Given the fact that the new Mental Health Act does not even acknowledge the human rights aspects of mental illness (Hossain et al., 2019), it would be too optimistic to ensure mental health support (as a human right) for marginalised populations. Nevertheless, the government intends to take the mental health sector one step further by formulating Mental Health Review and Monitoring Committees in every district so that it can be delivered to everyone (Dey et al., 2019). In other words, this stated intention indicates that mental health for marginalised populations is as important as for the majority of the population.

Iruyan expressed that transmen individuals suffer from tension and stress when they want to undergo gender confirmation surgery; consequently, transmen and transwomen may suffer from depression that can hamper their day-to-day life. For example, Ichand said that depression affected her work life and eventually she had to quit her old job.

In some cases, the participants said they visited psychiatrists and they were prescribed with sleeping pills and anti-depressant medicines. Ichand added that the side effects of such medicines could be long term or short term, but they are particularly harmful to health, which is often overlooked by the psychiatrists. For instance, Isalho said he had to take such medicines when he was younger, and he is still suffering from the side effects that affect his present health.

8.3.2 Gender confirmation hormone therapy

Understanding the participants' experience of gender confirmation hormone therapies is important because transperson participants said they wish to physically transform themselves into their desired gender. These hormone therapies can seriously impact on their health. However, the first and foremost challenge of gender confirmation hormone therapies for the participants is that it is very expensive. Kingshu expressed that many sexual and gender diverse people go abroad to undergo this hormone therapy and it is extremely costly. Sometimes, the participants can purchase gender confirmation hormones in Bangladesh, but it is equally costly. Iporane said "very few physicians would prescribe hormones for a trial, which is very expensive and costs around BDT 20,000 (US$235) and it is almost impossible to afford for a hijra individual." Bijito sometimes helped the participants to import gender confirmation hormone doses from abroad as there are very few pharmacies that sell this hormone, and these imported ones are very expensive. Inrose added that here are hardly any options to purchase this hormone dose from the Internet.

The lack of knowledgeable physicians who can provide advice about gender confirmation hormones is another problem faced by the participants. Iruyan stated:

> *কিভাবে হরমোন থেরাপি নিতে হবে, ডোজের পরিমাণ কেমন হবে, কোন ধরনের হরমোন নিতে হবে, তো এরকম অনেক সমস্যায় অনেকেই ভোগেন এবং পরামর্শ নেয়ার জন্য কোন ডাক্তার বা কেউ নেই বাংলাদশে। যতদিন না পর্যন্ত সরকার আমাদের [লিঙ্গ ও যৌন সংখ্যালঘুদের] স্বীকৃতি দিবে ততদিন পর্যন্ত কোনো ডাক্তারই আমাদের [হরমোনের] পরামর্শ দিতে আগিয়ে আসবে না।*
>
> *How to use hormone therapy, what amount of dose to take, what kind of hormone to use; many people suffer from such issues and there is no doctor or anyone to consult. Until the government recognises us [sexual and gender diverse populations], no physician will come forward to give us [hormone] consultation.* (Iruyan)

Therefore, some participants attempted to consult foreign doctors on the Internet and this online hormone consultancy was again more expensive than the participants expected. Iruyan added that regular check-ups with foreign doctors in Thailand to follow up his testosterone level is very expensive. If he had been able to see physicians for this consultation, they may have paid less than the online consultation with foreign doctors. He further added that he wants to go to India to see a physician for hormone consultation and he is saving money for his intended visit. There are few physicians available for hormone consultation, and in any event the participants were scared to visit physicians due to the probable humiliation and public disclosure. Thus, the participants tried to find gender confirmation hormones doses themselves. Iruyan usually took his hormone dose by himself, because going to the physician was a risk, so he tried to take it by himself. If he went to a physician or nurse for this, he would have to justify why he was taking this and so forth.

There are different forms of gender confirmation hormone therapies that are taken by transpersons so that they are physiologically able to transform into their desired sex. Tablets, gels and injections are three common forms of hormones available. The gel is the best option, but it is also very expensive; hormone tablets may have some side effects; hence the participants prefer to use the injections. But Freial explained that for legal reasons (there is no legal guideline around taking hormones as a process of gender confirmation), none of these three hormones is readily available.

The side effects of gender confirmation hormone intake are something that worried the participants. For instance, Isalho had undergone the ‘top’ surgery (in India) and is willing to go for ‘bottom’ surgery in the future. Therefore, he needed to take the hormone but he was worried about the side effects. He could not even get much information about the possible side effects during his consultation with physicians in India. Isalho was concerned because he had had to take a high dose of hormonal medication as a child due to delayed menstruation, which might have had long term side effects on his health.

There are barriers related to the use of hormone therapy for gender confirmation such as the lack of available medical consultations and the unknown risks and side effects of using hormone therapies. Nevertheless, some participants continued to take their hormonal dose. Kingshu expressed that the government needs to be conscious about gender confirmation hormone therapy, its consultation and availability so that sexual and gender diverse people do not need to suffer anymore.

8.3.3 Gender confirmation surgery

Famien expressed that gender confirmation surgery is not readily available or legally accepted because living as a different gender by transforming the birth gender is not legally accepted.

Hence, many hijra have attempted to perform this surgery (remove their male organs) by themselves, resulting in death in some cases.

Israne reported that very few people have undergone formal gender confirmation surgery, and most had to have it performed abroad, although a few physicians are willing to do it secretly but this can be very expensive. Idanam also explained that she and many of her friends are willing to undergo gender confirmation surgery but due to their financial crisis, they have not been able to do it. Iruyan said:

> *ব্যাংককে এই [লিঙ্গ নিশ্চিতকরণ] সার্জারি সম্ভব এবং ওদের প্যাকেজ আছে বিভিন্ন ধরনের। আমি যতদূর জানি যে ৮ লাখ টাকার [০.৮ মিলিয়ন টাকা - ৯,৪৩০ মার্কিন ডলার] মতো লাগে, যাওয়া-আসা মিলে হয়তো আনুমানিক ১২ লাখ টাকার [১.২ মিলিয়ন টাকা - ১৪,১৪৫ মার্কিন ডলার] মত দরকার হবে।*
>
> *This [gender confirmation] surgery can be done in Bangkok and they have different packages. As far as I know, it requires about BDT 8 lakh [BDT 0.8 million = US$9,430], and perhaps a total of around BDT 12 lakh [BDT 1.2 million = US$14,145] will be needed including the cost of travel.* (Iruyan)

Isalho spent a large amount of money for his 'top' surgery and he will require more money in the future when he will undergo 'bottom' surgery. Fortunately, his family was able to afford this surgery in India.

There are other problems regarding gender confirmation surgery. Iruyan explained that when a person undergoes breast removal surgery, they need to be cautious about the condition of the tissue because the tissue would define how their breasts will look, and it is a complicated matter to be treated. Iruyan further expressed that if a person undergoes gender confirmation surgery abroad and when returning to the country, immigration will probably find their face or hair look different from their photo on the passport; interrogation may take place and immigration will realise that they underwent gender confirmation surgery. Thus, immigration staff can humiliate the person and create further legal trouble, and Iruyan has heard of incidents like this.

Even after gender confirmation surgery, it would be difficult to find a job. Iruyan restated “even after becoming physically male by gender confirmation surgery, I have to keep my female identity in all the official documents which will make it hard for me to get a job, I would not even be able to apply for many jobs.”

8.4 Individual healthcare experiences

To understand if healthcare is accessed fairly and equally, we need to analyse the healthcare experiences of the participants. The participants experienced healthcare in different healthcare settings. There was mostly neglect, humiliation, insult, and negative behaviour experienced by the participants in the name of receiving healthcare. I have separated these experiences into two categories: (a) experience directly related to participants’ gender or sexuality, and (2) experiences related to other aspects, but their treatment was affected by their identities.

8.4.1 Healthcare experiences due to gender and sexuality

In the theory of social justice, there is an original positioning of a belief that social and healthcare services would be provided equally by different institutions. Some participants held a similar original position to obtain equally distributed healthcare facilities, thus they disclosed — either intentionally or sometimes unintentionally — their sexual or gender identity to healthcare professionals despite knowing that there could be potential risks. In this section, I analyse individual healthcare experiences directly related to the gender or sexuality of the participants in order to understand whether the original position of equally distributed healthcare services was maintained by healthcare institutions.

Karnen was a victim of humiliation and harassment in a government hospital where a group of hijra were called for so-called medical check-ups as part of an employment package (Human Rights Watch, 2016). Karnen said:

> *শারীরিকভাবে তো আমি একটা ছেলে। ওরা [স্যাস্থ্যসেবা কর্মীরা] আমাদের সাথে খুব বাজে ব্যবহার করল আর বলল যে আমরা কেন এখানে পরীক্ষা করতে আসছি কারণ আমরা আমরা নাকি পুরুষ এবং ভুয়া*

> *হিজরা। তখন আরও অপমান করেছে আমাদেরকে এবং আরো অনেক আজে বাজে ভাষায় গালিগালাজ করেছে। পরে চোখের পানি ফেলে চলে আসছি।*

> *Physically I am a male. They [healthcare providers] treated us badly and said why did we come here for a check-up because we are biologically male and fake hijra. Then we were insulted even more and verbally abused. We were all in tears while leaving there.* (Karnen)

It is evident that government hospitals are the most likely place for being humiliated and dehumanised for the participants. This further justifies the fear and anxiety among the participants that made them prefer private healthcare settings, NGOs and INGOs instead of visiting government hospitals for healthcare.

About two decades ago, when Karnen was working as a sex worker, she was suffering from a problem in her anus. She was told that there was a (female) physician in a clinic who treats sex workers. After she went there, the physician refused to see Karnen because she is physically a male, not female. It is likely that the physician was not ready to accept the fact that a male should be a sex worker because she presumably held a belief — the physician was a female — that men engaging in sex work does not align with a masculine social system. The physician asked Karnen to go someplace else where male sex workers can be treated. Hence, she took antibiotics prescribed by a pharmacy staff without any check-up or test. This was the time when Karnen was actually infected with syphilis, which she later found out while doing a blood test by an INGO. Benzathine penicillin, a powerful antibiotic used for the treatment of various bacterial infections, was given to her by this INGO to manage her syphilis infection. This is one of the incidents why most participants regarded the services of NGOs or INGOs as more reliable than the government hospitals.

Since Karnen was unable to go to a healthcare setting, she went to buy medicine from a nearby pharmacy and the staff there once found out about her. Karnen said:

> *উনি [ফার্মেসির কর্মচারী] একবার আমাকে তার সাথে এই [যৌনকাজ] কাজ করতে বললেন এবং উনি বুঝতে পারছেন যে আমি এই [যৌনকাজ] কাজ করি। তখন আমার সাথে উনি জোর করে সেক্স করলেন, আমার সম্মতি ছাড়াই।*
>
> *He [the pharmacy employee] once asked me to do this [sex work] with him and he realised that I do this [sex work]. Then he forced me to have sex with him, without my consent.* (Karnen)

Some may argue that being sexually assaulted and raped by the pharmacy employee may not be regarded as a negative healthcare experience because the person working in the pharmacy is not always a healthcare provider. Nevertheless, I argue that if Karnen could have accessed healthcare from a health setting, she would not have had to go to the pharmacy at all.

Imeen discussed that whenever she visited a healthcare provider, they hardly listened to her problems just because she was a transwoman. Imeen had a terrible healthcare experience in a government hospital. Once she was diagnosed with a fistula and she tried every way to avoid hospitals. For example, she tried to get antibiotics from the pharmacy, and they made her constipated and made her suffer even more. Eventually, she had no other choice but to go and be admitted to a hospital. Because of her female dress, the staff thought she was a woman, and admitted her in a female ward. The intern doctor behaved very nicely, but not the department head. Imeen said:

> *সার্জারি ডিপার্টমেন্টের হেড ডাক্তার আসলেন। উনি আমার দিকে তাকিয়ে একটু বিরক্তিভাব প্রকাশ করলেন যে আমাকে [একজন হিজড়াকে] সাপোজিটরি দেয়া হবে! [অবজ্ঞার প্রকাশ] কারণ উনি আন্দাজ করেছেন যে আমি হিজড়া।*
>
> *The head physician of the surgery department came over. She looked at me and seemed a little bit annoyed that I [a hijra] would be given a suppository! [expression of disgust] because she assumed that I was hijra.* (Imeen)

Then a nurse was called to administer the antibiotics. The nurse immediately started to scream when she noticed that Imeen has male organs while having breasts. Then the head of the physicians asked how she got admitted in this ward since she is not a female. Imeen responded that she did not ask to be admitted in the female ward, it was done by the staff. Another staff member asked for her to be removed from the hospital. Meanwhile, every staff member and the patients of this ward started to gather and look at Imeen's genitals and breasts, which was an absolute humiliation and dehumanisation for her. Imeen said:

> *আমার চোখে পুরো পানি এসে গেছে তখন। আমি ভাবলাম এখানে আর থাকব না, মরে গেলে মরে যাব। কি যে অবস্থা সব মহিলারা [রোগী] এসে আমার সবকিছু [পুরুষ অঙ্গ] দেখছে, কি যে একটা অবস্থা তৈরি করছে। ৫০-৬০ জন মানুষ সবাই এসে আমাকে ঘিরে ধরে দেখতেছে আমি তো শরমে কি যে করব কোথায় যাব।*
>
> *I burst into tears. I thought I would not stay here anymore; I would die if I have to. What a situation they have made, all the women [patients] came and peeked at everything [male organs]. About 50-60 people gathered and looked at me and I was very ashamed and feeling helpless.* (Imeen)

She was moved to a male ward after this humiliating experience. On the day of her surgery, the surgeon did not show up and was more than three hours late, so Imeen started to argue with the staff. Then they took her into the surgery room without the head surgeon and undressed her and started to touch her genitals whereas her problem was in her anus. They were looking at her from the front and back, interrogated her about her sexual and gender orientation and verbally abused her. However, the surgery was done eventually, and she was released from the hospital and determined that she would never go back to that hospital for any reason.

One purpose of such discriminatory behaviour could be that Imeen decided to voluntarily give up her male privilege to be a female and the masculine society finds this hard to accept, so she was denied appropriate healthcare and medication. However, people from the same patriarchal society would not mind sleeping with Imeen for free, this reminds us that it is not about the sex, it is about the socially assigned gender that Imeen does not want to be.

Although gender confirmation surgery is not readily available, Inrose underwent gender confirmation surgery from a surgeon in Bangladesh and it costs about BDT 50,000 (US$ 590). After this costly surgery, Inrose was still unable to change her name in educational and civil documents, even after a physical examination. This examination was an insult for Inrose because the physicians did not examine her in a private cubicle; it was more like a waiting lounge for the staff where people were coming in and out. Inrose said:

> *নার্স আমার আমার জামা-কাপড় সবার সামনে খুলল এবং সবকিছু দেখতে লাগল। আমার সামনেই মনে করেন আরও অনেক লোক ছিল, যেমন আয়া-পিয়ন, তাদের সামনে এসব করা শুরু করল এবং আমি তো একেবারে লজ্জায় শেষ।*
>
> *The nurse undressed me in front of everyone and looked all over me. I think there were many people in front of me, such as* maid-peon[3]*, and she started to examine me in front of them and I was very ashamed.* (Inrose)

The gender confirmation surgery to transform from a biological male to female was probably not well accepted by the healthcare providers. Therefore, they became hostile toward Inrose to assert that whoever voluntarily gives up the male privileges is supposed to be humiliated in any way possible.

Iporane went to a clinic for a medical check-up where the physician's assistant thought (while taking notes) that she was a woman and asked when she had last menstruated. Iporane said she never menstruated as she is biologically a male. After hearing this, the tone of voice of the assistant changed. Up until then, the physician's assistant was asking questions without looking at Iporane but after hearing that she is hijra, he eventually looked at her. Iporane said:

> *আমি হিজড়া এটা শুনে উনি [ডাক্তারের সহকারী] চেয়ার থেকে উঠে দাড়ালো এবং বলল 'আপনি এখানে আসছেন কেন এটা কি হিজড়াদের ক্লিনিক? এটাতো হিজড়াদের জন্য স্বাস্থ্যসেবা দেয়া হয় না। আপনি*

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[3] Maid-peon: In South Asian region, it refers to a low-ranking staff or worker in an office such as assistant, attendant or helper.

> *সেখানে যান যেখানে তাদেরকে [হিজড়াদের] স্বাস্থ্যসেবা দেয়।' আমি অনুরোধ করলাম কিন্তু উনি বললেন 'এটা কোনভাবেই সম্ভব না, আপনি এখনি চলে যান না হলে আমি সিকিউরিটি ডাকবো।'*
>
> *When he [the physician’s assistant] heard that I was hijra he got up from the chair and said, “Why have you come here? Is this a clinic for hijra? There is no healthcare given for hijra in this place. You can go someplace else where they provide healthcare to them [hijras].” I requested help, but he said, “This is not possible, and if you do not leave now, I will call security.”* (Iporane)

Iporane asked this assistant why his professor (physician) does not see any hijra, and in response the assistant was silent. Eventually, she could not get a medical check-up there. In addition to this, Ikhiyam and her friend were once beaten and taken to the hospital. But the healthcare providers were reluctant to touch Ikhiyam and her friend for medical attention. Ikhiyam stated:

> *শুধু আমি হিজড়া বলে আমাকে ধরতে চায় নি। আমরা তখন চিল্লাফাল্লা করি এবং তাদের [স্ব্যাস্থসেবা কর্মীর] কাছে অনুরোধ করি। তাদের হাতে ধরি পায়ে ধরি যে আমাদেরকে যাতে সাহায্য করে। তারপর দেখা গেল যে আমাদের কথা তারা একটু শুনল।*
>
> *They did not want to touch me as I was a hijra. Then we yelled at them and begged them [the healthcare worker]. We kept on begging so that they would help us. Then it turned out that they listened to us a little.* (Ikhiyam)

Once Karnen was ill and went to a hospital, she could not get in the queue because of being a hijra, so she took her mother to get in the queue. The staff asked her to accept some money (alms) and leave as they thought she was there to collect alms for the hijra community. She then insisted that she was there to see the physician. Eventually, the physician saw her but treated her differently from a regular patient. Her symptoms were completely ignored by the physician and she was quickly prescribed some tests and medication. While doing the prescribed tests, she also struggled because the staff kept laughing at her, saying what her gender should be on the test application form. She mentioned that such an experience has unfortunately become a common scenario for her whenever she visits a healthcare setting.

These incidents are an indication that the dominant patriarchal values and stigma toward hijra outweigh the professionalism and ethical obligations of healthcare providers to treat patients regardless of who they are.

During the expression of self-identification, Iksera found she was conflicted by her attraction to women and she decided to see a psychologist. But the (female) psychologist started to scold her and asked her how she understood that she was not attracted to men. Iksera explained frankly that she had even tried to be intimate with a man recently, but she could not do it and did not feel attracted at all. After this, the psychologist gave her a lot of moral advice and asked her to change her mindset. Eventually, Iksera and psychologist had some arguments and she had to leave. This experience suggests that not only men but also some women can hold strong patriarchal values that a woman should only be with a man.

Iruvo experienced sexual assault by a male healthcare provider. Once Iruvo was suffering from high blood pressure and went to see a local physician. Iruvo did not know that this physician was attracted to men. While performing the check-up, the physician touched Iruvo’s genitals and it shocked Iruvo. He added that “Perhaps, the physician figured that I was also attracted to men and this is why he did this.” The physician then offered to have sex with him but Iruvo refused. Iruvo panicked and did not disclose about his orientation and left from there. Later he found out that this physician is a homosexual and often attempts to sexually molest his male patients.

Sexual molestation of males and male rape is rarely reported. If a sexual or gender diverse male reports a case of being sexually molested or raped, he would be considered guilty for engaging in same-sex behaviour, which is a ridiculous imposition of Section 377 as the matter of consent is barely taken into account. Therefore. such cases of sexual molestation of men at healthcare settings remain unreported. However, one may argue that when women are sexually assaulted at healthcare settings, it can be reported, and action can be taken. This is because a patriarchal system normalises that it is only women who can be molested not men, as men are supposed to be the perpetrators.

Idujon was born with both deformed male and female genitals and they were named with a female name. Their parents wanted them to be treated by surgery when Idujon was only five years old. The physicians first told them that they have a hernia, and it can be treated. However, the surgeons made four surgical attempts and none of them was successful. Later the surgeons said that there was no need to perform any surgery and Idujon would be fine by the age of 18.

However, after these unsuccessful attempts of surgery, Idujon’s name was changed to a male name and they were growing up as a male child. Around the age of twelve or thirteen, Idujon’s breasts began to grow, and their mother wanted to attempt surgery again. She took them to many hospitals and there was no option of a probable treatment for Idujon. Their mother did not want to give up but deep down Idujon realised that there was no treatment for their condition.

Due to their breasts, Idujon started to walk with a forward-bending posture so that people did not notice their breasts as they were socially known as a man. This caused them back pain and they visited a healthcare setting for treatment where they were asked to undergo a physical test. In this test, the staff noticed their genitals and started interrogating them about it. Idujon refused to answer as they were there for their back-pain treatment, not for their genitalia examination. The staff started to mock Idujon and interrogated them about whether they were male or female. A physician then asked Idujon to perform more tests and once the physician saw the reports of the tests, he said Idujon’s breasts must be removed. The physician constantly told Idujon that if their breasts were removed then this back pain would go away, otherwise, it might eventually lead to cancer. They asked Idujon to be admitted to the hospital immediately but Idujon believed that they were trying to manipulate them to spend more money, so they did not listen to the physician.

After a few years, due to family pressure, Idujon again went to visit a hospital to find out if there was anything that could be done, and they were asked to undergo some tests. These tests were very expensive, and the staff of the hospital asked them how much Idujon earned and how they could afford such expensive tests, even though it was none of their business. Then Idujon could not undergo these tests and decided that they would give up trying. Idujon said, “so many places I have been for so many hormonal tests, blood tests, this test, that test; by having these tests my hands are full of injection holes.”

Once while undergoing an ultra-sonogram, a staff member looked at Idujon’s genitals and they protested why the staff needed to look at their genitals for an ultra-sonogram. Idujon felt very ashamed because of this. They added that “having deformed genitals does not mean that they were something for ‘demonstration’ and everyone had to look at them.”

All the healthcare experiences of Idujon indicate not only the struggles of intersex individuals but also the stigma, hatred, and social exclusion that they experience throughout their lives. Idujon’s experiences also suggest that healthcare professionals constantly attempted to transform them as a male, though they failed, suggesting the preference for masculine identity.

Israne explained that had he disclosed about himself the healthcare provider would have treated him as a stranger or alien, or as if he had just come out of a zoo. For this reason, Israne was reluctant to disclose his sexual and gender identity to the healthcare provider. Nevertheless, Israne believes that no matter how a healthcare provider behaves toward him, it would be up to him how he manages the situation. Despite all the negative experiences, a sexual or gender diverse person can have outstanding resilience.

To consider healthcare as a right from a social justice point of view, the data suggest that healthcare was not equally and fairly disseminated to the participants. All these individual healthcare experiences have some aspects in common: discrimination, insult, abuse, neglect, humiliation, and manipulation. While analysis if healthcare is delivered as a human right for the participants, it also leads to a debate whether healthcare discrimination is used as a tool for social control and oppression of sexual and gender diverse people due to the participants’ negative experiences. The later part of this analysis chapter describes healthcare from two different perspectives: a tool for oppression and a human right.

8.4.2 Healthcare experiences related to other aspects

Some healthcare experiences were not directly related to their disclosure but indirectly affected their treatment because of their identity. Some of the experiences stated by the participants may relate to their friends or family members but these experiences affected the participants’ understanding, attitude, and expectation toward healthcare.

Famzen used to undertake regular HIV tests in an NGO but unexpectedly this NGO stopped doing this test, therefore he did not know what to do. However, this NGO informed him that he could visit a private clinic to have his HIV test, and he went there. But the staff of the clinics behaved very differently and started interrogating him about such things as why he wanted an HIV test, and whether he had had sex with someone. These questions made him feel scared and he did not feel safe to disclose that he had sex with other men because of the clinic staff's interrogating behaviour, Famzen said "by way of their behaviour, I understood that had I told the truth, I would be a criminal in the country to them. Hence, I got out of there without doing the test."

In the healthcare setting, the behaviour of the healthcare provider also defined how safe the participants felt to disclose their sexual and gender orientation. Iruyan's healthcare experience is somewhat different because he has to have a check-up every six months to maintain his testosterone level. For this test, he usually goes to a healthcare setting where they do not know that he is a transman. Iruyan is reluctant to disclose about himself because he is worried that he might not be able to continue his check-ups in this hospital. Thus, he never writes his first name because this would alert staff that he is biologically a female. Thus, he writes his last name, which is a gender-neutral name, on the relevant forms and the staff cannot assume that he is physically a female. Iruyan also expressed that the prescriptions in this hospital do not contain a gender box, hence he does not have to worry about being exposed. The experiences of Famzen and Iruyan remind us how a sexual or gender diverse person has to assess the situation every time to understand whether it is safe for them or not to disclose.

Ikhiyam experienced an indirect healthcare incident when she took her ill father to a hospital. The staff at the hospital refused to admit her father as he had been brought by Ikhiyam, a hijra. Therefore, she had to leave and send her brother-in-law with her father so that he could be admitted into the hospital. Ikhiyam was also mocked when she visited the nearest pharmacy to buy medication. Even though the pharmacy did not have any other customers, they always ignored Ikhiyam and said, "Please move away or come back later." This is because they did not want to interact with her as hijra are assumed always to be begging or trying to get something without paying, which is another kind of stigma or prejudice toward hijra.

Idanam's friend once suffered from anal burning and he visited a physician. But this physician refused to treat him and started to ask why he is practising homosexual behaviour. Incidents like this scared Idanam and he rarely disclosed his sexual orientation in any healthcare setting. However, once he suffered from skin rash and visited a local doctor in his area and the physician identified his orientation. The physician then did not accept him very well and rushed into prescribing some medication without seeing or checking Idanam’s skin rash.

Similar to Idanam’s fear, Inrose also had experience in a healthcare setting when she took her friend to a hospital. Inrose’s friend was suffering from severe stomach-ache but the staff did not look at them and made them wait for a long time without any explanation. Then Inrose started to argue with the staff and they called to see her friend. Inrose explained that sexual and gender diverse people are ignored in healthcare settings and healthcare providers are reluctant to treat us on time. Inrose said:

> *দেখা যায় যে আমার কাছেও কেউ [স্বাস্থ্যসেবা কর্মীরা] আসতে চায়না, [তারা দ্বিধাবোধ করে যে] কি চিকিৎসা দিবে আমাকে, নাকি আমার সাথে কে কথা বলবে, কে আমাকে ধরে পরীক্ষা করবে, সবাই এরকম ইতস্তত বোধ করে।*
>
> *It turns out that no one [healthcare provider] wants to interact with me, [they are confused] what treatment they will give me, or who will talk to me, who will touch me for a check-up; everyone feels like this way.* (Inrose)

Once Iporane’s *guru* was shot in a clash between gangs. The *guru* was badly injured and was bleeding heavily. Iporane took her *guru* to the hospital and the physician removed a bullet to stop the bleeding, but there was one more bullet inside the *guru*. Many hijra (followers of the *guru*) were gathering at the hospital which alarmed the staff and they asked Iporane to leave with her *guru*. She immediately took the *guru* to another hospital where the injured *guru* was laid on the floor as if they are not a human at all. Thus, Iporane took the *guru* to a few more hospitals to get the necessary medical attention for the *guru*, but nobody was cooperative. Therefore, Iporane got help from a friend who is a senior police officer, and, with his help, the *guru* was admitted to a hospital.

It is evident that it is not only hijra who are discriminated at healthcare settings, but also a family member or a friend who is taken to a healthcare setting by a hijra is not given access to healthcare services. This suggests that the stigma toward hijra extends to the people around them.

Ichand explained that lesbians often suffer from urine infections because they sometimes fail to maintain hygiene and they rarely disclose the cause of their infection to physicians; consequently, lesbians suffer from mental depression. She further reported that the fear of disclosure about their sexual and gender orientation also affects their healthcare in terms of consultations. For example, if a lesbian cannot express her sexuality or explain about her sexual behaviour properly, the physicians may not be able to advise her how to stay hygienic. Ichand, however, said:

> *আমাদের [বিজিত এর] কাছে যখন হেল্প লাইনে কল আসে এরকম অনেকেই জানতে চায় যে কিভাবে সেইফ সেক্স করা যাবে, তখন আমরা এগুলো বুঝিয়ে বলি। আমরা ওদেরকে বুঝিয়ে বলি যে এই অবস্থায় হাইজিনটা কিভাবে মেইনটেইন করতে হবে। আমার আওতায় যারা আছে তাদের মধ্যে এরকম সমস্যা গুলো কম হচ্ছে কিন্তু আমার আওতায় যারা নেই তারা আসলে এরকম সমস্যায় ভুগছে এবং ডাক্তারের কাছে গিয়েও কিছু বলতে পারছে না।*
>
> *Many people who call us [Bijito] on the helpline want to know how to have safe sex, and we explain it to them. We explain to them how to maintain hygiene in this situation. Those who are in my network suffer relatively less from this problem but those who are not in my network may suffer terribly from such problems and cannot even go to the doctor.* (Ichand)

Isalho had been raised as a male child even though he was born as a biological female. He used to play outdoor sports and once his menstruation cycle was delayed. One physician prescribed him hormonal medication for regular menstruation, but the side effects of this medication were affecting his health. He became physically weak and his breasts were growing faster than usual and Isalho could not accept it as he had always wanted to be a man. From then on, he stopped taking the medication. However, Isalho found that he could no longer accept his body. Isalho’s father noticed that he was suffering from this and eventually he made Isalho stop the hormonal medication. Since then Isalho has been thinking about undergoing gender confirmation surgery.

Similarly, Imeen used to take the oral contraceptive pill to make her breasts grow without medical consultation and she thought that taking these pills might have caused some side effects such as physical weakness, craving for food and headaches, resulting in her become obese. Imeen recounted that if she could have been given advice regarding taking those pills, she could have avoided their side effects. The experiences of Isalho and Imeen regarding the adverse effects of harmful hormone doses indicate that there is still room for improvement in healthcare delivery relating to the use of hormonal medication.

All these indirect healthcare experiences suggest that the participants had a fear of disclosure, stigma and probable insult and humiliation, which are some of the major socio-economic factors of determining health that are emphasised in social justice theory. This can significantly affect the health-seeking behaviour of sexual and gender diverse populations. As a result, the participants were not able to access healthcare fairly and equally, which challenges the assumption of healthcare as a human right.

8.5 Healthcare discrimination: A tool for oppression?

Based on the assumption of justice theory, healthcare must be accessible by everyone equally and fairly and the data from the present study suggest that the healthcare experiences are mostly discriminatory and is seen as a tool for continuous oppression of sexual and gender diverse communities. Feyan discussed that discriminatory healthcare can be used as an instrument for oppression because depriving one particular group of the population of healthcare can affect their socio-economic condition. The reason for this is that sexual and gender diverse communities have become somewhat invisible due to oppression by a patriarchal society and threats by extremists; hence, Famien explained that whenever a sexual or gender diverse person visits a healthcare setting they tend to be discriminated, humiliated and verbally abused.

Patriarchy is deeply rooted in South Asian societies, and religious interpretations are incorporated to maintain male dominance in society. Further, British colonialism reinforced patriarchy by penalising homosexual behaviour so that males can hold on to the dominance by oppressing sexual and gender diverse communities. One of these forms of oppression is discriminatory healthcare practices. Using healthcare discrimination as a tool for oppression clearly suggests that there is a continuous influence of patriarchy and colonialism to maintain the oppression of sexual and gender diverse communities.

Negative healthcare experiences of the participants including insult, humiliation, and discrimination are some of the major tools for the oppression of sexual and gender diverse communities. Farnen explained that she used to work for an organisation helping injured hijra sex workers at night who were victims of muggers. She would take the victims to a hospital late at night, but physicians were mostly reluctant to treat them. Farnen added that sometimes, the physicians would treat them but once the night was over, the victims' make-up would wash away and hospital staff would realise their gender, and they would be publicly harassed.

However, Ichand assumed that the government is probably not hostile enough to deprive sexual and gender diverse people of healthcare to control the whole community as a whole. While working with Bijito, Ichand observed that it is clear that deprivation and discrimination against sexual and gender diverse communities are frequent in the healthcare system. Isalho explained that a few physicians may provide healthcare but may not give patients the necessary information relating to their ailments, which can be considered as discrimination in healthcare behaviour.

Due to the lack of adequate training or education about sexual and gender diverse identities, healthcare providers were left to rely on their own values. And since the only values they had were the dominant ones in society, some participants reported experiencing stigmatising behaviour from female healthcare providers. This indicates that regardless of the gender of the healthcare providers, the patriarchal values in society are so dominant that it leads healthcare providers to stigmatise and discriminate against sexual and gender diverse communities. It is interesting that it is their personal values rather than their professionalism that dominated these interactions with the participants.

8.6 Healthcare and public health

The necessity of health holds a higher value than any other social care in the framework of social justice: this is because health is generally held as the highest value in the welfare of society because individuals need to be healthy to participate fully in that society (Daniels, 2008).

If the assumption of oppressing marginalised people by discriminatory healthcare is somewhat true, then the irony is that while the government is oppressing marginalised groups, it is the government itself that pays the price because of untreated infections in the general population.

Some participants explained that the public health of a nation or a society can be affected by healthcare experiences of sexual and gender diverse people. To clarify, Freial related a story of a person (Farnab — pseudonym) who he once tried to help. Farnab, a feminised male (not a participant in this research) was planning to become a transgender person. Because of this, Farnab used to be harassed physically, and once was raped by local thugs. Later, he was diagnosed as HIV positive, which shattered his life. He became frustrated and could not continue his job, and as his father was a corrupt local politician who did not earn much, his mother started to work in a garment factory. Eventually, Farnab wanted revenge and wanted to spread HIV to other people in society as he thought that since society had put him in this condition, he would not spare society. He presumably continued to have unprotected sex with others. Bijito attempted to counsel Farnab and requested that he stay at the hospital, but he refused and left. This incident indicates that when a person is stigmatised and abused due to their sexual orientation, it can impact on both their health and public health. Ferial said:

> একজন ব্যাক্তির [ফারনাবের] মানসিক স্বাস্থ্য নষ্ট হয়ে যাবার ফলে তার জীবনের সবকিছুই খারাপভাবে প্রভাবিত হল। এর প্রভাব শুধু তার জীবনে নয়, তার পরিবার, সমাজ ও রাষ্ট্রে সব জায়গায় প্রভাব পরছে। অর্থনৈতিক কর্মকান্ড বন্ধ হয়ে গেল, সামাজিক আস্থা নষ্ট হয়ে গেল, এবং গণস্বাস্থ্যও প্রভাবিত হবে। অন্যরা যারা তার দ্বারা [এইচ আই ভি] সংক্রমিত হল তাদেরও ঠিক উনার মতই পরিনতি হতেই পারে।
>
> *One person's [Farnab] mental health was severely affected by what happened to his life. The impact was not just on his life, but on his family, society, and the state. His economic activities were hampered, social trust was shattered, and public health would be severely affected. Others who have been infected [with HIV] by him may also become aggressive like him.* (Freial)

If Farnab had received proper mental health support and counselling after being detected with HIV, he might have not decided to infect others; thus, it clearly shows that lack of healthcare for an individual has an implication for public health.

Kingshu said:

> *অনেক লিঙ্গ ও যৌন সংখ্যালঘু মানুষ কোন চাকরি করতে না পেরে অনেক সময় জীবনের তাগিদে বাধ্য হয়ে যৌন কাজে লিপ্ত হয়ে যায়। যার ফলে তাদের স্বাস্থ্য ঝুঁকি বেড়ে যেতে পারে। এই অবস্থায় যদি তারা যথাযথ স্বাস্থ্যসেবা না পায় তাহলে এই স্বাস্থ্যের ঝুঁকিগুলো সমাজের অন্যান্য মানুষের মধ্যে ছড়াতে পারে এবং জনসাস্থ ব্যাহত হতে পারে।*
>
> *Many gender and sexual minority people are sometimes forced to engage in sex work as they are rejected by employers. This can increase their health risk. If they do not receive proper healthcare in such a scenario, these health risks can spread to other people in society and affect public health.* (Kingshu)

Ichand recounted that public health is the state’s responsibility and putting the responsibility of a threat to public health on sexual and gender diverse people is nothing but a consequence of stigma. She further argued that, for example, if a client of a sex worker is HIV infected, having sexual intercourse with the client may infect the sex worker, thus it can spread among others. Given this situation, who is responsible? Kingshu added that it is time the government considered this issue and took necessary precautions to deal with the probable spread of sexually transmitted infections (STIs) which may endanger public health.

8.7 Healthcare as a human right

According to the UDHR, each person is entitled to proper health, medical healthcare and well-being (Global Citizenship Commission, 2016). Feezaz, therefore, explained that every individual should receive healthcare no matter their sexual and gender orientation. Freial discussed that the concept of human rights is a vision where people still change their tone of voice when saying the term ‘hijra’. He further expressed that the UDHR did not mention specifically about sexual and gender diverse identities, nor did the Constitution of Bangladesh. Freial added that the Yogyakarta Principles were introduced in 2006 to establish campaigns of human rights particularly for people with diverse sexual and gender characteristics.

While discussing human rights, Kelard also explained that healthcare or medical care is a basic necessity for everyone, and this is clearly stated in the Constitution. Kelard said, “any human being, regardless of their sexual or gender orientation, shall receive healthcare as a human right.” Yet, Kelard expressed that there have been many incidents of healthcare discrimination toward sexual and gender diverse people which have caught the attention of the media, and healthcare providers need to be sincere about treating every person equally. Healthcare may not be deemed as a human right for marginalised populations.

To consider healthcare as a human right, the social factors of health such as stigma, social exclusion, discrimination need to be addressed to ensure normal and fair healthcare services for everyone. Daniels (2008) emphasises that social factors affect health status, and equal opportunities are determined by social factors of health. Therefore, ensuring equal healthcare delivery for everyone can help to address adverse social factors such as stigma, social exclusion, and patriarchal oppression. If we consider the oppression of sexual and gender diverse communities stems from a patriarchal social system, then this oppression becomes a major social factor of the health status of the participants. To promote the health of participants, equal and fair healthcare services are required but this would require addressing the oppression of a patriarchal society. It is worth noting that ensuring equal healthcare for the participants implied by equal and fair distribution would threaten patriarchy, thus a patriarchal social and health system is not yet ready to provide equal healthcare for everyone.

Kelard recounted that violation of human rights by depriving healthcare may happen when the authorities – who hold the power to ensure human rights – lack understanding about sexual and gender diverse communities. Due to the conservative socio-cultural situation, freedom of expression is hampered for sexual and gender diverse people in Bangladesh (Amnesty, 2018). This implies a lack of visibility of human rights and all these violations occur because the relevant authorities who hold the power to secure human rights are often reluctant to believe in equality and the universal nature of human rights.

Kelard added Since human rights are considered as universal, there should not be any question about a person’s sexual and gender orientation; it is also emphasised that healthcare should be equal for everyone. Nevertheless, he argued that sometimes the nature of human rights can vary in terms of region and context, thus human rights are only universal from theoretical and conceptual perspectives, but, in reality, human rights may not be universal. Kelard said, for instance, freedom to express a sexual or gender identity can be a human right in Western culture where rights are determined in a much more liberal and individualistic way; in comparison, a socially conservative country where religious taboos and patriarchal values are still dominant does not encourage such freedom of expression. Nevertheless, I argue that patriarchy has been historically sustained in this country which has led people to believe that giving marginalised communities equal human rights would make them equal as men, which would undermine patriarchy, thus it becomes a human rights issue. However, Kingshu emphasised that healthcare is a human right that should be universal for every individual in any country, context, and time. This is why the nature of human rights becomes problematic: healthcare as a human right must be ensured for everyone because the right to health allows normal functioning for a person. Also, the freedom of expression of sexual or gender identity is a human right for everyone, but the conservative socio-cultural context is not yet ready to accept this as a human right. And this is exactly how the differences of socio-cultural contexts influence the nature of human rights in a different time, culture, and region.

Ichaned explained that the initiatives of Bijito are generally designed to work for healthcare and human rights of sexual and gender diverse communities, though the staff of Bijito cannot mention the term ‘human rights’ due to the lack of acceptance of sexual and gender diverse people. Some participants also held the belief that healthcare is a basic need for survival for any human being. For instance, Iporane said, “as a citizen, I would demand that healthcare is a human right.” Ichand expressed that most people and healthcare professionals do understand the fact that healthcare is a fundamental need, but they are often reluctant to hold this belief when it comes to interacting and providing medical treatment to sexual and gender diverse people.

8.7.1 Rights-based practices and their barriers

Sexual and gender diverse communities have been working for human rights for many years; this is why Mannan and Tonoy were assassinated in 2016 (Sanzum, 2017, May 19). As a result, Feyan expressed that rights-based practices have been hindered and the threat of being killed is one of the major barriers for rights-based practices for sexual and gender diverse people.

Freial discussed that a rights movement can be twofold: firstly, it can be needs-based, or it can be rights-based. He added that in needs-based movements, relevant or responsible authorities (e.g. government) would meet the needs of a sector of the population; while in rights-based practices this sector has to be active to encourage the relevant or responsible authorities to secure their rights. The purpose of rights-based practices is to enable a sexual or gender diverse person to secure their rights whether it is healthcare or any other rights. Freial said:

> *সমস্যা হচ্ছে অনেক সময় লিঙ্গ ও যৌন সংখ্যালঘু মানুষ নির্ভয়ে গিয়ে অধিকার চাইতে পারেন না। আবার চাইলেও অধিকারপ্রদানকারিরা সহনশীল আচরন করেন না, এসব কারনে অধিকারভিত্তিক অনুশীলন [আন্দোলন] গড়ে উঠছে না।*
>
> *The problem is that often sexual and gender minority people cannot raise their voice for rights without fear. Even if they do, the rights-providing authorities do not react very well. Because of this, rights-based practices [movement] cannot begin.* (Freial)

As expressed by Feyan, for rights-based practices there must be collaboration (e.g. communication, campaigns, and public discussion) between government and NGOs that work for the rights of the people; however, the government has always been reluctant to work with sexual and gender diverse communities, which is another barrier for rights-based practices. Feyan added that lack of cooperative attitude from government representatives has hampered the cooperation between sexual and gender diverse people and the government.

There are other barriers to rights-based practices. Freial recounted that despite the lack of governmental support, the sexual and a gender minority — a pressure group — experience limitations in unity, advocacy and publicising or campaigning tools. Both Fasrub and Feyan stressed that the Information and Communication Technology (ICT) Act has controlled the freedom of speech on the Internet and hindered online campaigns and blogging, which hampers activities of the rights-based practices in online platforms. Even the writings and blogs shared on social media such as Facebook are closely monitored by government agencies, which affects online campaigns. All these barriers for rights-based practices are creating a hindrance to securing rights of acceptance as well as the right to healthcare for sexual and gender diverse people.

8.7.2 Art-based movements

Throughout the history, including the British Regime, the artwork of Bengal has been syncretic: in other words, it has conflated different and incompatible ideas, while their artistic demonstrations have contained identifiable socio-cultural traits (Selim, 2014). However, artists during the British Regime were struggled to merge the local context and insert what they perceived as traditions derived from Western art movements and their ideas. After the Partition in 1947, artists from Bangladesh (then East Pakistan) gradually reconciled and extended their group of the intelligentsia of Dhaka and helped to agitate against the West Pakistani ruler's injustices, leading to the prolonged involvement of artists in the political formation of this country (Selim, 2014). After the liberation of Bangladesh, artists addressed the creation of an independent nation by demonstrating the liberation, war, nature, famine, festivities, language, culture and religion through the manifestation of various types of visual arts such as photography, paintings, drawings, folk art, and sculpture. Most of these art forms are either placed or exhibited in public spaces or at the National Museum where anybody can access them and learn about the history of the formation of an independent country. The role of such a display of art or gradual changes in the art movement is to educate people about how people have come to the place where they are now. Hence, art-based movements are essential to educate and affect the mindset of society's members and to spread the message that the way we have been treating minority populations can be changed for the better.

Due to the barriers to rights-based practices, art-based movements can spread the messages of sexual and gender diverse communities. Consequently, art-based movements can be regarded as an expression of resilience. Despite all the problems experienced by these communities, this is how the community has responded in strength. Feyan expressed that art-based movements are a campaign by which different forms of art can be used to create awareness regarding sexual and gender diverse identities. He further discussed that since most people are reluctant to talk about abortion, sex and sexuality, it is a difficult task to influence their psychology and attitude with rights-based practices. Thus, art-based movements can be useful. Due to the threats and attacks toward sexual and gender diverse people, queer communities have adopted innovative strategies (e.g. visual arts) to raise awareness and educate the public regarding sexual and gender diverse identities (Knight, 2019). Feyan expressed that the use of visual arts, literature, painting, movies and music may act as a renaissance for the public to change their understanding and mindset toward sexual and gender diverse people. He said that "we can capitalise on the expressions of art to move forward with our movements, and through this, we can have an impact on the thoughts of the general public."

Feyan added that there are many agencies, such as the Bangla Academy in Dhaka, that promote artistic programs and displays, but if there are any thought-provoking art forms or exhibitions, agencies do not encourage them much. He further discussed that it is quite surprising that many paintings relating to homosexuality are appreciated, while poems and stories are not. One reason for this can be the differences between art as a visual form and literature as a written form. Even though both paintings (visual form) and written literature (poems or stories) may have some artistic merit and thought-provoking elements, the implication of the Bangladesh Digital Security Act 2018 may hinder the freedom of expression of thought or speech that is written. Artists need to be thought-provoking and critical so that they can create an impact on the mindset of the people, otherwise, change would not come.

8.8 Other aspects of healthcare

To consider healthcare either as a basic necessity or a human right, we need to understand what aspects can be strengthened further to ensure equal and fair distribution of healthcare delivery. Aspects such as medical social work, ethical standards of healthcare professionals, and health and well-being can have implications for ensuring equal and fair access to healthcare by everyone.

8.8.1 Medical social work

In Bangladesh, the recognition of social work as a profession is in a developing phase. Feyan expressed that medical social work is a little-known aspect among healthcare professionals. Healthcare experiences of sexual and gender diverse communities have a connection to the lack of hospital or medical social workers because if medical social work is practised properly, every person would get access to healthcare equally and fairly. In addition to this, many physicians he worked with are not very familiar with the concept of medical social work. Freial stated that “physicians who do not know about medical social work — or even if they do — rarely comply with medical social work practise and often fail to accept a person as a human being.”

Therefore, Freial added that part of the rights-based campaigns should be to raise awareness about medical social work among healthcare professionals as well as queer communities in order to help sexual and gender diverse communities; this can allow every person to be treated with justice and equality which can ensure healthcare as a human right, especially for disadvantaged populations.

Once Feyan was working with physicians from a government hospital in a collaborative project where a Mental Health Resource Centre was developed to somewhat enhance medical social work. However, this centre was very expensive for the patients and only the rich and immigrants could afford to obtain services there. Given this scenario, there was no justice done because the needy and disadvantaged people could barely afford to receive healthcare from this centre. This suggests that a fair and equal distribution of opportunity was not maintained, and this is an example of structural discrimination that medical social work is capable of addressing.

8.8.2 Ethical standards and attitudes of healthcare professionals

The healthcare experiences and healthcare behaviour depend on the compliance of ethical standards and the attitude of healthcare professionals. Freial explained that he had worked as a trainer in an HIV Testing and Counselling (HTC) unit in a government hospital. During this time, he attended a seminar with the physicians of that hospital, and the physicians were using religiously conservative attitudes to exclude sexual and gender diverse people to access healthcare. Freial argued with the physicians and explained that the ethical standards of the healthcare profession do not allow them to hold such discriminatory attitudes as every patient should be treated equally.

Karnen explained that sexual and gender diverse people are not treated by health professionals in the same way as other people. Karnen said:

> *পাছার সমস্যার কথা শুনে ডাক্তাররা আর পরীক্ষা চায় না। যখন কোন রোগীর এন্ডোসকপি করানো হয় তার সাথে একটা পাছার পরীক্ষা আছে সেটাও করা হয়। তাহলে আমার পাছার সমস্যা হলে সেটা কেন পরীক্ষা করা হবে না?*
>
> *Physicians do not want to examine me after hearing that I have an anal problem. When a patient undergoes endoscopy, an anal examination is also performed. Hence, if I have a problem with my anus, why will they not examine it?* (Karnen)

Kalard discussed that a healthcare setting should be held responsible if healthcare professionals fail to maintain their ethical principles; the principles of privacy, confidentiality and equality are very essential and should be followed by healthcare settings, physicians and non-medical staff working in a healthcare setting. Kingshu also said that “the Declaration of Geneva emphasises that physicians are obliged to treat patients no matter who they are.” The Declaration of Geneva was adopted by the World Medical Association in 1948 and last amended in 2017; this Declaration stresses the dedication of healthcare providers to the humanitarian goals of medicine (World Medical Association, 2017). Kinghsu believed that discrimination and humiliation toward sexual and gender diverse people need to be stopped and healthcare providers need to learn more about sexual and gender diverse identities. In particular, healthcare professionals must be aware of and follow the guidelines of the Declaration of Geneva which defines the ethical principles for healthcare professionals so that they can treat everyone equally.

Karnen expressed that both law enforcement agencies and healthcare professionals need to change their attitude toward sexual and gender diverse people because their judgmental and stigmatising behaviour does not go along with the ethical principles of their occupation. This is important because negative behaviour toward sexual and gender diverse people from healthcare providers and law enforcement officers can encourage the general public to stigmatise sexual and gender diverse communities even more. Karnen added that proper education, training and awareness relating to sexuality and sexual and gender diverse identities need to be provided to healthcare professionals so that a person can be thoroughly examined and properly diagnosed and treated. This can help to ensure that healthcare is provided fairly and equally to everyone, regardless of the patient’s sexual or gender identity.

8.8.3 Health and well-being

Health has an impact on the overall well-being of a person. The definition of health given by the World Health Organisation (WHO) stresses the importance of social well-being (Felman, 2020). Feyan thought that sexuality is an integral part of the overall well-being of an individual because failure to express sexual or gender orientation can cause anxiety and depression. One may argue that a person can go through depression from time to time in their life but that cannot be regarded as a violation of any right or health. However, I argue that mental health status impacted by not being able to express one's own sexual or gender identity must be considered. This is because the concept of health is still underdeveloped, and most people still believe that health merely indicates the physical aspects. Without considering the implication of such mental health impacts on the well-being of a person we are unlikely to ensure equal and fair opportunities of health and healthcare for everyone.

However, Bijito and its staff are determined to work to support sexual and gender diverse people with the focus on community well-being. For instance, Ichand explained that the lack of awareness about mental health is one factor that pushed her to switch careers and work with Bijito as she thought that if mental health support was not provided for people in need, sexual and gender diverse minorities are unlikely to have their well-being addressed.

Imeen expressed that the well-being and welfare of sexual and gender diverse people is a movement that requires the participation of the whole society, particularly from female leaders: this is because women have recently started to raise their voice for their rights and their voice can be a powerful instrument to help secure the rights for sexual and gender diverse communities. In addition to this, the support from the media could be essential for sexual and gender diverse communities to promote healthcare facilities and well-being, she added.

8.9 Summary

It is important to understand in what circumstances healthcare can be considered as a human right and when not. From the analysis of the justice model, it is understood that healthcare is only seen as a right if it is fairly and equally provided to everyone. Before I analysed the participants' healthcare experiences, I discussed some common issues related to the participants' health. I reflected the understanding and perception of the participants in this chapter to identify how discriminatory healthcare may be used as a tool for oppression, particularly the oppression that is mainly influenced by colonialism and patriarchy. This chapter also considered whether healthcare can be deemed as a human right in a patriarchal societal context, particularly for sexual and gender diverse communities. I also analysed other relevant aspects such as rights-based practices, art-based movements, and their barriers. Also, I discussed healthcare and public health, and medical social work to exemplify what has been happening in the health sector for sexual and gender diverse people, and how these aspects can impact to ensure fair and equal opportunity of access to healthcare that justifies the argument of healthcare as a human right.

Chapter Nine: Discussion

9.1 Introduction

The main research question is focused on whether the access to healthcare can help to understand the oppression of sexual and gender diverse communities. To investigate this, there are three sub-questions: a) What is it like to be a sexual or gender diverse person in an Islamic patriarchal society? b) How do these communities experience healthcare in Bangladesh? c) How can the experiences of sexual and gender diverse communities help us to understand the continuing influence of patriarchy and colonialism in Bangladesh? These three sub-questions along with the main research questions are answered throughout this chapter by integrating the findings and existing theories and literature. The discussion chapter is also built on different arguments to understand whether healthcare is a human right or a tool for oppression in a male-dominant society.

The right to health and healthcare is considered a fundamental right around the world (Global Citizenship Commission, 2016). However, in some regions, healthcare discrimination of disadvantaged populations is found to be a barrier to health and well-being (Rivenbark, 2020), which can lead to oppression. I argue in this chapter that the latter is the case in Bangladesh. I consider how and what factors contribute to such oppression by using healthcare deprivation in a patriarchal society. I then discuss how a patriarchal society is constructed and further describe the root of patriarchy in Bangladesh through historical evidence. I explore how patriarchy is a legacy of religion and colonialism in order to understand the construction of homosexuality and oppression of sexual and gender diverse communities by a punitive law. The oppression of these communities is discussed through various forms such as sexual violence, public humiliation, assassination, or police violence. As a part of this oppression, sexual and gender diverse people are deprived of their right to healthcare. However, I argue that limited and insufficient initiatives provided by the government and NGOs explain how health and healthcare are conceived at or by different institutional levels. Then my main consideration — whether healthcare is a human right or healthcare is a tool for oppression in a patriarchal society — is discussed in terms of the findings and secondary literature. I argue how healthcare discrimination is one of many ways to perpetuate cis-het patriarchy in Bangladesh. The relevance of healthcare deprivation to public health, well-being, and justice is also discussed at the end of this chapter.

9.2 Nature of a patriarchal society

The main research question investigates how access to healthcare can help to understand the oppression of sexual and gender diverse communities in a patriarchal society. Therefore, it is essential to review the nature of patriarchal society. The historical background of patriarchy in the Indian Subcontinent predates the British Regime and the Mughal Empire. Notably, patriarchy affects gender roles and rights in different societies, including the South Asian region (Anagol, 2005). To elaborate, patriarchy mainly tends to sustain a society where men are dominant, and women are less authoritative and powerful than men. As a result, the rights and status of women have been suppressed in societies that privilege men.

During colonisation, the Contagious Diseases Act was designed to prevent the spread of sexually transmitted diseases and registered sex workers needed to “register themselves at police stations, get medically examined and surveilled”. There was an incident of a woman being imprisoned for evading a genital examination in 1868 as she claimed that she had not been a prostitute (Biswas, 2020). This indicates how colonial authorities “developed ideas about deviant female sexuality to control and organise modern society in India” and one of the ways to control sexuality was by classifying, registering, and medically examining women (Mitra, 2020).

The rights of women have been traditionally suppressed in Bangladesh by using religious interpretations and conservative values (Cain et al., 1979). After the independence, women’s rights were established as equal to men by the Constitution of Bangladesh in 1972; all the citizens irrespective of their gender are equal before the law and entitled to have equal protection under the law (Ameen, 2005; Momen et al., 1995). Despite the Constitution, other national-level policies and guidelines also emphasise the protection of women’s rights, but in many cases, women are not allowed to participate in the decision-making process in socio-economic, familial, and political matters (Banarjee, 2020). Moreover, women are deprived of many rights such as rights to education, health, socials security, nutrition, shelter, and freedom of expression (Ameen, 2005; Chowdhury, 2003).

Women are also legally deprived of their right to property: for instance, men are given the majority of the property and inheritance in some jurisdictions (Khan et al., 2016). This indicates that gender roles have had a significant impact on the dissemination of the inheritance property (Abdullah et al., 2014). Despite the current Western ideology of giving equal rights to men and women (Khan et al., 2016), property distribution from an Islamic perspective cannot be considered fair (Barlow & Akbarzadeh, 2006). Islamic jurisdictions imply that a son gets a double share of what a daughter inherits (Quran, 4:11). Despite this, the government legislated equal rights to property and inheritance between women and men based on the National Women Development Policy (2011) which aims to ensure equal rights and opportunities for women (Tusher, 2011, March 08). This amendment was protested by many religious communities and was argued as a political matter (Khan et al., 2016). But this protest can be theoretically justified as an expression of patri-normativity where cis-het men insist on using religion to serve their purpose of male dominance. Given this situation, cis-het men want to ensure that it is not only women who are subordinated, but anyone who threatens to destabilise existing social norms, structures, and privileges. Hence, all sexual and gender diverse people are also affected because religion is used in the same way they are used against women. Consequently, sexual and gender diverse communities are denied by society since they do not have any constitutional or other legal protections.

The findings in the present study indicate that transwomen participants who did not conform to the socially assigned gender and transformed their sexual or gender identity to female suffered an acute form of stigma from family and society. Transmen participants were less likely to be stigmatised than transwomen participants. This indicates that transwomen are rarely accepted because they decided not to represent the socially assigned male gender and are voluntarily giving up implicit male privilege to become women. In contrast, transmen participants who decided not to conform to the female gender and transition to a male gender are more likely to be accepted by families and society because they are appropriating male privileges and seen as raising their status. This indicates that the status and position of women are highly devalued and changing the socially assigned gender from male to female is somewhat an unaccepted behaviour. The reason for this is that a male-dominated society emphasises that men and women must know their place and anyone who does not conform to those standards must be suppressed and socially controlled. Further, a lesbian participant, Ichand, was forced to get married to a man due to the devalued status of women in and some other participants struggled with the marriage issue as a social and family expectation. It arguably seems that a patriarchal society insists on sustaining male dominance by suppressing women as well as other sexual and gender diverse identities.

The construction of patriarchy is not a modern-day phenomenon. During the Mughal Empire, despite the respect given to a few Hindu women of rich families (Yasmin, 2014), women, in general, were poorly respected due to different forms of social evils such as *sati*, child marriage, and polygamy among the rich people who could have many wives (Aggarwal, n.d.). The position of women was quite inferior to men and often they were considered as objects of pleasure (Aggarwal, n.d.). The Muslims often molested or captured Hindu-women which led to the *purdah* system. Thus, educational and other opportunities were not given to women except in rich families who could afford a home-educational system and would even consider educating a girl. The birth of a daughter was taken as an evil omen, which consequently led to the practice of female infanticide.

However, many poor Muslims and lower castes among Hindus rarely faced any social evils and had opportunities to divorce and remarry (Aggarwal, n.d.). This suggests there was greater gender equality among lower classes, and less among the upper. Patriarchy then becomes a characteristic of the wealthy, and those who follow patriarchal attitudes are not merely maintaining gender roles, they are practising wealthy gender roles. To clarify further, the role of capitalism in patriarchy can be enhanced. Capitalism is an essential factor of patriarchy because oppressing women can benefit men by gaining profits from women’s unpaid work. Capitalism relies on the devaluation of domestic work of women, which allows men to increase their financial savings, thus it creates a connection with wealth; without gender domination combined with the oppression of class and race, the system of capitalism would vanish (Bruneau, 2018). Rich women can also oppress poor women (Bruneau, 2018), perhaps to justify their position among the rich and upper-class. Hence, it can be argued that people from the upper class tend to oppress women because people may think of them as wealthy and respectful.

It is evident that patriarchy persisted during the British Regime in the South Asian region. The use of local customs, religious interpretations, and rituals were predominant during the British Regime to sustain male dominance in society (Mani, 1998). This suggests that the Raj effectively adopted local patriarchal attitudes to be more readily accepted. The British Regime brought their oppressive attitudes towards women and ‘crimes against the order of nature’, which integrated readily into the South Asian cultural norms, and the British Regime used to strengthen their grip and their acceptance. Since the people in the Indian Subcontinent were religiously conservative, it was relatively easy for the male-dominant society to use religions and rituals surrounding these religions to perpetuate the dominance of men. Given the scenario of suppression of women’s rights, it is arguably accepted that many Muslim men in this region did not intend to serve religion; rather, they successfully used religions to serve their purpose. Gradually, the historical formation of a patriarchal society had reached its brutal form by extending the oppression of sexual and gender diverse communities. In addition to the use of religion, the colonial law (Section 377) was the first punitive attempt to legally encode stigma toward sexual and gender diverse communities.

The consequences of British colonialism have severely impacted on the class system of the society and created a colonial mindset of discrimination between different social classes, which was probably one of the many reasons stigma toward sexual and gender diverse communities started to increase (Mertens & Myrttinen, 2019). It is worth mentioning that a similar kind of class difference affected the position and status of women during the Mughal Empire (Aggarwal, n.d.). Therefore, a post-colonial state still maintains the integrity of a masculine society by continuing both legal and social discrimination toward women and sexual and gender diverse communities. This patriarchal attitude toward sexual and gender diverse communities also exists in the governmental and judicial system as of today as the government is not yet ready to accept these communities. Religious interpretations make it easy for the government to justify this lack of acceptance. Perhaps the government and policy-level institutions are not completely aware that they are supporting a patriarchal system. To clarify, many people it can have a stigmatising attitude toward sexual and gender diverse communities due to a patriarchal influence which they are not even aware of because patriarchy is something that is deeply rooted in their epistemic framework. I believe such a mindset can be described as ‘patri-normativity’ in a post-colonial masculine society. In this kind of society, people tend to believe that accepting masculine values and customs are as normal as other social values because they are religiously, historically, and socio-culturally taught to think in a patri-normative way. This is one of the reasons some participants sometimes did not tend to conflate their religious beliefs and sexuality because they were socio-culturally taught to think in a patri-normative way, thus patriarchy was affecting their religious stances.

A patriarchal social system needs to be further discussed to understand its implications with the social construction of homosexuality, stigma, marginalisation, and taboo on sexuality. Conceiving homosexuality can vary in terms of different cultures and regions. In many parts of the world, religious communities belonging to the rich and upper class accepted homosexuality as an accepted behaviour (Greenberg, 1988), which was indeed nothing but an expression of claiming moral and virtuous superiority over others. This concept is further discussed by 'virtue signalling' by which people want to gain appreciation by justifying others' behaviour as non-virtuous to indirectly claim their virtue (Hamilton, 2019). One may argue that 'virtue signalling' was an expression of intolerance against the participants' sexual and gender orientations. But I intended to understand what the purpose behind the intolerance was. Was it really that the healthcare providers care about religious interpretations or did they just want to express their moral/virtuous superiority over the participants? The findings indicate that participants sometimes experienced 'virtue signalling' by healthcare providers, family, and friends. Thus, I believe that healthcare providers or family members may have used 'virtue signalling' to make themselves look good/moral/virtuous by signalling to the participants that what they were doing was non-virtuous. The phenomenon of 'virtue signalling' can be related to religious campaigns against homosexuality in the thirteenth century in order to assert and claim moral superiority over a certain class of people. Similarly, in contemporary Bangladesh, a patriarchal society applies 'virtue signalling' to point out that a receptive man taking on the feminine role is showing non-virtuous behaviour and he should know his place, otherwise there would be no difference between gender roles of male and female, which undermines patri-normativity.

The patriarchal attitude toward homosexuality and sexual and gender diverse communities has created a stigma toward these marginalised communities. The oppression of these communities can be expressed by stigma, marginalisation, and social control. In theory, stigma is a feature of devaluing a person in order to make them feel inferior to others (Arboleda-Flórez, 2008). A person can experience stigma due to many reasons, but sexual and gender identity is one of the most significant causes of stigma. Many scholars have argued that stigma is a dynamic concept that may vary in terms of its purpose and consequences. From a social constructionist perspective, stigma is expressed as values about certain social identities: non-accepting values toward sexual and gender diverse identities are reasonable examples of stigmatised identities (Dovidio et al., 2000). However, stigma can be sustained for different reasons such as sharing hatred and socially control certain communities to maintain boundaries about what is acceptable and unacceptable behaviour. Nevertheless, what matters most is who wants to maintain this stigma toward sexual and gender diverse communities in a patriarchal society and what is their purpose. It is evident in the findings that traditional norms and values influenced by patriarchy are responsible for holding on to the stigma to perpetuate male dominance so that sexual and gender diverse communities cannot receive equal rights and opportunities as others. These men could be representatives of the government, police, or religiously conservative healthcare providers (who hold religiously conservative attitudes); they can also be regarded as guardians of patri-normativity. For example, police violence on the participants reminds us that, either deliberately or unintentionally, police play a big part in perpetuating stigma toward sexual and gender diverse people. This form of stigma and its spread can easily marginalise a community who would be deprived of many basic needs to survive due to their marginalisation. The irony is that the deprivation of their rights would rarely be reported as the government has been very successful in denying their existence. Further, the stigma on marginalised communities can have adverse effects on both physical and mental health.

A male-dominated social system pervasively tends to spread stigma toward sexual and gender diverse communities to serve another purpose: the sharing of a particular taboo so that it can be converted into a social value to overlook the stigmatising attitudes (Stangor & Crandall, 2000). Therefore, the taboo around sex and sexuality is found to be interconnected with the stigma in a society that privileges men. The common issue found around this taboo is sexual health, which is a severely overlooked concept and has an impact on the participants' mental health status. The taboo of either not performing or talking about sex has been reinforced by a religiously conservative society. The patriarchal system enforces a stigma toward homosexuality that further maintains the taboo on sex and sexuality. As a result, it can be noted that patriarchy lies behind every factor and consequence surrounding the oppression of sexual and gender diverse communities. Values associated with patriarchy are deeply embedded in the social fabric, which does not allow the general public to think beyond a masculine paradox. Also, a patriarchal system oppresses not only women but also the younger men in the family (German, 2006). This indicates that patriarchy is not only the oppression of women but also a dominance over people from different ages and genders, which is discussed in the psychoanalytic theory of patriarchy (Ehrenreich, 1992). Therefore, I regard that oppressing sexual and gender diverse populations is a direct impact of patriarchy. Therefore, patriarchy can be considered equally responsible not only for the position of women in this country but also for the oppression of sexual and gender diverse communities.

The taboo around sex and sexuality is also affected by religious values. Sex is often considered as an expression of bodily desire. But from a religious point of view, heterosexual behaviour can be accepted because it may at least have the implicit possibility of reproduction. If sex is bad but reproduction is not, then reproductive sex can be sanctioned as good whereas sex for pleasure and sex for non-reproductive purposes (masturbation, same-sex behaviour, and pornography) cannot be excused as such, and therefore are deemed as sins in the beliefs of Roman Catholicism (The Holy See, n.d.). Similarly, the Islamic beliefs suggest that sex for pleasure that is non-reproductive (e.g. oral sex) is not encouraged (al-Hudha, 2001). Saint Augustine believed that sexual behaviour is not the evil act but it is the emotion that accompanies it. Augustine compares love and lust from Christian tenets that say love is enjoyment on account of God while lust is not on account of God (Augustine, 426/2009b). Augustine further claims that pure love stays in the denial of selfish pleasure and the subjugation of corporeal desire to God (Augustine, 400/1997) but sex within marriage is not a sin despite it producing the evil of sexual passion (Augustine, 426/2009a; Russell, 1945). This argument reconciles Islamic and Christian traditions due to the similarity of perception and prohibition of physical desire.

In contrast, the Apostle Paul argued that abstaining from the pleasure of the body that is a source of temptation is of no value. This is because if we are tempted to sin sexually we should try to stay away from sexual temptation; this can keep the sin at bay but the body ultimately remains dissatisfied (Gilkerson, 2014).

The Apostle Paul stressed that it is good for unmarried women and widows to stay unmarried but if they cannot control themselves, they should marry, for it is better to marry than to burn with passion (Bible, I Corinthians 7:1-10). Paul thought everyone should stay as they were (married or unmarried) because he assumed the world was going to end shortly. However, there are different interpretations of what Paul wrote, each highlighted by personal values about sex. For instance, Gilkerson (2014) interprets that the contestable philosophies to prevent the temptation of bodily pleasure such as cold showers, more hours in prayers, fasting, and trying harder are of no value. Also, there is an argument that no explicit command is stated in the Quran and Hadith to prohibit oral sex (Keating, 2012, April 23). This kind of religious debate has affected the beliefs and practices of religion in today’s world, thus influencing the taboo on sex and conflicting the religious stances of the participants.

Understanding the patriarchal nature of society includes the factors and consequences of patriarchy such as the social construction of homosexuality, the taboo on sexuality, and stigma, which perpetuate the oppression of marginalised communities. For decision making and policy amendments regarding the protection and acceptance of sexual and gender diverse communities, the government’s attitude is not very supportive. For instance, government duplicity is maintained by stressing the healthcare needs of sexual minority groups in the 7th Five Year Plan whereas the National Health Policy does not entail any provision regarding this. The data suggest that the situation of sexual and gender diverse communities in a male-dominant society is very oppressive, whereas many would argue that this is a usual way of living for marginalised communities due to a patri-normative social construction.

9.3 Oppression in a male-dominant society

The first research question focused on understanding what it is like to be a sexual or gender diverse person in an Islamic patriarchal society. The findings of the research indicate that the participants felt and experienced the direct consequences of oppression in a male dominant society. This oppression was experienced from the different ways patri-normativity was enforced, such as fear of disclosure, sexual violence, public harassment, police violence, and social exclusion. The fear of disclosure was the primary threat to the participants because of the risks of being murdered. Stigma from society was also another fear that did not allow the participants to disclose themselves. As long as Section 377 remains enforced, sexual and gender diverse communities are not legally accepted. Thus, the law creates social permission for stigma, oppression, and violence against these communities.

Notably, fear of disclosure can have both mental and physical health impacts and when visiting healthcare providers, the participants sometimes made a rational choice to disclose when they were not forced to do so. The rational choice model implies that a person assesses the possible consequences of their action and decision (Sen, 1990). The participants assessed the probable consequences of disclosing to healthcare providers by hoping that the justice of healthcare would be ensured, but they mostly experienced a negative and stigmatising response. This is one of the biggest consequences of disclosure, particularly in healthcare settings. The participants did not necessarily always disclose themselves to society, but they may have some health issues related to their sexual and gender identities where they felt obligated to disclose to a healthcare provider. Despite the relationship between disclosure and healthcare experiences, bullying and mockery was another oppressive expression experienced by the participants. For instance, hijra participants were usually disclosed, and they frequently experienced verbal abuse in public places.

Other risks and consequences did discourage the participants from disclosure. Firstly, many of the participants became homeless and were excluded from the family due to their disclosure. Secondly, the deprivation of basic needs such as education, healthcare, and employment is a common risk of being exposed to society. Thirdly, disclosure did not only affect the participants' lives but had an impact on other family members of the participants. In other words, if a sexual or gender diverse person discloses themselves, the family members also experience mockery, stigma, and social exclusion. Eventually, the fear of disclosure hindered the participants from expressing their feelings and emotions to their loved ones, which had an adverse effect on their mental health. The participants' relationships with their loved ones often struggled to continue due to the stigma and fear of disclosure, which affected mental well-being. Not only is the fear of disclosure a threat, but the struggle of self-identification is closely related to disclosure in an oppressive patri-normative society. Due to the stigma and misconception toward the sexual and gender diverse population, participants were mostly scared to express their self-identification with their parents. As a result, they severely struggled with conflicts of self-identification which led to extreme mental trauma, drug abuse, and suicidal tendencies.

Sexual violence was another form of oppression experienced by the participants. A patri-normative social system is unlikely to raise its voice against sexual violence toward sexual and gender diverse communities despite these minority communities experiencing a higher rate of sexual violence than the majority of the population. Sexual violence involves sexual abuse, harassment, and rape which has a negative impact on both physical and mental health. Being sexually abused was a common scenario for many participants in every sphere of life. Sometimes they are sexually molested at their work, and sometimes they are sexually abused in the healthcare sector. Participants who were sex workers were the most vulnerable individuals because they often experienced sexual abuse during their work. Ironically, sexual abuse of sex workers is rarely considered as abuse since they are engaged in the sex trade, thus it is almost impossible for them to make a legal complaint against the abusive experience. Moreover, sexual violence is sometimes justified by a patri-normative attitude. In other words, many would think that every sexual or gender diverse individual is a sex worker so they can force these individuals to have sex without consent, which can be seen as a reflection of patriarchal perception. Such attitudes toward marginalised populations are also an expression of dehumanisation.

Sexual harassment in the workplace is another form of sexual violence. Being sexually harassed in the workplace often means losing one’s job due to humiliation. As a result, sexual and gender diverse people can face financial struggle as an indirect impact of sexual abuse. Sexual harassment was found to be one of the reasons for becoming involved in the sex trade, particularly for hijra participants. Hijra individuals are frequently raped and sexually molested and they are often unable to get justice because sexual abuse is one of the hate crimes against hijra communities that police rarely take into consideration. As a result, some hijra are forced to become sex workers instead of being raped for free by local thugs. This indicates that many hijra experience a brutal form of oppression in a male-dominated society where they are given no other choice but to engage in sex work.

Male rapes are deemed to be an unreported and invisible form of sexual violence because there are hardly any lists of reported male rapes in Bangladesh (e.g. Odhikar, 2018a). According to Cohen (2014), male rape cases are reported at a lower rate compared to the rates of reported female rape cases. The reason for this is that many males who are victims of rape do not tend to report it because they fear the reaction of family, friends, and society (Javaid, 2017). Rumney (2009) further explains that male rape victims rarely report the rape to the police because of the homophobic attitude and behaviour of the police officers. Findings suggest that another common reason for the lack of reported male rape is the impact of Section 377. As per the interpretation of this punitive law, the person who is raped is also considered as a criminal for being engaged in homosexual behaviour and, ironically, no consideration is given as to whether the raped person consented or not. Such ludicrous implications of Section 377 often discourage victims of male rape from reporting the incident, otherwise the victims may have to spend time in prison. Victims of male rape may suffer from health problems due to forced intercourse, but healthcare providers are sometimes not willing to treat them because they also assume that he was not raped but deliberately engaged in homosexual behaviour. Perhaps a society that privileges men does not accept the fact that the dominant gender (men) can also be humiliated by sexual violence. Therefore, many would think that men are born to dominate, not to be dominated, and this is why it is very difficult for healthcare providers or police to accept that a male can be raped.

Police violence is the next type of oppression experienced by the participants. Police sometimes collect money as an illegal levy from the hijra sex workers who work in public areas and parks. Beatings are another form of violence committed by the police, and the customers of hijra sex workers are also often harassed and arrested. Police violence is also considered a direct expression of male dominance in because male police officers are often violent toward sexual and gender diverse communities. One of the most important factors behind police violence is social dominance. According to Pratto et al. (2006), social dominance theory explains that some members – heterosexual men in a patriarchal society – hold more socio-economic power than the minority groups of populations. As a result, it can be noted that the police represent a patriarchal institution that uses its power to dehumanise and humiliate sexual and gender diverse people. Police violence against the participants is a part of the structural violence that defines the overall socio-economic and political oppression of marginalised communities.

While police as a law enforcement agency is supposed to protect marginalised communities, the participants often experienced negative and abusive behaviour from the police. The attitude and behaviour of the police toward the participants, particularly when they were in trouble, was not very supportive. This reminds us that police exploit the power over these marginalised communities to perpetuate the social dominance of men in society, indicating that police reflect the traditional patriarchal norms. These oppressive attitudes of police are accepted not only from a judicial and justice point of view, but also a health perspective. Violence perpetrated by police on sexual and gender diverse people is found to be severely detrimental to the health of the victims (Crofts & Patterson, 2016). Further, Davis et al. (2020) explain that despite the adverse mental health outcomes of police violence on stigmatised communities, a lack of trust of authorities is another consequence of the violence that is committed by police. Distrust of authorities, especially of law enforcement agencies, is the worst scenario for stigmatised communities who are frequently threatened with violence and assassination. The oppression cannot get any worse for marginalised communities if they lose trust in the authorities who are supposed to protect them. Hence, police violence is considered as one of the most important aspects that perpetuates the oppression of sexual and gender diverse communities in a patriarchal society.

The violence that is perpetrated by police also reinforces the stigma toward sexual and gender diverse communities. This is because the findings indicate that verbal abuse by police in public areas was something that hijra participants frequently experienced. This stigmatising behaviour in public places allows the general public to see how marginalised communities are treated by a law enforcement authority, which spreads the stigma among other people. The participants' lack of awareness and understanding of their own sexual or gender diverse identities contributed to extending the patriarchal oppression. In the same way as the general population lack awareness about these marginalised populations, police also have a misunderstanding and misconception about these communities. However, as a frontline authority of law enforcement, one should expect the police to be well trained and informed, and respectful of all marginalised communities so that they can protect these communities when needed instead of committing violence against them.

Police violence can turn into its most inhumane form when sexual violence against sexual and gender diverse people is committed by police. The findings suggest that some police would force hijra sex workers to have sex with them for free. Sometimes, this sexual abuse can take place in a public park in the dark or perhaps inside a police station. There is a certain police station in Dhaka that is very notorious for sexually molesting hijra individuals. Sometimes hijra sex workers are taken inside this station to engage in sexual behaviour but sometimes hijra are forced to let this happen because they are left with no other choice. This kind of forceful sexual abuse is sometimes performed in a group. The findings suggest that some police engage in the rape of men because there are fewer risks of being caught compared to having sex with women, which could eventually mean losing their job. If they can express their domination and control by rape, they would be less suspected by their administration. This also suggests that such behaviour of the police can be a way to protect the appearance of patri-normative family values where having a wife is necessary to preserve that appearance.

This kind of patriarchal and dominative attitude of the police creates a tension with the concept of homoeroticism. Homoeroticism refers to the sexual desire between individuals of the same sex: this refers to the desire itself, which is corporeal and can be temporary (Younger, 2005). Cantarella (1992) suggests that homoeroticism can be expressed as a brutal code of male domination (As cited in Kuefler, 2018), rape can be considered as an expression of domination and control by which men tend to sustain a fear among women (Brownmiller, 1975). Therefore, rape committed by the police can be regarded as a way of expressing humiliation and violence, not the satisfaction of sexual desire.

The humiliation and violence are committed by the police to maintain the oppression of sexual and gender diverse communities. Foucault argued that what homosexual individuals need to overcome is not homosexuality but the oppression that hinders them from living their homosexuality (Crespo et al., 2016). This oppression is often reinforced by the occupational culture and sexual violence of the police. As a result, the police present as hyper-masculine representatives of the state with an undercurrent of genuine homoeroticism that they satisfy by enacting and thereby justifying sexual humiliation. To clarify, male rape victims rarely fight against their offenders due to the fear, intimidation and control (Javaid, 2017). The police take advantage of this to gain control over sexual and gender diverse communities. This is because if the police rape (homosexual) men, people are unlikely to believe such a case as men are expected to initiate sexual violence instead of tolerating it (Javaid, 2017). Hence, the police know that raping homosexual males would be considered a joke because the stories of the male victims would seem unbelievable (Capers, 2011). Additionally, male rapes would bring potential risks under jurisdictions where homosexuality is illegal (Vojdik, 2014). Therefore, some police can sexually abuse and rape homosexual men, not only to excuse their homoerotic behaviour but enact a dangerous expression of male dominance and control.

This kind of expression of male dominance is closely linked to the concept of hegemonic masculinity, which refers to the practice of sanctioning and justifying the dominance of men in society (Connell, 2017). However, Clark (2019) argues that sexual violence against men can expose the vulnerability of the penis, thus creating a threat to hegemonic masculinity. Therefore, the police would do anything in their power to conceal their sexual violence against homosexual men so that the hegemonic masculinity that they represent does not face any threat. Police can sometimes be inspired to sexually abuse and rape men to spread STIs or HIV among males who belong to stigmatised and marginalised populations (e.g. Sivakumaran, 2005, p. 1298).

Findings indicate that the police sometimes perform group sexual behaviour or abuse and this can be deemed as an expression of patriarchal domination and oppression (Brownmiller, 1975). To do this, the police do not mind exposing their genitals to each other during this homoerotic behaviour as long as it serves the purpose of domination of the individual who is being abused or raped. Some police do not mind raping hijra sex workers in front of their customers or other police officers. The concept of homoeroticism is very crucial because people would find it difficult to understand group sexual behaviour due to the socio-cultural construction of sex and sexuality. However, when it is a matter of domination and humiliation, one may be encouraged to perform group sexual abuse which is merely a temporary sexual desire to express a social dominance over marginalised people (Connell, 2017).

Police violence in any form is detrimental to health perspectives. Physical beating by police is a common incident experienced by hijra sex workers who work in public parks. This may cause severe physical injuries to sex workers. Also, sexual violence (rape) performed by police is often performed without using condoms, which increases the risk of spreading STIs among others. Sex workers may not have STIs but the police may, which would increase the infection among sex workers, leading to the spread of the infection to their customers, thereby causing a major public health concern. As a result, the oppression of sexual and gender diverse communities through police violence may have more dangerous outcomes than would be expected.

The participants were often exposed to public harassment which is one of the ways used to oppress sexual and gender diverse communities. Harassment in public places is also a consequence of stigma and hatred toward marginalised communities. According to Sheridan et al. (2017), stigma and discrimination are closely linked with harassment of sexual and gender diverse communities. It is worth noting that public harassment can bring detrimental health outcomes for sexual and gender diverse communities. Harassment in public places is considered as humiliation and dehumanisation of a person, which can lead to trauma, frustration, and isolation (Brenner et al., 2010). As a result, the mental health status of an individual can be severely affected. There is a link between public harassment and the overall well-being of sexual and gender diverse people. To elaborate, being harassed and insulted at the workplace due to sexual and gender orientation could mean that the person would not be able to continue their work. Consequently, they may become jobless and it would bring further financial miseries in their life; thus, harassment can indirectly affect the overall livelihood and well-being of a person. Emotional distress and frustration are two other major consequences of public harassment (e.g. bullying) that can negatively affect mental health status and are often found to be responsible for creating suicidal tendencies. Public harassment may sometimes seem nothing more than mockery in front of others, but this could sometimes mean the loss of life. A patriarchal social system is responsible for expressing contempt through public harassment toward sexual and gender diverse communities in order to claim male dominance over these marginalised communities.

Beatings, insults, muggings, and bullying were the major forms of public harassment experienced by the participants. Ironically, police are also partially responsible for the public harassment of sexual and gender diverse people because they can also verbally abuse hijra on the street. When participants experienced public harassment in different forms, the police seemed to be reluctant to help them. This reminds us that the police represent a patriarchal institution that either directly or indirectly affects the perpetuation of the oppression that stigmatised populations experience.

Sometimes public harassment can turn into legal harassment. For instance, the incident of public harassment experienced by Idujon led to a physical offence and the complaint of this public harassment became a legal case. However, the offenders of public harassment tried to corrupt the police and judicial system to legally harass Idujon. Eventually, justice was done by an MP who made the offenders apologise in front of everyone. However, the legal system frequently suppresses sexual and gender diverse people with corruption and injustice. By the nature of the struggles Idujon had to go through to get justice, it can be assumed that not many sexual and gender diverse people are treated with justice due to corruption and the negative attitude toward sexual and gender diverse population. This reminds us that patriarchal oppression of these marginalised communities exists not only in the workplace and public places but also in every system in society.

The oppression of sexual and gender diverse communities is multifarious, and it has many facets. The government has denied the existence of these communities in the official document, tacitly avoided the health needs, and penalised them based on colonial attitudes, which refers to structural oppression of these communities. For such structural oppression, one of the radical emancipatory social work models is the anti-oppressive practice to help these communities (Morgaine & Capous-Desyllas, 2014). For anti-oppressive practice, the recognition of the social work profession needs to be strengthened to reduce such structural oppression to undesired populations. However, the anti-oppressive practice has been critiqued as putting oppression based on sexual orientation at the bottom of the list of oppressions (e.g. Dominelli, 2002, p. 9) that usually starts with sexual and gender diversity, race, class, and so forth. Therefore, the oppression of sexual and gender diverse communities are frequently ignored (Massaquoi, 2011). Anti-oppressive practice is sometimes unable to acknowledge the ordering of the needs as well as the social attributes that lead to oppression, for instance, ‘gender’ in their ordering is neglected (Dominelli, 2002, p. 21).

One of the major facets of this structural oppression is the deprivation of rights; these are rights to education, accommodation, food, and employment (Global Citizenship Commission, 2016). Due to being socio-culturally conservative, some parents may deny accommodating their sons or daughters who disclose themselves as sexual and gender diverse (Macias-Konstantopoulos & Bar-Halpern, 2016). Consequently, the right to shelter is frequently denied to participants whose families were not supportive and accepting. Losing accommodation sometimes pushed hijra participants to live in intentional hijra communities.

Being excluded from educational institutions was a common scenario for hijra participants due to their sexual and gender orientation. However, transmen and transwomen participants generally continued their education by hiding their sexual and gender orientation. But sexual or gender diverse individuals who lose family support and become homeless due to their disclosure find it almost impossible to continue their education. As a result, their educational background leaves them comparatively less qualified to become employed. This oppressive nature begins with denying them the right to education so that the impact of this deprivation can affect them throughout life by excluding sexual and gender diverse populations from the job market and making them financially dependent on others. Some sexual or gender diverse persons may be forced to involve themselves in the sex trade when there is no other choice left to lead their life. Therefore, we can understand that suppressing sexual or gender diverse persons, especially hijra, by denying their right to education is one of the drivers for them to engage in sex work.

The individuals who manage to finish the minimum level of education required to enter the job market still struggle to find a job due to their sexual and gender identities. For example, transsexual persons who have gone through gender confirmation surgery cannot change their name and gender in educational certificates and civil documents. Subsequently, this restricts them from applying for many employment positions, particularly in government institutions. Due to the expressions of not conforming to the socially assigned gender through their attire and hairstyles, and by crossdressing, a sexual or gender diverse person can be forced to leave their employment. Therefore, it is evident in the findings that participants who finished their education still struggled to find a job or continue their job because of who they are. It is a tragic irony that some hijra may have to collect alms in the street to survive despite being educationally qualified to work.

The findings suggest that due to certain internal conflicts, sexual and gender diverse populations somewhat struggle to unite as one community. Patriarchy also plays a significant role in generating internal conflicts. In other words, some transmen tend to believe that transwomen are inferior because transwomen have chosen not to conform to the socially assigned dominant gender role (male). Thus, refusing to represent male gender is considered to be an unaccepted behaviour in a patriarchal system, which leads to an imbalance between transmen and transwomen individuals. Such internal conflicts among sexual and gender communities do not allow them to unite and stand against the patriarchal oppression. Therefore, movements and awareness campaigns have not been successful due to this internal conflict amid the communities.

The oppression of sexual and gender diverse communities sometimes made the participants socially excluded. Social exclusion is a concept to ostracise certain communities from the mainstream social system and its rights and opportunities due to their belonging to a minority social group (Lassa & Li, 2016). The data suggest that deprivation of basic needs to survive can be seen as an attempt to socially ostracise marginalised communities. But other factors could help to reduce the social exclusion of these communities. Two important factors were found in this research which is closely linked with social exclusion: firstly, support from the family, and secondly, understanding the worldviews of sexual or gender diverse individuals. This kind of social exclusion is used as an effective means to socially control people who are stigmatised in society (Fischer & Poland, 1998).

The ostracism begins in the family and therefore the attitude of the family members is significantly important to understand how it affects social exclusion. Due to the social stigma and socio-cultural conservativeness, families of the participants were often reluctant to accept sexual or gender diverse individuals after their disclosure. In some cases, support from the family was withdrawn and the participants became homeless. Nevertheless, some families were supportive and accepting to a certain point but eventually, the family members tended to loosen their relations with the participants. The reason for this is that perhaps social stigma is not only expressed to sexual or gender diverse individuals but also their family members. As a result, the family also experience mockery from the society, thus they tend to gradually lose their connection with the sexual or gender diverse person. The support from the family is essential because it has a direct impact on the rights to education, and financial and employment struggles. For example, if a young sexual or gender diverse person becomes homeless, they may not be able to continue their education; subsequently, they can struggle to find a job and may experience a financial crisis. But if one does get support from the family then they may not become homeless and the chain of education, employment, and financial stability may become feasible for them.

Another reason for social exclusion was the lack of understanding of the participants’ viewpoints and worldviews regarding life, sexuality, and religion. For instance, if the family members consider that being homosexual is a mental disorder, then a sexual or gender diverse person may not be accepted in the family. This is because the lack of awareness of sexual and gender diverse identities and stigma towards these identities cause misunderstanding between parents/family members and a sexual or gender diverse person, leading to family conflicts (Ryan, 2009). Thus, the family members can lack understanding of the participants’ worldviews regarding life and sexuality. Consequently, many young sexual and gender diverse people can become homeless due to these conflicts (Wilbur et al., 2006), which increase risks for abuse and serious mental health problems (Ryan, 2009).

The worldviews and perceptions of sexuality, identity, life, and religion of the participants remind us that how the participants looked at life was not well regarded by the majority of the population even if these worldviews were logically justified. This is because it can substantially challenge the whole social system, which is constructed on patriarchy. Ironically, if the general public attempted to understand how the participants think of sexuality, life, and religion then it would be clearer to them that denying them home is nothing but the outcome of a patriarchal attitude that uses religious interpretations to sustain the oppression. Perhaps this is why investigating issues regarding sexual and gender diverse communities is not often encouraged a conservative society. Consequently, researchers who are willing to delve into the issues that formed an oppressive social system for sexual and gender diverse communities can be threatened with stigma and violence.

The different consequences of oppression of sexual and gender diverse communities make these communities somewhat invisible in society. The public invisibility of these stigmatised communities is affected by two other factors — lack of awareness and understanding of sexual and gender diverse identities. Due to the lack of public information and taboo on sexuality, it is quite difficult for the general public to gain awareness about sexual and gender diverse identities. Sometimes, sexual or gender diverse individuals can lack awareness about each other. For instance, transmen can lack awareness and understanding of transwomen individuals or vice versa. I found that many participants were unable to receive appropriate information during their self-identification expressions which created conflicts and trauma about their self-identification. Such limited understanding and knowledge about their self-identity and orientation give us a hint that the general public may also be affected by the lack of information and awareness. As a result, the participants tended to become publicly invisible to the majority of the population.

While public invisibility was also a consequence of the stigma and oppression of sexual and gender diverse communities, lack of education and family support were also found to be responsible for restricting the participants' ability to obtain necessary information and knowledge regarding sexual and gender diverse identities. As a result, sexual and gender diverse people may fail to explain who they are. For instance, some hijra individuals are not quite sure how to define and express hijra tradition or orientation to others; this creates further confusion amid the general public which leads to a lack of awareness and public invisibility. The result of this public invisibility is detrimental for marginalised populations because the government can ignore their existence and deprive them of their needs.

The lack of understanding and awareness about sexual and gender diverse communities is not only seen among the general public but also in people at different institutional levels. This study has identified that policy-level representatives, police, and healthcare professionals frequently hold misconceptions about people with diverse sexual and gender identities. The lack of awareness about sexual and gender diverse communities can make these communities invisible to the general public. As a result, a patriarchal society can utilise this invisibility to put these communities in a more vulnerable situation to be oppressed. This lack of awareness can be used to marginalise and further denounce minority groups of communities (DeNicola, 2017). Patriarchal oppression of marginalised communities can be reinforced by the lack of awareness among the general public. People do not know what they do not know, and someone needs to take actions to inform the people about their lack of awareness that is related to the concept of conscientisation (Freire & Ramos, 1970). But continuous threats and violence perpetrated by the extremists do not allow to take measures to make people aware of sexual and gender diverse identities.

The participants experienced different kinds of oppression in different circumstances and there were also various consequences of this oppression. All these consequences and many facets of oppression are discussed through sexual violence, police, violence, public harassment, fear of disclosure, public invisibility, ‘virtue signalling’, social exclusion, and deprivation of rights and opportunities. Discussing these aspects from the participants’ experiences indicate what it is like to be a sexual or gender diverse person in an Islamic male-dominant society.

Sexual and gender diverse communities in both Bangladeshi society and Māori communities experienced a similar kind of colonial oppression (Aspin & Hutchings, 2007). Contemporary New Zealand society still reflects the impact of British colonial legacy, and the racialised assumptions of British hegemony (Gray & Crichton-Hill, 2019). For example, Māori and Pasifika young people are sometimes regarded as brown as ‘others’ in post-colonial New Zealand (Fitzpatrick, 2011). Also, healthcare discrimination based on cultural identity remains a major issue in New Zealand for the health status of Māori communities (Bécares et al., 2013). The findings of this study document how even in post-colonial societies marginalised communities continue to experience the legacy of colonialism in negative ways, such as poorer health outcomes, or lack of access to appropriate healthcare. The findings and recommendations from this study of marginalised peoples in Bangladesh may be applicable to marginalised people in Aotearoa New Zealand, so that their mana too may be respected not only in iwi and hapū, but also in health and social care, and the wider society.

Although takatāpui (same-sex identified persons) were present and widely accepted prior to the imposition of British Christian missionary values and British law (Te Awekotuku, 2001), British colonisation affected the Māori way of understanding gender and sexuality (Marino, 2020). Christian missionaries and Puritans suppressed the expression of sexuality or gender fluidity; thus, takatāpui gradually became invisible as colonial authorities intentionally did not record takatāpui stories, or deliberately mistranslated them (Kerekere, 2017). This experience is quite similar to contemporary Bangladesh because most participants of this research hid their sexualities by maintaining a dual identity, thus becoming invisible. Kerekere (2017) further states that since colonial laws and values hegemonised the indigenous culture of Aotearoa New Zealand, for almost a century same-sex behaviour was considered immoral and illegal. A similar legal prohibition is seen in the South Asian regions imposed by the British Regime to impose and ensure social conformity and control. In this way, we can understand the similarities of colonial oppression of sexual and gender diverse communities among Bangladeshi and Māori communities. The suppression of takatāpui in both Bangladesh and New Zealand signposts how British Regime used religion, colonial values, and laws as tools to marginalise sexual and gender diverse communities.

9.4 Perception and initiatives of healthcare

The next sub-question focusses on how do sexual and gender diverse communities perceive and experience healthcare in Bangladesh. To respond to this question, a discussion about the perceptions of healthcare from different institutional aspects is important. Understanding the implications for society, law, government, and NGOs to understand health and healthcare is essential because it can lead to the justification of how healthcare discrimination can help to understand the oppression of sexual and gender diverse populations. To begin with, the explanation of healthcare theories can be useful to explore how healthcare is constructed. Among the three popular theories of healthcare — classical liberal, industrial society, and socialist theory — the relevance of socialist theory are more relevant in this research because it gives significant consideration to providing healthcare for working-class poor people, and minority groups in a population (Shannon & Young, 2004). While the socialist theory of healthcare is determined to ensure the quality of life by reducing discrimination and inequality in society (Dlugacz, 2017), a healthcare system has an obligation to offer equitable care to all persons, and not to add to their trauma.

The socio-economic formation is a major determinant of many aspects of the healthcare system: for instance, the dependency on the private medical sector is either barely visible or absent to a point in socialist countries where the healthcare system is predominantly sustained by the state (Segall, 1983). However, the private medical sector such as clinics, NGOs and donor agencies play a big part in the healthcare system of Bangladesh. The data suggest that participants experienced stigma wherever they accessed healthcare, private or public. This builds a clear though an improper connection between the healthcare system and the socialist theory of healthcare because this theory particularly proposes ensuring healthcare for people who experience inequality and discrimination due to their belonging to lower or minority social groups. This further suggests that healthcare providers are enacting or reinforcing social norms wherever they work, regardless of government policy.

Participants frequently explained that they were less likely to be discriminated against in private medical settings than in government hospitals just because they had to pay more money to receive healthcare in private medical settings. By depending mostly on the public healthcare system, many socialist countries may have been successful in reducing healthcare discrimination. The scenario is quite opposite because even though the private medical sector plays a significant role in the country’s health system, healthcare discrimination is not reduced because healthcare is expensive in private settings. Arguably, a patriarchal society tends to divorce the participants from their rights to acceptance, education, and employment so that they face financial problems. This can push them to visit a private health setting, which would be very expensive for the participants to afford, thereby further marginalising them. Consequently, the participants were mostly bound to visit government health settings where they were more likely to experience neglect, insults, and humiliation. It can be said that healthcare discrimination, regardless of whether it is private or public, can therefore be used as a lens to understand the overall oppression of sexual and gender diverse communities because it connects all other deprivation of rights and opportunities.

The socialist theory of healthcare is also considered in this research because participants who were engaged in sex work experienced health risks and stress from work which caused ill health. According to Shannon and Young (2004), socio-economic factors of illness and health are considered by the socialist theory of healthcare because the health status of a person is both directly and indirectly affected by their socio-economic situation. The findings indicate that social control by socio-economic discrimination can affect their health status, thus health and healthcare are considered to be an important aspect to demonstrate the overall oppression experienced by the participants.

Many hijra are involved in the sex trade for their livelihood because they are often left with no other choice to survive. This may increase HIV and other STIs and create threats to public health. If they were allowed to receive a proper education, they could contribute to the labour market by working in different sectors other than the sex trade. As a result, risks to public health could be reduced. It seems strange that the government and a patriarchal system would harm their society by socially controlling sexual and gender diverse communities because treating public health problems would cost the government more money than prevention. This explains that health and healthcare are as important as other issues faced by sexual and gender diverse communities because it draws a connection between the participants' socio-economic situation and public health.

Since healthcare delivery is investigated to understand how healthcare discrimination can be used to exert social control, the findings are also somewhat related to the constructivist approach of healthcare. This approach is determined to ensure a co-operative healthcare system that is mostly controlled by community-level providers (Barr & Dowding, 2015). For example, healthcare can be supported by community-level agencies (e.g. Bijito's health services) because these agencies can deliver healthcare by identifying what kind of health support is required, and who requires it. The probability of discrimination can be minimised since individuals can receive health support from community-level organisations. This type of healthcare support is not very inclusive because community-level agencies may not have sufficient resources to support every person who requires healthcare. Therefore, Bijito also depends on funding from INGOs or donor agencies to keep their health services operational.

The limited number of health services run by both NGOs and INGOs are mostly funded by international donor agencies. This implies that the government allows these NGOs and INGOs to work for marginalised communities so that the government does not need to take any initiative and can thus avoid appearing to condone non-conforming or stigmatised behaviours or communities. The findings explain that participants used to receive many health services from Bijito but these now tend to be limited. This has created a degree of anxiety among sexual and gender diverse communities and some would argue that one group of sexual and gender diverse people is getting more health support than others. However, the primary evidence suggests that the reduction of funds and donations from INGOs is one of the biggest challenges for this agency to operate its broad health support system for sexual and gender diverse communities.

The notion of the reduction of funds from donor agencies is also closely related to the relocation of many HTC units from private medical settings to government hospitals. Perhaps, the government believes that HIV testing and related services can be managed and operated without any funding support from abroad, so government hospitals can take the sole responsibility to operate HIV testing and services. This still does not make it clear why HIV testing and services in NGOs could not be continued simultaneously with government hospitals. Gradually relocating HTC services to government hospitals had a significant impact on the health-seeking behaviour of the participants. The attitude of the participants toward healthcare delivery changed due to this gradual relocation of many HTC units because they believe government hospitals are places where they are most likely to be humiliated and discriminated. The incidents of humiliation and insults to sexual and gender diverse people in government hospitals have created fear among the participants of visiting government health settings. One may argue that perhaps there are incidents of discrimination in private medical health settings that do not attract media attention, thus people are not informed about them. However, the findings indicate that the participants sometimes received proper healthcare from non-governmental health settings even after their disclosure.

The social stigma around HIV is acute in Bangladeshi society and there is a significant misconception about the causes of HIV infection (Ullah, 2011). Hence, the general public tends to believe that unsafe sexual behaviour is the only cause of HIV infection and some believe that HIV is an infection that only belongs to sexual and gender diverse communities. This perception is irrational because sexual and gender diverse minorities are identified as the only communities who can have HIV, which is nothing but a consequence of patriarchal attitude. Consequently, the participants feared going to government hospitals if they wanted to undergo an HIV test because that might expose themselves to public harassment and stigma.

Another reason why the gradual relocation of many HTC units to government hospitals impacted the health-seeking behaviour of the participants was due to the increased probability of disclosure. The participants mostly lived with dual identities by not disclosing their sexual and gender orientation to the public. Nevertheless, while visiting health setting the participants may need to disclose themselves and if their privacy and confidentiality are not ensured then it may put them at a greater risk of being humiliated and discriminated. For instance, HIV testing services of NGOs may be operated with more integrity to privacy and confidentiality than government hospitals, which may discourage individuals among sexual and gender diverse communities from going to government hospitals for HIV testing, particularly those who live with dual identities.

I argue that probably the reason why the government has been gradually relocating many HTC units in the government hospitals is to be able to maintain control of the data of HIV infection. The government may also have wanted to socially control sexual and gender diverse populations as a whole but failed to do so because they are hidden from public view. Therefore, HIV testing services at government hospitals might be one way of identifying who belongs to sexual and gender diverse communities as a way of naming, containing, and controlling these communities.

The perception of healthcare from the governmental level is expressed by the inclusion of ‘sexual minority groups’ in the 7th Five Year Plan (2016-2020). This provision provides a succinct overview of these minority groups, particularly from their health perspective. This is slightly contradictory to the government’s point of view because the National Health Policy does not mention anything regarding the health needs of sexual and gender minority populations. As a result, this puts the government in conflict with itself, as what has been stated in the 7th Five Year Plan does not properly align with the National Health Policy.

In the 7th Five Year Plan, ‘health insurance’ for ‘transgender and sex workers’ is emphasised because they probably need ‘health insurance’ more than others (Planning Commission, 2015, p. 706). However, the way the government has stated the need for ‘health insurance’ for ‘transgender’ and ‘sex workers’ under the section of ‘sexual minority groups’ is arguable because there are cis-het female sex workers who do not belong to sexual minority populations. It could have been a clearer statement if the need for ‘health insurance’ of sex workers is mentioned in a completely separate provision rather than the provision of ‘sexual minority groups’. I believe this kind of contentious statement in government planning is an expression of institutional-level stigma to justify that sex workers only belong to ‘sexual minority groups’, which we all know is incorrect. Due to the probable risks of STIs, having a separate category of ‘health insurance’ for ‘sex workers’ is completely understandable, but including ‘sex workers’ under the provision of ‘sexual minority groups’ is a stigmatising statement. This reminds us that the cis-het patriarchy has also impacted the formation of national-level policies and guidelines related to health and healthcare.

The term ‘health insurance’ for ‘sexual minority groups’ in the 7th Five Year Plan is also contradicting because ‘health insurance’ is barely available or accessed by the general public. This is why it might sound a little bit extravagant to consider the need for ‘health insurance’ for sexual minority groups while it is barely available for the majority of the population. Perhaps the government could have used a term such as ‘health support’ or ‘healthcare’ instead of ‘health insurance’. This plan is reported in English so using the term ‘health insurance’ cannot be a translation issue. This ludicrous use of terms in the 7th Five Year Plan has undermined the efficacy of the inclusion of ‘sexual minority groups’ in this plan. Key informants in this research have argued that the only probable explanation could be the government’s attempt to attract international donor agencies by using this imprecise inclusion in this plan.

The governmental attitude toward sexual and gender diverse populations and their healthcare is reflected by the interest of political parties. To begin with, the acceptance of sexual and gender diverse communities has been a controversial matter that hardly any political party is willing to discuss. The reason for this is that the political parties worry that discussing the acceptance of these communities creates anxiety among the majority of the population who are mostly religiously conservative. Since homosexual behaviour is seen as a religious sin due to some contestable interpretations of Islam and regarded as a crime because of Section 377, political parties and institutions are cautious to raise the issue about the acceptance of these communities. This is because political parties worry that their popularity among the majority of the population could be lost if they want to prioritise the rights and acceptance of minority groups. The public support from the majority of people is essential for political parties because they are the majority of the voters.

Many would justify that using religion or religious prejudice is found to be an effective way to gain political advantages. For instance, the punitive law against homosexual behaviour is further reinforced by the religious interpretations so that the government can avoid the discussion about the acceptance of sexual and gender diverse people. Thus, the political parties and institutions are silently serving the purpose of a patriarchal system to oppress sexual and gender diverse population. The socio-cultural and political system is constructed in a way where these populations have been historically denied due to a patriarchal suppression. It seems that the use of old British law and justification by debatable religious interpretations are used to sugar-coat the actual patriarchal interest of the political parties and institutions. It is an irony that modernist and presumably forward-looking political parties are supporting ancient religious and colonial views causing oppression of marginalised populations.

Despite the fact that homosexuality is prohibited, sexual and gender diverse communities are still citizens of the country, and they have equal rights to receive education, healthcare, and employment. Therefore, political parties need to take accountability regarding this discrimination of rights to these marginalised communities in order to deal with the patriarchal oppression. However, such actions and responsibilities from the political parties would not emerge unless they learn to think out of the patriarchal mindset. This is certainly not an easy task because most political parties would be unaware that they are playing a role as servants of a male-dominant social system. Therefore, the interest of political parties is overshadowed by the influence of patriarchy that leads to many conflicting attitudes and perceptions toward health and healthcare, which is expressed by the duplicity mentioned between the National Health Policy and the 7th

Five Year Plan. Political parties and organisations are the paramount stakeholders to influence and regulate a country's policies, but since the interests of political parties are manipulated by patriarchal culture, they continuously fail to identify the needs, particularly the healthcare needs, of marginalised communities.

Not only political parties but the government itself hold various interests that do not allow the government to manage misconceptions toward sexual and gender diverse communities. One of the consequences of these misconceptions can be exemplified by the use of different terms (e.g. transgender and hijra) in policies and guidelines. The findings indicate that the government has been playing with these communities by using different kinds of terms to avoid the existence of sexual and gender diverse communities. This is because the denial of their existence can help the government to justify the need for health support for these communities. The use of the term 'sexual minority groups' and 'health insurance' in the 7th Five Year Plan indicates a lack of intention to manipulate the terms associated with sexual and gender diverse identities. Furthermore, the government has avoided using the terms such as 'gay', 'lesbian' and 'bisexual' in reports (e.g. Universal Periodic Review), policies, and guidelines by replacing them with the term 'transgender', which only refers to hijra individuals (e.g. Office of the High Commissioner for Human Rights, 2018). Therefore, it has become easy for the governmental authorities to conclude that health support is not widely required because there is no other group of sexual and gender diverse people except hijra.

It is assumed by the participants that the government and its representatives are aware of the existence of sexual and gender diverse populations. However, they are not ready to acknowledge them and their issues in policies and guidelines. Many would argue that the manipulation of the terms is an expression of the taboo around sex and sexuality. The data suggest that any term that relates to 'sex' (e.g. homosexuality and transsexual) is barely tolerated by governmental institutions. This reminds us that the taboo on sex and sexuality is not just expressed by the prohibition of talking about sex or performing pre-marital sex, but also by a prohibition on writing about sex and sexuality in national-level guidelines and policies. As long as this taboo remains, it may be difficult to discuss sexual health issues, which is not only a problem faced by minority populations but can also be experienced by the majority of the population. Rashid, Akram, et al. (2011) discuss that the domain of sexual health is highly neglected in Bangladesh, with not enough trained healthcare professionals in government facilities. Therefore, we can see a clear impact of the government's manipulation of different terms on understanding the health and health needs of the people.

Sometimes, agencies and stakeholders who work with sexual and gender diverse communities are summoned to jointly work with government representatives in drafting proposals and guidelines. But the manipulation of the terms again plays a big part to deny the existence and healthcare needs of these communities. The data suggest that it is a mockery to sexual and gender diverse communities because if the government is not ready to accept their proposals and ideas then why were they called for a joint discussion in the first place. The implementation of plans and policies regarding health needs (e.g. 'health insurance' as indicated in the 7th Five Year Plan) would be less emphasised since the guidelines do not explicitly state the target population of this 'health insurance'. As a result, it becomes easier for the government to avoid measures and actions that are supposed to be taken to implement its plans and policies regarding health support.

The attitude of the government is questionable because healthcare discrimination of sexual and gender diverse communities poses a threat to public health that could affect the government in the long run. Ichand's observations suggest that despite the lack of willingness of the government to support these communities, the general public seems to be more accepting of these marginalised communities than in the past. This is probably because healthcare providers and police reflect government norms only, and not public opinion; these government norms are influenced by dominant patriarchal values. One may argue that there is not enough evidence to support such a statement. Nevertheless, I propose that perhaps the government is not only out of touch with the people, but that it may be attempting to maintain so-called traditional values against the will of the people who are more progressive, which I consider is a further scope of research.

Governmental response toward these communities is often compared with its neighbouring Muslim majority country Pakistan. But as Ichand observed, the attitude of the Pakistani government is slightly different because governmental recognition of transgender communities is not very well accepted by the majority of the population. If the people in a Muslim majority society (Pakistan) do not accept sexual and gender diverse communities, which may be correct if Ichand's observation is true, then it creates incongruence because the situation in Bangladesh seems to be the opposite. Perhaps the practice of Islam may vary between the people of Bangladesh and Pakistan, which may affect the mindset of Bangladeshi people to think relatively more liberally than Pakistani people. As a result, the general public of Bangladesh seems to be more accepting toward sexual and gender diverse people, said Ichand. There is no strong evidence to support this argument but the observation of Ichand is worth noting.

The difference in governmental attitudes is very important because this difference can affect how a government navigates their plans and policies associated with sexual and gender diverse communities. If the government solely attempts to recognise a sexual and gender diverse population without the mass support of the general public, then it becomes relatively difficult to formulate guidelines and policies to support these communities. This is because there would be certain concerned communities (e.g. religious communities and extremists) amid the unsupportive majority of the population who would protest against those policies and guidelines. Therefore, due to these protests of concerned communities, it will be critical for the government to support sexual and gender diverse communities with plans and policies. Perhaps this is one reason why the government and its representatives are manipulating terms to avoid the accountability to accept these communities. Hence, health and healthcare issues of sexual and gender diverse communities have not been able to attract proper attention from the government and its policies.

The position of the government may be confusing because they may be in a situation where they cannot take any initiatives to support sexual and gender diverse populations. Thus, the government has either intentionally or unintentionally overlooked the health and healthcare aspects of these stigmatised communities and there have been initiatives taken by NGOs to provide health support for these communities. There are a few INGOs and foreign agencies who have come forward to provide healthcare needs in a limited spectrum. For instance, ICDDRB and CARE provide healthcare services to sexual and gender diverse communities. The types of health support provided by different NGOs and INGOs include counselling and peer support, distributing contraceptive condoms, providing health awareness, and various medical and blood tests.

The healthcare initiatives of non-governmental organisations are very useful because some of these organisations are deemed as community-level agencies (e.g. Bijito). The advantage of healthcare being delivered by a community level agency is that the individuals would feel safe while receiving health support because there would be no hesitation to disclose their sexual and gender orientation. This can reduce the level of anxiety that a person may have while visiting a healthcare setting. It is worth noting that the fear of disclosure while visiting a healthcare provider can also cause hesitation, which can have a mental health impact on a person (Wilson & Cariola, 2019). This can be well managed if healthcare delivery is ensured within the community level agencies. However, there might be limitations for these NGOs to operate their health services due to the lack of funds and resources. For instance, the data from this project show that Bijito's health support is often affected by the limited number of medical tests it can offer, and by insufficient medicine and medical instruments.

Another concern of these NGOs is to ensure the privacy and confidentiality of the individuals who receive health support from them. While ensuring health needs, they also need to be cautious that the individuals are not exposed to the public. Therefore, most of their healthcare services are operated discreetly so that only sexual and gender diverse people and their networks are aware of these services. Nevertheless, the health supports provided by INGOs are not exactly following an 'approach to hide' while delivering health support to these communities. Kelard discussed that 'Approach to hide' refers to the services provided for stigmatised people without the general public being informed. The reason for not following this approach by INGOs is that perhaps they are less likely to be dependent on the government funding to operate their healthcare services.

Healthcare initiatives of non-governmental organisations are also essential to build networking among sexual or gender diverse individuals. This is because the information about these organisations' healthcare services is often passed through word of mouth communication or chain referral approach. Many people have come to receive health support from these organisations and eventually found their way to be involved with the network of sexual and gender diverse communities to receive help. This can provide a sense of belonging and reduces the feeling of isolation and hopelessness, thus creating positive mental health impacts. Due to the lack of availability of information and the taboo on sexuality, many sexual or gender diverse persons may fail to obtain necessary health awareness. Education and awareness relating to health issues is another prominent support provided by these NGOs and INGOs. The healthcare initiatives of NGOs and INGOs are outcomes of the governmental failure to ensure healthcare delivery for sexual and gender diverse communities. Therefore, the government should express its intention to provide additional or joint support so that a public-private partnership can be formed for better healthcare delivery for sexual and gender diverse populations. The way INGOs have been allowed to provide limited healthcare support for these populations suggests that such public-private partnership is somehow maintained to avoid the governmental liability of these undesired populations. Therefore, in order to support these populations single-handedly, the government would require a change in their attitude.

The lack of government healthcare initiatives can be seen as one reason why health support from NGOs has emerged for sexual and gender diverse communities. The peer educators are a prominent example of how NGOs have been disseminating health information among these communities to build health awareness. Peer educators usually belong to sexual and gender diverse communities who work in public places, particularly where sex workers are based. This is because sex workers are exposed to different to STIs due to the nature of their work and they require awareness regarding their health risks. The type of information related to health and health risks which is given by peer educators is essential because sex workers and sexual and gender diverse people may not get access to this kind of information from anywhere else. The role of peer educators is significantly important to remind sexual and gender diverse people that health must be emphasised and initiatives should be taken to minimise both mental and physical health risks. Therefore, peer educators play a significant role in helping sexual and gender diverse people to understand the concept of health from both physical and psychological aspects.

The data suggest that despite the implications of physical and mental health, peer educators also contribute to the understanding of sexual health. Due to the risk of stigma and discrimination, sexual and gender diverse people cannot disclose their sexual or gender orientation in health settings, thus they may not be able to discuss and obtain the necessary information about sexual health. However, the information given by peer educators is free of charge and sexual and gender diverse people do not need to worry about discrimination or insults due to disclosure. Hence it becomes an outstanding source of information to build sexual health awareness among these communities whereas there hardly any government policies or guidelines which emphasise sexual health. Peer educators are considered as key persons for distributing free condoms and lubricants among sex workers and sexual and gender diverse communities. The supply of condoms and lubricants to the sex workers who are vulnerable to STIs is supposed to be a government responsibility. But lack of attention to this kind of responsibility reminds us how the government is oppressing marginalised communities by endangering their health status as well as the public's health.

The data suggest that there are a number of problems faced by peer educators that can affect their contribution to health awareness among sexual and gender diverse communities. The lack of funds and resources of the NGOs is a limitation that arguably reduces their supply of condoms and lubricants and support given by health-related information. Police frequently track down peer educators in public places and harass them by searching the bags in which they carry condoms and lubricants. Police further investigate why they are interacting with sex workers and what their motives are. This kind of behaviour indicates that police, who represent a patriarchal attitude, maybe attempting to restrict access to information and awareness regarding health risks and sexual health.

It is quite evident from the data that the implications for governments and their policies, laws, and non-governmental initiatives are closely linked to the understanding, awareness, and information regarding the health and healthcare of sexual and gender diverse communities. This is because all these facets represent how health and healthcare are perceived and considered from the government and institutional level, which directly affects healthcare plans, policies, and delivery. The participants believed that there is a lack of perception and awareness of different aspects of health (e.g. sexual health) due to the lack of attention from the government and institutional level. Therefore, denying the right to health is not only an issue of human rights but based on limited awareness and perception of health risks and restricted healthcare caused by an oppressive and male-dominant socio-cultural system. Therefore, investigating access to healthcare can help to understand the oppression of sexual and gender diverse communities.

9.5 Is healthcare a human right, or a tool for oppression?

To consider healthcare as a human right, it needs to be equally and fairly provided for everyone, which is also emphasised by a theory of justice. A theory explained by Daniels (2001) refers that health must be held as a higher value than other social goods because of the ethical reasoning that health ensures normal social functioning of a person. Social justice theory further recognises the impact of socio-economic factors of health. The lack of education and employment, public harassment, police violence and stigma were some of the major socio-economic factors that affected the participants' health.

To understand if the investigation of access to healthcare can help to understand the oppression of sexual and gender diverse people in a patriarchal society, we need to discuss whether healthcare is a human right or a tool for oppression. This argument is somewhat discursive, and it demands additional discussion regarding the participants' health risks and healthcare experiences to understand if discrimination is a prominent factor among the participants' healthcare experiences. This is important because it can influence how the participants perceive health and healthcare in a male dominant society and explain barriers that prevent a rights movement from preserving their healthcare rights. Discrimination of sexual and gender diverse communities in the healthcare sector can have other effects on the public health and well-being of these communities that are constantly overlooked by a patriarchal social system.

To discuss health risks, the data suggest that the participants frequently suffered from mental health issues. One reason why mental health problem is common is because the concept of mental health is still underdeveloped. Sexual or gender diverse persons arguably can suffer from more mental health problems than non-stigmatised communities due to the stigma, isolation, and violence they experience in a patriarchal society. The concern of mental health problems for the younger generation and sexual and gender diverse populations was also raised by the participants in their interviews. These interviews have highlighted the need to be connected so that one feels a sense of belonging to a community as well as the role of peer support to receive psychological support that is needed to address suicidal tendencies and substance abuse.

The Mental Health Act introduced by the government in 2018 does not provide for a sufficient amount of the financial resources which are required for the mental health sector (Hossain et al., 2019). A very small number of mental health services are available, but they are severely unorganised, which prevents Bangladesh from sustaining a solid mental health service model. Another limitation of the Mental Health Act is that it does not incorporate any significant guidelines regarding the assurance of patients' privacy and confidentiality (Hossain et al., 2019). All these issues surrounding mental health and its policy indicate that mental health services are not yet readily and adequately available for the majority of the population. Therefore, I argue that it is quite difficult to ensure mental health support for marginalised communities who are barely accepted by society and the state. Therefore, the participants had very limited access to mental health support and even if they could access it, there was a risk of being exposed as the privacy and confidentially were not appropriately ensured.

Another health risk participants reported was the unknown consequences of gender confirmation surgery and gender confirmation hormone therapies. The findings indicate that the participants knew very little about this surgery and its side-effects. The fear of disclosure and legal restrictions can prevent a gender diverse individual from consulting about the issues associated with gender confirmation surgery. Therefore, gender diverse people can experience negative health impacts due to the lack of information and consultation regarding gender confirmation hormone therapies and surgery. One may argue that these health risks for the participants put them in a situation where they are continuously unable to live with dignity. This is because without gender confirmation hormone therapies and gender confirmation surgery they are often forced to represent the socially assigned genders.

Trans participants reported that it became almost unbearable to live a life with dual identities by representing the socially assigned genders. This unbearable situation can be seen as one of the many reasons why many gender diverse persons may have to think carefully about visiting healthcare settings by considering the fact that the consequences are unknown. The individual healthcare experiences shared in this research explain that the participants frequently experienced discrimination, insults, neglect, violence, and negative healthcare behaviour in healthcare settings. The discriminatory individual healthcare experiences evidence that healthcare professionals reflect traditional patriarchal norms and values despite their professionalism. This further implies that there is a continuous influence of patriarchy and colonialism to perpetuate the oppression of sexual and gender diverse communities. A paramount factor behind these discriminatory and oppressive healthcare experiences is disclosure. The participants were rarely forced to disclose their sexual and gender orientation. They made a rational choice of making a decision about disclosure even though they could anticipate the consequences of their disclosure. The hope to receive justice in healthcare settings was the main cause of such disclosure, which often led to negative healthcare experiences. Sometimes, the disclosure was not explicit, and the healthcare providers recognised the participants' sexual and gender orientation, which still led to discriminatory healthcare experiences. The participants could get access to healthcare as long as they are not disclosed. Hijra participants were usually disclosed due to their attire, thus disclosure cannot play as a variable for them while visiting healthcare settings. Hence, accessing healthcare has become a source of oppression due to the fear of discrimination and it affects their health-seeking behaviour.

Despite the possibility of experiencing healthcare discrimination, other problems can hinder sexual and gender diverse populations from promoting their rights. We assume that healthcare is a basic need to survive but, considering the findings, this right is generally not protected, according to the participants' experiences.

The human rights regime is gradually being extended by introducing new mechanisms, actors and proposed responsibilities (Brysk & Stohl, 2017). The concept of human rights is expanded to contest dehumanisation (Brysk, 2018b). Hence, sexual and gender diverse communities are often considered in order to understand whether human rights are expanding or contracting. The way people think of human rights may be universal, as is how human rights are presented by international organisations and settlements; theoretically, they can be called universal and apply equally, regardless of culture, religion, time, and region. Many post-colonial scholars and feminists argue that rights are the wrong politics for liberation because rights are poised with both disdain and hope (Brysk, 2018a).

Healthcare is regarded as a 'basic necessity' in the Constitution of Bangladesh, making healthcare a legal right for everyone. It is questionable whether healthcare is considered a human right in a post-colonial state based on a couple of arguments. First of all, different contestable interpretations of Islam (religion) prohibit homosexual behaviour; and secondly, sexual and gender diverse people cannot disclose their sexual and gender orientation. These two impacts create a barrier to the right of freedom of expression where sexual and gender diverse people cannot freely express and disclose about themselves. Despite the factor that freedom of expression is a universal human right, it is not practically implied in the Bangladeshi context, simply because of the predominant influence of Islam. Therefore, I can posit that human rights are not practically universal in Bangladeshi society.

Sexual and gender diverse communities have attempted to promote campaigns and movements to raise their voice against such deprivation of rights. Rights-based practices have gradually progressed but they are now under threat due to the assassination of activists and violence committed against sexual and gender diverse people (Sanzum, 2017, May 19). The fear of being killed has created fear among other activists of sexual and gender diverse communities. To deal with this, many activists have started to resume their movements to secure the rights of sexual and gender diverse communities through online campaigns. However, the Information and Communication Technology (ICT) Act of Bangladesh 2006 has created another barrier to continuing online movements against the oppression of these communities. This Act was further toughened in 2013 by the government, removing the need for an arrest warrant (Reuters, 2018, December 13). Moreover, the Bangladesh Digital Security Act 2018 is regarded as an invasion of freedom of expression, which can be more repressive and poses a severe threat to human rights (Amnesty, 2018). As a result of these laws, online campaigns of marginalised communities have been severely threatened.

I argue that the patriarchal society is established in a way that consistently forms one way or another to oppress sexual and gender diverse people. Since online campaigns are also inhibited, new ideas have been proposed by the activists. Participants reported, and I observed that an art-based movement can be operated to demonstrate the situation and increase awareness about sexual and gender diverse identities among the general public through various kinds of art forms such as poems, paintings, novels, stories, and multimedia (e.g. films and drama). For instance, it is notable that films have been released in the neighbouring country of India (*Aligarh* in 2015, *Ek Ladki Ko Dekha Toh Aisa Laga* in 2019, and *Shubh Mangal Zyada Saavdhan* in 2020) to document the oppression of sexual and gender diverse people and raise their voice to create awareness. Films and other forms of art can be useful to reveal how sexual and gender diverse people struggle to fit in and be accepted among the majority of the population. One can suspect that the government may find another way to prevent this innovative approach of the rights-based practices in order to perpetuate the patriarchal oppression of these communities.

The data suggest that divorcing sexual and gender diverse communities from the right to access healthcare have a direct impact on public health, the well-being of the communities, and justice. By suppressing stigmatised communities and healthcare discrimination, the government is risking the whole society. To elaborate, some sexual and gender diverse people are involved in the sex trade and their clients usually belong to the majority of the population. One can assume that if a sexual or gender diverse person who works as a sex worker is not allowed to get medical treatment for STIs, they can easily spread the infections to their clients. Consequently, the spread of this infection can grow among the general population. One can argue that such a potential threat to public health may have been calculated by the government and health experts. If that argument is correct, then the reason for the society and government to continue the oppression of sexual and gender diverse communities is still not clear. Perhaps the patriarchal attitude has made the whole society and its systems blind so that they overlook public health threats derived from the perpetual oppression of marginalised communities. The patriarchal values and taboos are so strong that they do not seem to allow the general public to acknowledge what harm is being done, with or without their consciousness of masculine values.

Healthcare discrimination can affect the well-being of sexual and gender diverse communities (Perales & Todd, 2018). The data also suggests that health is considered the most important factor to ensure social, mental, spiritual, and physical well-being. Similar to the concept of mental health, the notion of well-being and issues surrounding this notion are still underdeveloped in Bangladeshi society. However, there is no denying that the sexual and gender diverse communities’ well-being can be affected due to healthcare deprivation as found in this research because health plays the most essential role to ensure overall well-being. A negative effect on well-being can be considered as a further consequence, which emerged from the oppression experienced by the participants. Ironically, the participants were barely given an opportunity to understand what overall well-being is because they had to concentrate on other important issues such as living with stigma, violence, harassment, and deprivation of rights. All these forms of oppression experienced by the participants rarely allowed them to think about the well-being of the community as a whole, whereas well-being is substantially important for a community that is stigmatised and marginalised.

There are community-level agencies such as Bijito that emphasise the need for community well-being for the sexual and gender diverse population. However, one of the major problems was the lack of understanding of mental health that limited the scope for community well-being among the participants. Freial, a staff member of Bijito also noted that the role of political leaders and activists, especially those who are female, is essential so that the whole society can be included under an approach of well-being. This is because working for the well-being of a community that is stigmatised may not be a feasible campaign, thus working for the well-being of the whole society needs to be such that it can include the well-being of every group of disadvantaged and marginalised communities.

Justice is also another relevant concept that is connected to healthcare discrimination. The reason why justice is essential is because the participants often made a rational choice of disclosure to healthcare providers with the expectation of getting justice and equal rights to health support. Moreover, justice models, in theory, have also signified the role of socio-cultural factors of health (Braveman & Gottlieb, 2014). For example, justice theory proposes that health is affected by numerous social factors such as working conditions, nutrition, social exclusions, stress, addiction, social support, and early life conditions (Ekmekci, 2017). These factors are severely affected by the oppression experienced by the participants and they simultaneously affect the participants' health.

I have argued from the literature that healthcare is a human right. It is evident from the data that participants experienced exclusion and deliberate stigmatisation when they attempted to access healthcare. Therefore, participants were arguably being deprived of a basic human right. However, depriving stigmatised people of accessing healthcare becomes a human rights violation. However, there has been a noteworthy contradiction regarding the nature of human rights because universal human rights are undermined due to the complexity and differences among various cultures and regions. Hence, many would argue that perhaps universal human rights are not considered as such in the Bangladeshi context. Different societal imbalances can create barriers for human rights, thus affecting its universality, particularly for queer populations (Mulé, 2018). Hence, patriarchy one of the social influences, especially the right to health and healthcare for sexual and gender diverse populations.

Human rights are frequently undermined based on the limitations of recognising the complete personhood of sexual or gender diverse people (Hogan, 2015). A reason for such censure of human rights is argued by Ammaturo (2017), that human rights traditions have not been adequately flexible to understand the fluid conceptions of sex and gender (As cited in Cornwall, 2020). For example, although there has been an uplift of recognising the individuals born with intersex characteristics in international human rights strategies, such recognition is barely considered in many national laws of different countries, leaving these individuals noticeably vulnerable to human rights violation (Cornwall, 2020).

Since I identified a potential explanation of how human rights and their nature can differ in terms of region, culture, and religion (Mutua, 2002), it can be argued whether healthcare is practised as a human right in Bangladesh. The evidence suggests that the participants were frequently denied access to healthcare after their disclosure, which implies that healthcare is not equally provided to everyone in this society. One may argue that looking at healthcare as a human right from the perspective of one section of the population does not mean that healthcare is not a human right in the overall scenario in Bangladesh.

Bangladesh is a signatory to many international declarations and treaties, and ratified covenants to ensure the ‘right to development’ as a mean to promote human rights; it also ratified the International Covenant on Civil and Political Rights, International Covenant on Economic, Social, and Cultural Rights (Rahman, 2006), and Convention on the Rights of the Child (Office of the High Commissioner for Human Rights, 2018). Despite not being a signatory to the UDHR, many of the rights claimed in the UDHR have been incorporated in the Constitution in Part III. However, a number of rights are yet to be given the status of enforcement in case of violation (Hosain, 2013). The Declaration clearly sets out medical care as a right (Article 25) and the Constitution of Bangladesh (Part II - Article 15) also defines medical care as a basic necessity (Rahman, 2006), which makes medical care or healthcare a legal right in this country. By denying healthcare to any segment of the population — either in theory or practice — it is clear that the government and its functionaries do not believe that human rights are universal. Therefore, Bangladesh is in violation of its obligations under the Constitution as well as not promoting the Universal Declaration of Human Rights.

Arguing that healthcare is not a human right in may seem ambiguous to many people because many people are not yet ready to unveil the curtain of patriarchy. This is not their fault because historically, socio-culturally, and religiously, many people have been taught to think in a patri-normative way where masculine attitudes and values are thought as normal or default beliefs in society. Hence, it may be almost impossible for many Bangladeshi people to think out of the patriarchal box to see what is going on in the name of oppression of sexual and gender diverse communities. As mentioned above, human rights can differ due to the variation in culture and society. The socio-cultural system has been historically constructed in a patriarchal way where the state and the general public are often willing to marginalise and stigmatise sexual and diverse communities. It can be argued that different government institutions and many people may not be aware of the fact that the stigma they demonstrate against these communities is indeed a consequence of patriarchy. This is why it may be difficult for the government, police, and many people to acknowledge that they are unconsciously serving the purpose of patriarchal oppression by using religious interpretations and an old British colonial law.

While studying the socio-cultural construction of homosexuality, many scholars have argued that the prohibition of homosexual behaviour in religion was an outcome of class struggles (Greenberg, 1988). Similarly, the homophobic oppression of sexual and gender diverse communities can be regarded as an outcome of the dominance of a gender class, which is male. Many men do not accept people from sexual and gender diverse identities as equal to them. As a result, the participants were given a few equal rights and opportunities, so they were suppressed under a male-dominant system.

One of the facets discussed in this research is medical social work. Social workers in health settings can reduce discrimination and help maintain fair and equal healthcare for everyone including disadvantaged populations (Ali et al., 2020). Medical social work is a concept that is not yet properly developed in Bangladesh due to the lack of professional recognition of the social work profession. Therefore, there is very limited evidence to further analyse it. Nevertheless, I propose that installing properly trained social workers into healthcare environments can go some way to safeguarding human rights and human dignity of all people. Respect for human dignity for every person is one of the core values stated by the *Global Social Work Statement of Ethical Principles* (International Association of Schools of Social Work/International Federation of Social Workers, 2018). But the understanding of respecting human dignity can be mediated in many ways by social workers depending on the cultures and contexts in which they are practising (Sewpaul & Henrickson, 2019). The findings indicate that stigmatised populations, especially sexual and gender diverse communities, are neither treated equally to the dominant culture nor with human dignity. Therefore, social workers can play an important role as cultural mediator to minimise discrimination in healthcare settings regardless of a person’s socio-economic background and sexual and gender orientation.

I argue from the data that healthcare is used as a tool for oppression by discriminating against the participants to get access to health support. There are two major reasons to justify this argument. First of all, sexual and gender diverse communities are mostly hidden. Therefore, it is almost impossible for the government to identify or socially control them as a whole as long as these communities are not visible. Given this scenario, it can be regarded that healthcare discrimination is one way to socially control these communities by forcing sexual or gender diverse individuals to identify themselves.

Secondly, in terms of historical and socio-cultural construction, we can assume that the prohibition of homosexuality was an outcome of the suppression and social control of a particular social class. Similarly, the participants’ experiences of healthcare discrimination can be seen as a patriarchal attempt to control a particular group of people who belong to sexual and gender diverse communities. Such use of healthcare as a tool for oppression can contribute to the patriarchal oppression of sexual and gender diverse communities. Previously, this oppression was perhaps reinforced through religious interpretations and later by the punitive law introduced by the British Regime. However, contemporary Bangladeshi society is using a new approach of depriving the participants of healthcare to hold on to this patriarchal oppression in society.

One may argue that the government and the state are not deliberately attempting to deny access to healthcare for marginalised communities. Some may also argue that the findings are nothing but random and unexpected incidents in healthcare settings. Thus, they may challenge the findings by saying that a few individual healthcare experiences cannot generalise the oppression of the whole society. Nevertheless, I argue that healthcare discrimination is neither an individual nor an unexpected incident for the participants. The agencies that work with sexual and gender diverse communities also shared the same belief pertaining to healthcare issues through their many years of service and observation, and this is one reason they urged that healthcare should be the main focus of this research in order to represent the overall oppression experienced by sexual and gender diverse communities. Furthermore, the purpose of the research findings is not to generalise healthcare discrimination among sexual and gender diverse communities because positive healthcare experiences are also reported in the data. However, every incident of healthcare discrimination of the participants was followed by a similar pattern or trend — the expression of stigma in the form of insults, neglect, abuse, and humiliation, which were expressed through the behaviour of the healthcare providers. This evidences that ostracising the participants from health support is an impact of stigma, which is an expression of a patriarchal social system that oppresses marginalised communities. Therefore, it can be stated that healthcare is used as a persistent instrument for the oppression of sexual and gender diverse people in a male-dominant society.

There is no denying that socio-economic discrimination — such as a lack of education and employment, and a lack of acceptance — is also as important as any other form of discrimination. The reason why I focused on healthcare discrimination throughout this research is because of the implications of a justice model. A theory of justice emphasises the role of the socio-economic factors of health to discuss that health is a central concept of justice. Not only do socio-economic factors affect the health status of a person but the effect of health status can influence the socio-economic life of a person in the future. Therefore, health and healthcare deprivation can be considered as important as other forms of socio-economic discrimination experienced by the participants of this research.

The relationship between healthcare and Section 377 of the 1860 Penal Code is also found to be an important factor in this research that creates a connection between health and oppression of sexual and gender diverse communities. The data suggest that this punitive law created a major barrier for the participants to disclose their sexual and gender orientations in society, especially in healthcare settings. The disclosure of their identities may create legal problems due to the implications of this law, thus a fear was implanted among the participants to disclose, which affected both diagnosis and treatment. Moreover, it is undeniable that this fear of disclosure while visiting a healthcare setting can create a significant impact on mental health. Considering this scenario, the participants often faced a complicated situation whether to disclose or not while visiting a healthcare provider. Hence, it can be seen that Section 377 creates an immense effect on the healthcare experiences of the participants, which further prolongs the oppression through healthcare.

9.6 Summary

I discussed the limitations of this research at the beginning of this chapter by considering the sensitivity of the topic and safety issue of this research. I also described the limitations to justify how I applied research methods and methodology in this research, and how future researchers can use different methods in different ways. The analysis and discussion of this research suggest that oppression of sexual and gender diverse communities emanates from the patriarchal social structure that is perpetuated by religion and colonial values and mindset. Therefore, the chapter considered the nature of a patriarchal society to discover masculine beliefs embedded in a post-colonial state. The first sub-question emphasised the understanding of what it is like to be a sexual or gender diverse person in an Islamic patriarchal society. The discussion of the oppression in a male dominant society entailed participants' experiences of different kinds of fear, violence, sexual abuse, public harassment, police violence, and stigma that are derived from a male dominant socio-cultural system. I regarded all these facets as different forms and consequences of patriarchal oppression. Then I discussed the implications for society, law, government, and NGOs to understand the perceptions of the government, NGOs, and other institutions toward health and healthcare. To discuss this, it was necessary to explore taboos on sexuality, healthcare services of NGOs, the relevance of law, and the government's attitude, policy and guidelines.

The next sub-question aimed to investigate the healthcare experiences of the participants. I described healthcare experiences in this chapter to argue whether healthcare is a human right or a tool for oppression through healthcare discrimination. This section also discussed how healthcare discrimination is theoretically important to expose the oppression experienced by the participants. The overall discussion in this chapter is based on the findings that are related to the three sub-questions. The arguments discussed in terms of these research questions give us an understanding that healthcare is not practised as a human right and can be regarded as an important lens to look at the oppression of sexual and gender diverse communities in a patriarchal society.

Chapter Ten: Conclusion

10.1 Introduction

Throughout the analysis and discussion chapters, I discussed how healthcare can be regarded as a major lens to understand the oppression of sexual and gender diverse communities in a patriarchal society. This argument was supported by three major sub-questions of this research to justify my opinions based on the findings. The purpose of this chapter is to provide a transparent though succinct overview of the concluding thoughts derived from this research and to consider some next steps. The concluding remarks include a discussion of the main research aim alongside the answers to the research questions by summarising the research findings. Based on the research questions, my findings are briefly explained so that the argument of the main research theme can be justified. The concluding remarks also summarise the relevance of this thesis to the field (social work) of the research. This chapter includes some policy and practice recommendations and suggestions for further research resulting from the findings and discussion of this study.

10.2 Concluding remarks

Bangladesh is a post-colonial nation. The colonial legacy has been a predominant characteristic for the construction of the socio-cultural system in this country. One of the major features of the colonial influences that continues in Bangladesh is the oppression of sexual and gender diverse people. From the simplest of understandings, the oppression against these people is empowered because they decide not to conform to the socially assigned gender roles. Many argued that this oppression is arguably a consequence of a modern-day phenomenon: homosexuality. However, there has been historical censure for such argument because homosexual behaviour is not a modern-day phenomenon: instead, it has existed in the South Asian region for at least millennia. Other religious mythologies (e.g. Greek and Hindu) also have examples of same-sex behaviour. Nevertheless, the British Regime officially started the oppression of sexual and gender diverse people by introducing a punitive law (Section 377). This was an attempt to legally exclude sexual and gender diverse communities from mainstream society and deprive them of their basic and human rights. Many would argue that the reason for ostracising, stigmatising, and oppressing sexual and gender diverse communities is the interpretation of religious excerpts. However, I argued throughout this thesis that the main factor of this oppression is neither colonialism nor religious interpretations alone, but rather patriarchy is the main cause behind the oppression that has been deeply embedded in the South Asian countries for many centuries. Therefore, societal discrimination against sexual and gender diverse people deriving from a male-dominated society gradually turned into its current brutal form.

Discrimination against sexual and gender diverse communities is multifarious. This discrimination has emerged from patriarchy constructed since the Mughal Empire — or even before — and it was also reinforced by British colonisation. One can argue that the reason why colonialism was tolerated for so long is that colonialism and Islam had common goals of preserving the power of men. Further, it was not all men who were served by colonialism, but only those who collaborated with the British — certain castes and classes of people were invested in the maintenance of historical patriarchy. Patriarchal influences have led to discrimination, which is multidimensional because the stigmatising behaviour and incidents against sexual and gender diverse people impact different facets of their life, which manifests the overall social control and collective oppression.

This oppression is collective because it has many facets: for example, disclosure of sexual and gender diverse people can expose them to public harassment, abuse, and insults. However, disclosure is arguably a two-edged sword because, despite the risks of disclosure, hijra have been recognised as a third gender, which is regarded as an outcome of their public exposure. Additionally, police violence is another form of oppression sexual and gender diverse people can face in day-to-day life. Due to their disclosure, they can become homeless, isolated and socially excluded. All these aspects of oppression are analysed and investigated in this research from the participants' understanding and experiences, and one of these is deprivation of basic needs. One of the most essential rights is the right to health and healthcare, which was frequently violated for the participants. The reason why healthcare deprivation becomes a major issue is that health and healthcare relate to all the other important rights such as the right to education, accommodation, employment, and to be legally accepted. While theorising justice, I argued that health becomes a core lens because the socio-economic situation affects the health of a person and the health status can affect a person’s socio-economic condition in the future. Hence, healthcare is taken as a major lens in this research to understand the overall socio-economic oppression experienced by the participants.

The problem of considering healthcare as a major lens to understand the oppression of sexual and gender diverse communities is that, in theory, the right to health is a human right. I explained that human rights may not be universal, and the nature of human rights can vary in terms of region, time, and culture. Based on the findings, the right to health and healthcare is neither respected as a human right nor a legal right in the Bangladeshi context as this right was not available equally to the participants. Although the participants often disclosed their sexual and gender orientation in healthcare settings, hoping that justice and equality would be maintained, in most cases their rational choice to disclose brought negative consequences. I, therefore, claim that healthcare is in practice not a human right in Bangladesh, at least not for sexual or gender diverse individuals.

To justify healthcare as a lens to understand the oppression of sexual and gender diverse communities, an explanation of how healthcare is perceived from an individual and institutional point of view was required. The implications for society, law, NGOs and government and its policies were analysed in this research to understand how sexuality, health, and healthcare is conceived in a post-colonial state. It is evident in the findings that healthcare discrimination, a human rights deprivation, is one of many ways to socially control and collectively oppress marginalised populations. This is because providing equal healthcare access to everyone is inconsistent with cis-het patriarchy and undermines a male-dominated system. This system defines sexually deviant behaviours and identities and implied that deviance must be stigmatised, controlled and extinguished because it challenges the gendered roles required by patriarchy to maintain its privileges and power.

The findings and analysis of this study urge that patriarchal social construction is the main factor that influences many men (and some women) to hold on to the historically existing male domination or privilege over any other sexual and gender identities except cis-het men. This social construction of hegemonic masculinity is historically, religiously, and culturally implanted in the mindset and attitude of most people, and embedded in the government system, law enforcement agencies, and different institutional levels. This has been rooted in every aspect of society in a way that most people are taught to subconsciously think everything in a masculine way. Additionally, perceiving every small matter of life from a patriarchal perspective has become the default or normal way of living, which formed a patri-normative society. The patri-normative values are so powerful and influential that people can barely realise that what they represent is nothing but an expression of hegemonic masculinity. It is difficult to deal with such patri-normativity because people are rarely aware of the fact that they represent patriarchal values and behaviour; thus, it becomes almost impossible for them to deal with. My thesis seeks to expose this patri-normativity to everyone so that people can be aware of patri-normativity that has been implanted inside their head since the moment they were born. The goal of this research is to look for ways to rebuild an inclusive society where disadvantaged groups of people can have equal rights and opportunities. To do this, I envisioned this research to help people realise that by stigmatising and oppressing sexual and gender diverse people, they are only serving a patri-normative society.

However, debating the issue of patri-normativity is not an easy task since it is socio-culturally and historically rooted in society. Hence, I focused on three different research questions and the answers to those questions can help clarify the debate of patri-normativity. The first question emphasises the understanding of what it is like to be a sexual or gender diverse person in an Islamic patriarchal society. To respond to this, I explained the nature of patriarchal society. Since Bangladesh is a post-colonial state that still maintains colonial values in the socio-cultural system, the societal attitude and stigma toward marginalised communities have hardly changed. Additionally, the government and law enforcement agencies represent hypermasculinity values at different institutional levels that do not allow sexual and gender diverse people to be legally accepted. As a result, the participants experienced the oppressions of their society in their daily lives.

The oppression that a sexual or gender diverse person can experience is multifaceted because it has numerous forms and impacts. It is worth noting that all these forms and consequences of the oppression have a direct and indirect impact on the physical, mental and sexual health of the participants. First of all, the lack of legal acceptance has created a major hindrance for sexual and gender diverse communities to be publicly disclosed, thus they are somewhat invisiblised in society. Furthermore, the taboos associated with sex and sexuality impact and reinforce this nondisclosure, which allows the government to claim that sexual and gender diverse communities rarely exist in Bangladesh. By doing so, the government has been successfully avoiding the existence of these communities. One of the major reasons for being invisible in society is the fear of being threatened, abused, and killed by extremists. In this respect, extremists are aligned with the government agenda and help to enforce it. Self-identification expressions are also related to disclosure. The reason for this is that lack of visibility due to nondisclosure is one of the major reasons that prevent the younger generation from having necessary information and awareness, particularly when many of them struggle during their self-identification expression. This is a consequence of the oppression of sexual and gender diverse communities that can force younger sexual and gender diverse people into frustration, isolation, and suicidal tendencies.

Secondly, even though sexual or gender diverse persons can sometimes disclose themselves in society, this often brings negative outcomes such as homelessness, denial of the right to education and employment, and public harassment. These are the common risks that a sexual or gender diverse person has to live with if they want to disclose who they are. However, disclosure can also be unintentional because friends, family, or even healthcare providers can expose a sexual or gender diverse person, which is related to the concept of ‘virtue signalling’. For example, a healthcare provider can expose a sexual or gender diverse person to emphasise the so-called moral correctness of the provider. Moreover, disclosure is also found to be detrimental for relationship experiences. The relationship experiences of most participants did not last long due to the risks of disclosure. For example, as we have seen, after disclosure, both individuals of a same-sex relationship are often exposed to physical and emotional abuse, thus their relationship cannot continue.

The oppression of sexual and gender diverse communities was also seen at the family level because participants often lacked support from their family after disclosure. Consequently, they have to leave home and break ties with their families. One reason for such a lack of familial support is found in this research: the dearth of understanding the worldviews of sexual and gender diverse people toward sexuality, life, and religion. The differences between the worldviews of sexual or gender diverse individuals and their family members create psychological distance between them and the relationship tends to gradually break down. In addition to this, family members were also affected by the societal stigma and mockery that the participants experienced, which eventually separated them. The lack of family support also has some negative impacts. For instance, if a young sexual or gender diverse person is left without familial support, it is difficult to continue their education, thus they can rarely find work and are forced to engage in the sex trade.

The oppression of sexual and gender diverse communities become more brutal as the participants were also exposed to sexual abuse, harassment, and rape. It is an irony that the police as a law enforcement agency are supposed to protect marginalised people, but they play a big part in the sexual abuse of sexual and gender diverse people. Additionally, at educational institutions, workplace, and public parks, the participants were exposed to sexual harassment. Male rape is a very critical issue because there are few reports or statistics of male rape in Bangladesh. The implications of Section 377 do not allow the victims of male rapes to report the incidents. It is important to mention that male rapes that go unreported and unnoticed by the legal system can have severe health consequences for sexual and gender diverse people, which are completely overlooked.

Participants experienced the violence of the police in different ways. Firstly, gender-based victimisations such as physical abuse, beatings, and public humiliation were frequently experienced by hijra participants. Secondly, the attitude of the police is not very helpful when a sexual or gender diverse person is in trouble, which is an expression of showing control over marginalised populations. For example, it may take more time than usual to file a legal complaint or a general diary for sexual and gender diverse people. Additionally, rape or gang rape performed by police is another form of oppression that is related to the concept of homoeroticism. One can argue that such sexual assaults of marginalised populations are an expression of unlawful punishment perpetrated by the police. The purpose of such rape and homoerotic behaviour of the police can be constructed as an expression of male domination. Thus, the expressions of gender based-victimisations, unlawful punishments, and showing control over marginalised people manifest a social world where power is practised by police — as a hypermasculine institution — representing an expression of patriarchal oppression faced by the participants.

The oppression experienced by sexual and gender diverse people further extends to the deprivation of basic needs such as education, accommodation, and employment. Consequently, the participants faced financial, educational, and occupational problems. This deprivation of rights works like a chain. To elaborate, if a sexual or gender diverse person is homeless without familial support, they are often unable to financially support themselves for education, thus they can become unemployed in the future. Subsequently, they may experience financial problems and can sometimes be forced to engage in occupations that involve a considerable number of health risks, such as sex work. This deprivation of rights is also affected by a lack of awareness and internal conflicts amid sexual and gender diverse communities. This is because internal conflicts and lack of awareness can encourage the majority of the population to pressurise and oppress these communities to an extended degree. The internal conflicts are mostly patriarchal effects because there can be significant differences in attitudes between transmen and transwomen, which is an impact of patri-normativity.

The implications for society, law, government and NGOs in understanding health and healthcare are important because they clarify how healthcare is conceptualised and perceived from the individual level to institutional levels. The taboo around sex and sexuality in society is the first implication that can affect the understanding of health, particularly for sexual health. Since this taboo does not allow talking about sex, it severely affects the understanding and awareness about the sexual health of the people. Although we know that sexual health is a matter of importance for the whole population, the societal taboo around sexuality does not let people discuss it or raise awareness of it. The taboo of sexuality is also supported by the use of religion because, from a religious point of view, discussion about sex and sexuality is often discouraged. Additionally, the way a patriarchal society used religious rituals and interpretations in favour of serving masculine interests did not allow the participants to think out of the patriarchal box, thus affecting the participants' religious standpoints. The religious stances of the participants were also affected by patriarchy and this somehow created conflicts. For example, the way religious interpretations are used to prohibit homosexual behaviour can simply contradict the worldviews of the participants. Such a contradiction between religious values and justification of one's own sexual and gender diverse orientation can create substantial mental impacts, such as frustration, isolation, and suicidal tendencies. Hence, mental health was affected by the taboo of sexuality and religious stances of the participants.

There is also a societal lack of awareness to understand sexual and gender diverse identities. This lack of awareness can come at a big cost because as long as the government, law enforcement agencies and other institutions do not properly learn and understand about sexual and gender diverse communities, they can perpetuate the discrimination against these communities. For instance, the intolerant attitude of healthcare professionals in healthcare settings can expose sexual and gender diverse people to stigma, insults, and deprivation of rights. Most importantly, with this intolerance, these professionals are maintaining patriarchal oppression of sexual and gender diverse communities, and sometimes they are even unaware of this fact.

The government is aware of the fact that sexual and gender diverse communities are frequently discriminated against in health systems, thus the 7th Five Year Plan has included a provision for 'sexual minority groups' which stresses the need for health support. This provision has a significant drawback as it does not specifically mention every group of sexual or gender diverse individuals. Additionally, the term 'health insurance' is used in a way that can be contradicted in the context of the health system that hardly provides health insurance for any people in society. This indicates that the lack of understanding of health and healthcare remains a challenge in government.

Many would argue that manipulation of terms related to sexual and gender diverse identities and health needs in the 7th Five Year Plan is deliberate because then the government does not necessarily need to accept these populations. The reason for such governmental behaviour is perhaps encouraged by the interest of political parties to hold on to power. In other words, by providing legal acceptance to sexual and gender diverse communities, political parties could lose support from the majority of the voters, thus the government is reluctant to take any measures to help these communities. Given this scenario, the government persistently denies sexual and gender diverse communities their rights which ostensibly continues the momentum of patriarchal oppression of these communities. The government is not willing to mention terms such as 'gay' or 'lesbian' in their statement because they worry about the loss of public support. Therefore, the manipulation of terms that is currently in effect excludes sexual and gender diverse communities from the society and exposes them to discrimination of rights, including healthcare. Thus, the government can be regarded as a patriarchal institution that does not allow marginalised communities to be free of patriarchal oppression. Nevertheless, I considered the differences in attitudes of the governments in Bangladesh and Pakistan may be different, despite both these nations being populated with a Muslim majority, and there may be a difference in how the general public behave toward marginalised populations due to the impacts of religiously conservative attitudes.

It is worth noting that the attitude of the general public toward marginalised communities is usually based on traditional norms and male-dominant values that have created a collective stigma toward these communities. This stigma is created by a society that privileges men so that any other gender identities except male can be continuously disempowered. For example, the position and status of women have been historically suppressed by using religious rituals and values. To continue this suppression, stigma is further formed so that sexual and gender diverse communities can be ostracised from mainstream society.

The impact of this stigma was detrimental to the mental health of the participants, which was rarely understood by the government or healthcare agencies. The concept of mental health is still underdeveloped and the participants' messages for young sexual and gender diverse people shared in this research utterly emphasised mental health. However, a few NGOs and INGOs have been providing healthcare services for sexual and gender diverse people in order to enable them to cope with their mental health problems as well as sexual health issues. Importantly, the role of the peer educators of Bijito is significant because they educate sexual and gender diverse people about different aspects of health risks such as STIs, sexual health, and mental health. Because the funding and access to the donor agencies have become limited, it has confined the health services provided by non-governmental organisations. The gradual relocation of many HIV testing services from NGOs to government hospitals has created major concerns for sexual and gender diverse communities. This is because the participants were more likely to be exposed to discrimination in government health settings than private ones such as clinics. This indicates that government decisions and policies can directly affect the health-seeking behaviour of the participants.

The last research question focuses on how sexual and gender diverse people experience healthcare in Bangladesh. The findings suggest that the participants often experienced insults, discrimination, and deprivation of healthcare. The participants experienced different types of health issues, for which they needed medical attention. Mental health problems are the most important reasons why sexual and gender diverse people arguably need healthcare more than others. The mental health problems are largely created because of the stigma and fear that they have to live with. Additionally, many sexual and gender diverse people live with dual identities by hiding their sexual and gender orientation from their family, neighbours, and friends (Rashid, Standing, et al., 2011).

Thus, isolation and frustration become a common part of their life. Apart from mental health issues, gender confirmation surgery is another aspect that requires significant consultation from healthcare professionals. This is because gender confirmation surgery can have many negative impacts on health that were unknown to the participants as they found it difficult to discuss such impacts with any healthcare providers. The legal barrier to performing gender confirmation surgery does not allow physicians to consult or perform this surgery in Bangladesh. As a result, participants were mostly unable to receive proper consultation regarding this surgery. Even if a healthcare provider is willing to help, gender confirmation surgery can be risky as well as expensive. Similarly, gender confirmation hormone therapies are expensive. Transman and transwomen participants tried to use gender confirmation hormone therapies, but they found it very expensive. There was little access to consultation about these therapies, which made these therapies rather risky for the participants because the side effects of a certain hormone dose were often unknown. All the special health and medical attention required for sexual and gender diverse communities can make then more vulnerable to healthcare discrimination.

Individual healthcare experiences of the participants suggest that sexual and gender diverse people can be exposed to discrimination in healthcare settings. Both insults and negligence were expressed to the participants, including negative healthcare behaviour of the healthcare providers. Discriminatory and negative healthcare experiences indicate that patriarchal and colonial values continue to influence the way sexual and gender diverse communities are treated. It is very important to note that disclosure is one of the major factors that can impact on healthcare experiences. For example, if a sexual or gender diverse individual makes a rational choice to disclose their sexual and gender orientation, they may be exposed to negative healthcare behaviour. In contrast, without disclosure, a sexual or gender diverse person is less likely to be exposed to discrimination. This discrimination of healthcare is a tool for oppressing sexual or gender diverse individuals. The implication of a justice theory is that healthcare can be heeded as a major lens to understand the overall oppression of sexual and gender diverse people because healthcare discrimination can affect the socio-economic situation of an individual.

While arguing healthcare as a human right, I am forced to question the universal nature of human rights due to the differences in socio-cultural construction of different regions at different times. For example, due to a conservative socio-cultural situation, freedom of expression (e.g. expression of sexuality) cannot be considered as a human right, despite this right being clearly set out in the UDHR (Article 19). To be able to ensure healthcare as a human right, society, government, law enforcement agencies, and other relevant institutions need to change their patriarchal attitude so that every group of disadvantaged people in this country can access equal health services. Additionally, to consider healthcare as a human right, I envision a society where disclosure of sexual and gender diverse people would not make any difference to health services while visiting a healthcare setting. However, the findings do not seem to resemble this vision, thus healthcare cannot be claimed as a human right in the Bangladeshi context.

Discrimination in healthcare can also have an adverse effect on public health that the government seriously needs to reconsider. This kind of public health concern, along with the oppression of sexual and gender diverse communities, is a challenge for the few organisations that work with these communities. Consequently, rights movements in the form of activism and campaigns are conducted, but due to the threats of assassination and violence, rights-based practices cannot move forward. Online campaigns such as blogging are also threatened due to the ICT act and Digital Security Act. A new approach, art-based movements, is proposed by the activists so that different forms of arts can be demonstrated to create an impact on the attitudes of the general public in order to raise awareness of sexual and gender diverse identities. There are some useful facets analysed in this research that are relevant to healthcare, such as medical social work, maintaining ethical standards of healthcare professionals, and the importance of well-being. These aspects are very crucial because if we can work on each of these aspects, it may undermine a patriarchal system in order to ensure equality and justice, especially in healthcare delivery. Hence, these facets are also regarded as keys to deal with the patriarchal oppression of sexual and gender diverse communities.

This research is relevant to the social work field in several ways. First of all, the notion of human dignity and human rights are major concepts of the social work profession. This profession aims to work for a system that can serve human dignity and human rights for every human being regardless of their sex, age, socio-economic and cultural backgrounds. Secondly, medical social work is a very well-developed concept in many developed countries. However, in the Bangladeshi context, medical social work is still underdeveloped due to the lack of recognition of the social work profession. Still, the necessity of social workers in health settings is immense, particularly in dealing with healthcare discrimination of marginalised communities. Lastly, reforming a society that liberates beyond the challenges of human rights is a duty of social workers, by which they can achieve social justice. As a social worker, I take this responsibility very seriously and professionally so that human dignity, human rights, and social justice can be ensured for every everyone.

The findings disclose the oppression of sexual and gender diverse people, creating a connection with anti-oppressive social work practice. Anti-oppressive social work practice is a radical emancipatory social work approach that aims to free people from oppression and discrimination (Dominelli, 2002). Understanding the nature of the oppression of sexual and gender diverse people from a humanistic and social justice point of view are two major elements of anti-oppressive social work practice.

The most significant impact of this thesis is to expose patri-normativity to the reader so that they can understand there is a hidden agenda of oppression of a marginalised population, which is the reinforcement of male domination. This male domination is harmful to our society because it lies in every corner in society: from family to government systems. I strongly believe that my research has contributed to the understanding of the concept of patri-normativity that arguably extends and clarifies the brutal nature of patriarchy. This thesis is considered to be essential to help the policymakers, healthcare settings, law enforcement agencies, government and other authorities to realise what they have been doing to these marginalised communities is nothing but a silent expression of masculinity. Therefore, the findings and arguments presented in this thesis can help the mentioned authorities to reconsider their actions of stigmatising and oppressing sexual and gender diverse communities.

Policy and practice recommendations

Based on the findings and analysis of this research, I would like to propose some policy or practice recommendations.

- The government could consider avoiding ambiguity by using different terms to acknowledge the existence and existing issues of sexual and gender diverse communities.
- Also, the next (probably 8th) Five Year Plan needs to be planned in a way that the health provisions are congruent with the National Health Policy, even if it requires amending the Policy itself.
- The government needs to take measures so that healthcare providers at different levels are well informed and trained about sexual and gender diverse identities.
- Instead of solely relying on international donors and contributions from NGOs and INGOs, the government needs to be serious about providing necessary support and resources so that HTC units can be increased, necessary medications for HIV can be widely available, and everyone can get access to healthcare delivery regardless of who they are.
- Transparent guidelines must be formulated in favour of gender confirmation surgery and gender confirmation hormone therapies so that people can consult with healthcare professionals before undergoing the gender confirmation process to any avoid adverse health effects.
- Policies and guidelines need to be further strengthened to address the issues related to mental health so that both stigmatised and non-stigmatised populations can benefit from useful mental health services.

10.3 Recommendations for further research

There are some major recommendations for further research that can be made based on the findings. The understanding of mental health and mental health status of sexual and gender diverse populations can be studied so that we can investigate the factors behind mental health problems. Additionally, it can also be useful to identify the reasons behind the underdeveloped concept of mental health, particularly from a queer perspective. Future research could be an investigation of the attitude of healthcare professionals while seeing sexual and gender diverse patients. This research can be influential to study how socio-cultural construction and religiously conservative attitudes influence the behaviour of healthcare providers to treat patients who are sexual and gender diverse.

The healthcare experiences are analysed in this study, though there are differences in healthcare experiences of queer men and women, to understand the subtle impact of patriarchy in healthcare settings. If an intra-analysis can be conducted of the differences in healthcare experiences of different groups (e.g. men and women, or transmen and transwomen) of sexual and gender diverse communities, then it can bring a much clearer picture of healthcare discrimination. Furthermore, since disclosure plays an important role in healthcare experiences, it might be a better idea to study the differences in how queer men and women experience healthcare. This research scope can further extend to the understanding of how the attitude and behaviour of the healthcare providers change based on the gender identities of queer patients. This idea can be investigated from another point of view: for instance, how gender identities can affect the disclosure of sexual and gender diverse patients in healthcare settings.

An extensive systematic analysis of government policies, the intentions of public agencies, and objectives of state actors could not be developed from the experiences of participants, who largely saw policy from a ‘consumer’ point of view. The inability to engage in this kind of analysis could be considered a limitation of this research. Such a systematic analysis of government policies and an investigation of objectives of state agencies and actors is an area for further research based on the foundations provided by the present study.

Many sexual and gender diverse people may find themselves in two minds whether to disclose or not. The decision of disclosure versus nondisclosure can create some mental conflicts and anxiety even before visiting a healthcare setting. Therefore, the mental health impacts before disclosure or nondisclosure in front of healthcare providers need to be studied to understand how this decision influences the emotional and psychological conditions of sexual and gender diverse patients. It is also important to delve into the factors behind the rational choice of disclosure or nondisclosure in healthcare settings. A sexual or gender diverse person often assesses the situation and anticipates the probable outcomes before disclosure. Thus, it would be essential to understand the motivating factors that encourage sexual and gender diverse people to make this rational choice of the disclosure.

Since I drew a connection between homophobia and patri-normativity throughout this thesis, it could be important to further analyse this issue by investigating how homoeroticism is related to the expression of male dominance. Also, the universality of human rights can be examined from a queer perspective to understand how socio-cultural differences weaken the universal nature of human rights. Lastly, further research can be conducted to study the risks for rights-based practices of sexual and gender diverse communities. This research idea can help to identify probable challenges for bloggers and academic researchers to raise their voice to support marginalised communities.

One participant observed that the attitude of the general public toward sexual and gender diverse communities in Bangladesh is different from the people in Pakistan. However, having inadequate evidence for such an observational statement can lead to a cross-national analysis between Pakistan and Bangladesh.

Some friends and colleagues in Bangladesh had tried to discourage me from undertaking this project due to my interest in working with sexual and gender diverse communities. In this way, I experienced a kind of secondary stigma. Nevertheless, my passion for human rights, the social work profession, and justice for the people who have been killed and frequently oppressed enabled me to remain motivated with this project. This research significantly impacted my understanding, worldviews and epistemologies toward life, religion, and especially gender and sexuality. During my fieldwork, several incidents also made me realise how sexual and gender diverse communities live with fear and threats. Before starting this research, I was not completely aware of how and why sexual and gender diverse identities are marginalised through patri-normativity and heteronormativity. This research helped me to understand how my values and norms were previously influenced by patri-normativity. The journey in this research allowed me to challenge those norms and values and overcome the influence of patri-normativity. It is my hope that other people will examine how so-called traditional norms and values have influenced their individual values, and so understand what has contributed to the stigmatisation of sexual or gender diverse persons.

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Appendix A: Research ethics approval

MASSEY
UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Date: 08 November 2018

Dear Kanamik Khan

Re: Ethics Notification - **NOR 18/58** - **What are the health care experiences of sexual and gender minorities in Bangladesh?**

Thank you for the above application that was considered by the Massey University Human Ethics Committee: **Human Ethics Northern Committee** at their meeting held on **Thursday, 8 November,**

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

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