GUIDELINE ON STANDARD OPERATING PROCEDURES FOR Sexual and Reproductive Health Services for the Third Gender Population

National AIDS/STD Control
Directorate General of Health Services
Health Service Division
Ministry of Health and Family Welfare

Guideline on Standard Operating Procedures for Sexual and Reproductive Health Services for the Third Gender Population

Developed and supported by:

USAID Shukhi Jibon, Pathfinder International

Reviewed and approved by

HIV/AIDS Technical Working Group, Bangladesh Country Coordinating Mechanism (BCCM)

This document is made possible by the support of the American people through the United States Agency for International Development (USAID). The contents are the sole responsibility of Pathfinder International and do not necessarily reflect the views of USAID or the United States Government.

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Preface

Sexual, gender, and bodily diversity are characteristics of every society, every culture, and every country around the world and across time. There are different types of diversity included in the term LGBTQI: lesbian, gay, bisexual, transgender, queer, and intersex. This standard operating procedure focuses on the transgender community.

Like different parts of the world, in Bangladesh, the transgender/hijra community experience rejection from families, religious communities, and other social networks. These factors limit their abilities to exercise their rights and access to essential services such as education, employment, and health care. Moreover, pervasive discrimination and exclusion prevent meaningful inclusion in broader development efforts.

We know that transgender people predominantly seek services from selected healthcare drop-in centers (DICs) that have been developed for reaching out to mostly key population who are at risk of HIV/AIDS. In addition, services at the DICs are not sufficient for meeting overall healthcare needs of the Hijra community. The USAID Accelerating Universal Access to Family Planning, also known as Shukhi Jibon, and implemented by Pathfinder International, seeks to address the SRH needs and ensure access and use of SRH service by the transgender community. Transgender people are citizen of Bangladesh and legally they have access to different facilities and services. This operating guideline describes the detail process of on services of sexual and reproductive health and rights. Besides drop-in centers, this guideline will support the managers, service providers and managers working in different public or private hospitals.

I would like to acknowledge the contribution of the working group members, DGHS and DGFP focal persons and USAID Shukhi Jibon team for their contribution in developing this standard operating protocol.

We specially provide our gratitude to the independent consultant Dr. Nazneen Akhter, Public Health Policy, Planning, Research, and HSS expert for her contribution in developing the SOP.

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Acknowledgement

Guideline on Standard Operating Procedures for Sexual and Reproductive Health (SRH) services for the Third Gender Population has been developed as an emerging need of that community to access SRH care from the mainstream service delivery facility sites. The need to have a clear step-through implementation guideline for the Third Gender service management has remained unattended, henceforth Pathfinder International took the initiative to develop a Standard Operation Procedures (SOP) to deliver SRH service for transgender as part of mainstream care.

The initiative is taken with the guidance and direction from AIDS/STD Program, Directorate General Health Services (DGHS), and with the technical support offered by HIV/AIDS Technical Working Group, Bangladesh Country Coordinating Mechanism (BCCM). I would like to thank the AIDS/STD Program, DGHS, and HIV/AIDS Technical Working Group, BCCM for their generous support.

I would also like to offer my gratitude and thanks to the sub-working committee for their wisdom and intellectual contribution in taking this SOP to a final stage. Also, sincere appreciation to many others who had enormous contribution from the beginning of the development of this document.

I hope that this Guideline on Standard Operating Procedures for SRH Services for the Third Gender Population would contribute a lot in providing quality sexual and reproductive health services to the Third Gender Population.

Md. Mahbub Ul Alam
Project Director, USAID Shukhi Jibon and
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Executive Summary

Making health care services more third gender-inclusive is part of a larger effort for any public or private agencies in order to access improved services to all marginalized and underserved groups. Compared to the severity of public health concerns faced by the greater third gender community, a various range of health system responses such as making SRH information, counselling and care accessible to all third gender as a part of mainstreaming care is the timely initiative to be considered. Successfully promoting public health at community and national levels are deeply linked to and also dependent on providing inclusive services at the individual level of the marginalized community.

Making the health care environment more supportive and inclusive is invaluable for each of the clients, including third gender clients who often feel discouraged and denied due to the inherent body-mind identity chaos which is further fueled by the prevailing stigma and discrimination. The health center may be one of the few public spaces third gender individuals visit where their gender identity is acknowledged, respected and even understood. It is only possible when the health providers are equally sensitized and responsive to the third gender health care needs as a part of the human rights-based response. Educating staff about third gender issues will certainly help the health care centers (public or private) to provide more inclusive services to third gender clients.

It will help to broaden the pool of health care professionals in the community and in the public health field who are sensitive to third gender issues. The only important issue is how to make the ongoing health services and health care facilities more third gender friendly. The development of a standard service operating protocol (SOP) is an essential and timely effort to make the health care facilities accessible and third gender friendly. "***The protocol is an agreed framework outlining the care that will be provided to patients in a designated area of practice. This does not describe how a procedure is performed, but why, where and when and by whom the care is given".*** This protocol will be a directional outline for the remodeling and reorganizing of the ongoing SRH clinics and Govt health facilities more accessible to the third gender community. As health care providers, educators and advocates, we aim to serve all people in our communities with care and respect. The health care service is the best possible avenue through which third gender can access the freedom of socialization and communication can be primarily established in a gradual way thereby the mainstreaming of third gender can be further expanded over the course of time. This can be done through health sector response by allowing third gender people irrespective of their gender orientation and providing them with a supportive, inclusive and nonjudgmental array of services. Part of valuing sexuality as a lifelong aspect of being human is acknowledging and respecting the diversity of individual sexualities, including individual gender identities. Our society becomes increasingly aware of the challenges third gender individuals face in seeking healthcare and education, we should be responsive enough to serve their emerging Sexual and Reproductive health care needs as a part of mainstreaming human rights response.

This third gender/hijra SOP is aiming to bring that vision into reality through developing this protocol alongside trial out/piloting this to understand the pattern of response among third gender in accessing SRH care.

Abbreviation

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
BCC	Behaviour Change Communication
CBO	Community-Based Organization
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHW	Community Health Worker
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DIC	Drop-In-Center
EHR	Electronic Health Record
FSW	Female Sex Workers
FTM	Female to Male
GFATM	Global Fund to Fight AIDS TB and Malaria
HIV	Human Immunodeficiency Virus
ICDDRB	International Centre for Diarrhoeal Disease Research, Bangladesh
INGO	International Non-Governmental Organization
IPC	Infection prevention and control
MARA	Most At-Risk Adolescents
MSW	Ministry of Social Welfare
MoH&FW	Ministry of Health and Family Welfare
MTF	Male to Female
NASP	National AIDS/STD Programme
NGO	Non-Governmental Organization
NID	National Identity Card
OP	Operational Plan
PCP	Primary Care Providers
PWID	People Who Inject Drugs
SCF USA	Save the Children Fund USA
SME	Small And Medium Enterprises
SOP	Standard Operating Protocol
SOPG	Standard Service Operating Protocol Guideline
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TG	Third Gender
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UH&FWC	Union Health and Family Welfare Center
UNICEF	United Nations International Children's Emergency Fund
USAIDS	United Nations Programme on HIV/AIDS

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Chapter: 1

1.1 Background and Introduction:

In Bangladesh, “Third Gender” is the historically adopted appellation as “hijra” which is often translated to mean this third gender, which is basically the persons whose gender identity and expression differ from their sex identity at birth, the lexicon of “Third Gender” more known word in the South Asian context for portraying the hijra community (both male & female). A survey by ASP shows that the estimated number of TG/Hijra in Bangladesh from mapping and size estimation in 2015-16 ranges from 6,867 to 10,199 but other surveys have estimated there are up to 500,000 Hijras/Third Gender in Bangladesh.

The Hijra/Third Gender community is one of the most socially and economically marginalized communities, with a long history of discrimination and exclusion that continues to date. They are the population cohort whose existence is viewed as if they are born to live with an isolated communal existence under a guru (leadership) who is more connected, powerful, and strong also to set the rules for that community. The most heartbreaking fact is that they are unable to live with their families. Parents, siblings, and other relatives, who are hesitant to reveal their true identities. As a result, they must either conceal their sexuality and assimilate or leave the family. Both are unquestionably difficult options to choose from.

They are unable to study in schools due to the poor way they are treated by their classmates and even teachers. For their gender non-normative behavior, they are bullied and humiliated at a young age in school settings. Due to their lack of education, they are unable to obtain good jobs; even jobs that do not require literacy are not offered to hijras because employers and coworkers do not approve of their presence at work. The situation is nearly identical in hospitals. They do not have access to medical care because doctors and staff are uncomfortable serving them. Even if they can afford to pay the fees in the doctors' private chambers, the doctors occasionally mistreat them. Furthermore, most doctors are unaware of their cultural and social status and thus treat them as social outcasts. Due to existing social stigma, medical professionals also provide negative advice to families leading to marginalization. Hijras/Third Gender are frequently subjected to violence, discrimination, and inequality; and treated as outcasts, they are often targets of human rights violations.

For the last many years, the national and international development organization and philanthropic agencies devoted their work and investment to this community in order to reduce stigma and discrimination also enabling society to gradually accept their existence and contribution as a part of the mainstream response. This mainstreaming of the hijra/third gender may take a long course, but the fact is that, many positive pieces of evidence have been created in the society where currently hijra/third gender people are accessing the basic social amenities like HIV/STI awareness and services through Drop-in-centers, primary education, skill full employment through NGOs in Bangladesh. Although the Bangladesh government has recognized hijras as the "third gender," (TG), the social acceptance is not guaranteed. In private, public, and political spaces, Hijras/third genders still face various forms of sociocultural exclusions.

1.2 Justification for third gender SOP in health care

The Hijra/third gender often do not have access to medical health care because of discrimination, not having legal identification documents, and are often a victim of patient rights violations in healthcare settings. There are still huge gaps in providing adequate healthcare and sexual and reproductive health (SRH) services to Hijra/third gender communities. Hijras/third gender (TG) have long been subjected to social stigma, discrimination, isolation, and separation, and many people in Bangladesh still hold a

negative perception of hijras. Also, in many cases, doctors refuse to see them, and attendants/nurses make them wait for longer than others to see the doctor. Most commonly they kept being referred to other doctors, in an endless cycle, where no one ultimately provides them with healthcare. Technologists and technicians refuse to properly do their diagnostic tests, leading to huge expenses. In most cases, they waited at home until illnesses passed whenever they fell sick. Study findings from the "journal of Women and Gender" (2019) and another study on "Transgender Realities in the Context of COVID-19 In Bangladesh" EJAIB , (2021) shown that , third gender people do not have access to good quality SRH services from community clinics, UH&FWCs, Upazila Health Complex and District Hospitals, as well as Private Hospitals, since they feel like to be a victim of stigma and discrimination which may not be true case always. These findings are further echoed by other studies like "Living on the Extreme Margin: Social Exclusion of the Transgender Population (Hijra) in Bangladesh", (2009) and also in an open letter by an independent expert on the "Topics in focus covid-19 and the Human Rights of LGBTI people". (17 April 2020). Given the facts, their long-impregnated mindset discourages them to seek services from mainstream outlets rather they tend to visit informal and clandestine service care sources. There is evidence that when the third gender wants to visit a health care specialist because of a critical medical situation, they cannot access them. They are often informed that the doctors are not present, therefore, they often have no choice but to take care of their medical issues by themselves, even if they are in critical medical needs.

Research has shown that gender dysphoria regarding gender identity usually occurs during and before adolescence when someone is reaching puberty or directly after puberty. Adolescents thus end up dropping out of school and leaving their families behind to live with their Gurus during this age. Moreover, during their adolescent period while they are at the high peak of body-mind transition, often confused, traumatized and also are ignorant of where to seek information, counselling and services. Currently, there is no such dedicated resource exists to provide sensitization to stakeholders regarding gender dysphoria among adolescents. With or without much awareness they tend to get engaged in peer sex, or sex-selling activities and often get infected with STI/HIV. On the other hand, they do not have an option for seeking proper treatment. The hijras are also vulnerable in the sex trade and in several cases their clients sexually assault or forcefully engage them to have unsafe sex, as a result, they are frequently infected with STIs.

During the recent COVID 19, hijra /third gender in Bangladesh have been adversely affected by the pandemic, especially during the national lockdown. During the lockdown, there was discrimination in who received primary healthcare treatment, especially for hijra people. Mental health issues such as anxiety, depressive symptoms, discrimination, suicide, and domestic violence increased worldwide, including in Bangladesh, during the lockdown.

Obtaining treatment and tests for third gender was much more challenging because hospital wards are classified as men or women, with no centre for hijra community members. Health-care providers' insensitive attitudes towards hijras always make them uncomfortable, hijra /third gender people tend not to seek timely COVID-19 treatment, compounding their health risks.

As citizens, the hijra/third gender people continue to be denied access to adequate healthcare, which is a basic right for all Bangladeshis, regardless of their social status. In health facilities, there are no guidelines for providing services to this community, and facility providers and managers are also unaware of their services. The development of a standard operating protocol (SOP) for SRH for the hijra/third gender community, will be used by health facilities and providers to gain a better understanding of the health and well-being of the third gender community, with a focus on SRH issues.

1.3 Purpose/necessity of third gender SOP as a mainstream health care

A landmark decision has already been made by the government of Bangladesh acknowledging the hijra as the third gender on 11th November 2013. However, after the acceptance, they are facing various forms of sociocultural exclusions. The health sector is the most straightforward way to integrate the hijra/third gender into society. They will be reassured about their acceptance by the government and the community if they can find a welcoming environment in this sector. They will also begin to believe in society and try to avoid being violent. Then sociocultural exclusion can be reduced to the bare minimum. By providing them with a friendly health service, we can also provide them with additional benefits.

This is why a Standard operating protocol (SOP) needs to be developed to ensure that hijra/third gender people are treated with dignity and that they are not subjected to discrimination or harassment when seeking medical care due to their gender identity.

1.3.1 Objective of the SOP development initiative:

- To develop a standard operating protocol (SOP) for SRH services for the third gender community to be used in facilities serving the hijra /third gender community
- To develop a concept/plan to introduce and pilot/test the SOP in selected health facilities following the SOP as a test case.

This SOP will help to raise awareness among the health care provider working for a service delivery point in the public sector, as well as build the capacity of health providers to provide services to the hijra /third gender community.

This SOP will aid in dispelling myths and educating people about the law and their rights to health services, including SRH. The practice of third gender SOP will bring into consideration other system-strengthening needs to ensure and maintain the health and SRH of the hijra/third gender community. From the community's perspective as well as the government's, this SOP will assist in accelerating the mainstream response. The SOP's purpose is to ensure that hijra/third gender people are treated with respect and that they do not face discrimination or harassment while seeking health care because of their gender identity.

This SOP will be a job aid raising awareness among staff working under a service public sector delivery point, as well as building the capacity of health providers to provide services to the hijra /third gender community. This SOP will help to dispel myths and educate people about the law and their rights to access health services, including SRH.

1.4 Transgender/Third Gender definition, SRH care seeking and barriers

Definition of transgender/third gender: The term **transgender**, or **trans**, is often used as an '**umbrella**' term to cover the many ways in which people might refer to a range of gender identities which differ from those assumed and expected by society and do not match the sex they were assigned at birth. We also recognize that people may identify differently at different times in their lives and in different circumstances. As an umbrella term it may include people who identify as:

Transgender/third gender: Transgender is an umbrella term used to describe people who do not identify with the gender they are assigned at birth. Therefore, a transgender individual can be anyone who does not identify with their given gender identity. In modern cultures, infants are assigned a gender role from the time that they are born. This differentiation is done based on the biological sex of the individual. If the infant has a penis, they are assigned to be a man and if the infant has a vagina, they are assigned to be a woman. However, a transgender individual is someone who, once they grow into adolescence or even further, does not psychologically identify with the ascribed behaviour of their given gender. It is important to note that this does not result from any kind of biological/hormonal/genetic imbalance or physical infirmity of the individual.

Transmen: Transmen are those who are biologically female, but identify with the male gender.

Transwomen: Transwomen are those who are biologically male, but identify with the female gender. Even though Hijra and transgender are used interchangeably, and several Hijras in Bangladesh call themselves transgender, transgender individuals outside the Hijra community do not identify as Hijras.

Transsexual: Transsexual individuals undergo sex reassignment surgery to change their sex organs and physically embody the gender they psychologically identify with.

1.4.1 Existing SRH service Context for Transgender /Hijra/third gender Communities [1]

Due to the proliferation of NGO-specific HIV / AIDS interventions, Hijras/third gender (transgender women) had been identified as a key population at risk of HIV/AIDS. As such, funding for prevention and treatment from many different funding streams, including the (GFATM) Global Fund for Aids, Tuberculosis and Malaria has led to the development of grassroots organizations (CBOs) of hijra/third gender-identified communities that have partnered with NGOs and INGOs. Hijra/third gender CBOs are already present across the country, and more are being created. The first Hijra-led CBO was Shustho Jibon, formed by Laila Hijra in 1997. These CBOs were to act as local implementers of HIV/AIDS prevention and treatment facilities. They have since evolved to undertake broader SRHR activities and social work. The recent mapping (Landscape Analysis) identified 29 Hijra/third gender CBOs operating in several districts across the country. There may be several more CBOs that are involved in work with Hijras, and at the grassroots level, there is little distinction between Hijra/MSM-based CBOs. A majority of these CBOs partner with NGOs like Bondhu, Badhan Hijra Songho and INGOs (like icddr,b, SCFUSA and so on) to provide HIV/AIDS treatment, preventive awareness and awareness on safe sex to hijra /third gender community members. The job of the CBO is to provide community mobilization through BCC materials and through awareness raising to encourage safe sex practices and encourage healthcare-seeking behavior among the hijra/third gender communities. The CBOs also train and provide peer educators who are themselves hijras/third gender who can access the communities. /STI program in the country 4th HPNSP also a special HIV/STI program in the country through Public Health Facility, implemented by Padakhep Manabik Unnayan Kendra.

The problem is that all CBOs, NGOs, and INGOs are more devoted to social care and social integration services and also not in a position to provide continued, need base sustainable SRH services as a part of a continuum of health care. The hijra/third gender community need to be redirected to the mainstream health care service approach (essential SRH service package) as a part of the continued and sustainable solution to their SRH care needs.

[1] Landscape Analysis

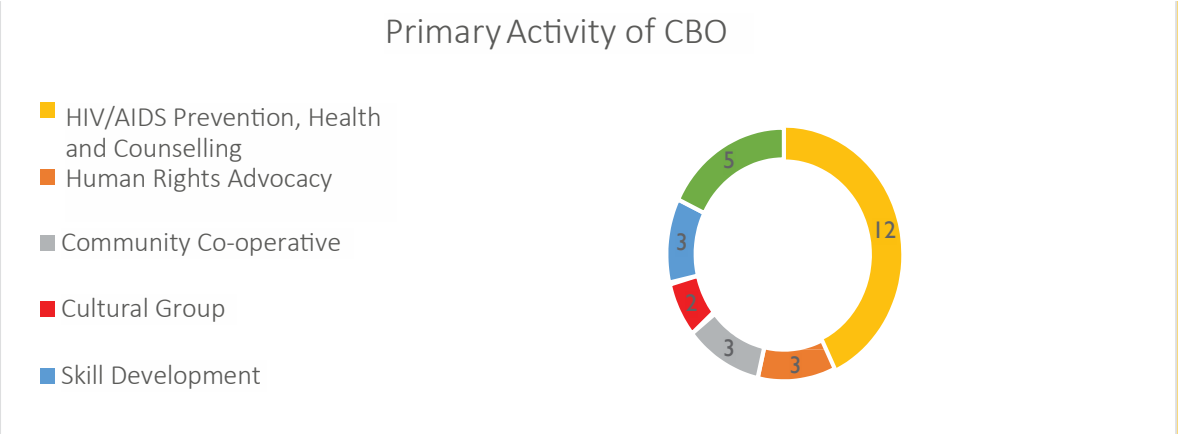


Figure 1. Breakdown of primary activities by Hijra CBOs

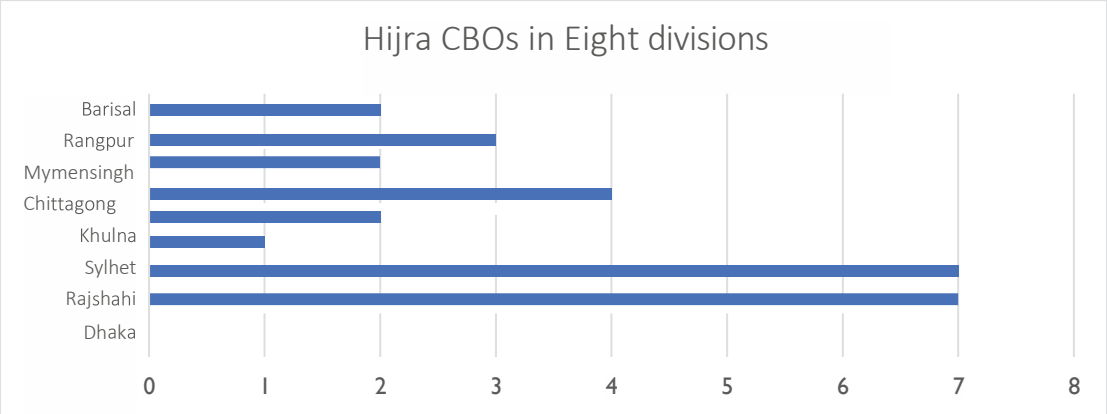


Figure 2. Distribution of Hijra/third gender CBOs by division

In the 4th health sectoral operational plan of MoH&FW, the marginalized community including third gender have a provision to access quality primary/basic care as part of UHC/Universal Health Coverage. **There is a clear guideline for Health, HIV/STI service, that is implementing by 4 districts hospital under the support of Padakhep under HPNSP.** But in that service implementation, there is no such clear-cut indication or guideline on how these discriminated and stigmatized communities will be redirected to access health care from the mainstream service outlets.

Chapter: 2

2.1 Barriers and Legal Supports

Our Society can't consider third gender people as normal human beings and can't see in the good eye also. As this community are recognized as an ignoring community so they are faced several critical problems in society.

These problems include the followings-

a) Barriers in accessing health information and healthcare
b) Often get stigmatized while accessing SRH service from public or private facilities
c) Can't attend any family programs, weddings and funerals etc.
d) They are excluded from the inheritance.
e) Devoid of basic human rights and amenities from the government.
f) Face discrimination in the case of education, employment both from governmental and private
g) Third Gender are not recognized to marry of the same gender.
h) Can't participate in political issues and exercise their right to vote as same as normal human beings
i) They are unable to use proper gender-segregated facilities.
j) They can't get refugee or asylum status equally as other normal human beings get.

2.2 Stigma and discrimination: hijra /third gender community

In Bangladesh, hijra /third gender people are looked down as though they are not human beings and are treated brutally only because they do not have the gender identity approved by society or the government. Although the government of Bangladesh has recognized this hijra/third gender group of people as 'third gender' it is not implemented even in their national identity cards. The phenomena are not the same everywhere. Even some Asian and South Asian countries have laws to protect the rights of these people and they are recognized as the third gender group. Bangladeshi society has a taboo that bounds these people either to assimilate and hide their gender crisis or to live the life of the most marginalized group.

As a consequence, they persist to be regressive given the circumstances in Bangladesh. Moreover, they are also precluded by their own family and have also been excluded from all prospective opportunities. As a result, they have been unsuccessful to own their parental property, to develop and complete their educational skills, so they are also deprived of their employment rights. Suffering from a severe financial crisis, they earn money through begging and dancing for their livelihood.

They are also getting involved in different crimes and illegal activities for the same purpose. As the present world is more concerned about human rights issues, their basic rights are also secured under international conventions, treaties and communities. Being the sexual minority group, they are neglected by many societies, whereas they should be treated equally as a human irrespective of their gender through the enforcement of constitutional and international human rights obligations. Neither by the constitution people of the hijra/third gender community is barred from getting family property, nor by any religion practiced in our country.

There are numerous barriers to health care for third gender individuals with the largest barrier reported by hijra /third gender individuals being the paucity of knowledgeable providers. Barriers to health care include those that are direct, like lack of insurance coverage along with those that are indirect, like

unfriendly office environments and perceived stigma for both the patients themselves and the providers of hijra /third gender health care.

2.2.1 Challenges, Gaps, Opportunities for hijra /third gender health care

Entrance in healthcare facilities are restricted, particularly in government healthcare facilities. However, such entrance limitations might due to the higher number of patients from mainstream societies as well as restrictions by hospital authorities, and/or physicians

Higher rate of exclusion of the third gender population from mainstream societies in Bangladesh are associated with depression, frustrations, and insecurities, which make them more vulnerable to illness that demands enough healthcare services

Service is strictly only focused on HIV/AIDS prevention, while broader healthcare needs are largely ignored due to both existing bias against Hijras, as well as misconceptions and wrong ideas regarding their physiology.

Healthcare seeking behaviour from the Hijra/TG communities remains limited to services provided at DICs, such as STI antibiotics, HIV treatment/testing and distribution of condoms and lubricants. Poor experiences with healthcare service providers make Hijras reluctant to actively seek healthcare services from other institutions.

Current capacity building, motivation and IPC materials do not train or sensitize healthcare providers to the issues faced by Hijras, and do not provide guidelines on how to approach and provide service to them.

Existing planning under Universal Health Coverage (UHC) mandate does not adequately take into account the presence of third gender and does not provide guidelines for mainstreaming their access to health services.

Even though Hijras/third gender have been identified as a category of Most At-Risk Adolescents (MARA). The current National Plan of Action for Adolescent Health does not adequately take this into consideration and existing programs from the DGHS and DGFP on adolescent health and reproductive health do not have any activities linked to Hijras/third gender.

Administrative policies of healthcare facilities also impose barriers. For example, administrative documents were designed for either male or female patients only, whereas third gender patients have no option to report. Moreover, in some cases, a physician from the government and private healthcare organizations does not prefer to treat the third gender population because of a limited understanding of culture.

Assess the knowledge and sophistication of the provider workforce to provide third gender medical care – along with barriers to that education. Lack of knowledge may manifest as assumed complexity of knowledge needed along with a report of anxiety regarding uncertainty. Identify solutions to overcome the knowledge gap.

Assess bias and other barriers to provider care independent of knowledge. The other barriers may include the fear of the stigma associated with providing third gender medical care. Other barriers may also include bias in the structure of clinics, forms, and electronic medical record systems in addition to gaps in knowledge and bias among support staff. Identify solutions to the gaps which are not solely a lack of knowledge.

The other barriers include societal stigma, mental health issues among patients, and socioeconomic issues that represent barriers to third gender individuals receiving high quality care.

2.3 Human rights law and constitutions in Bangladesh

In Bangladesh, there are no anti-discriminatory laws which will specifically protect sexual minorities or laws that recognize the diverse gender identity. Additionally, there are many surveys which describe the people from the third gender community do not get any protection from the police station. There are several news reports on this issue. According to article 27 of The Constitution of The People's Republic of Bangladesh (1972), 'All citizens are equal before the law and are entitled to equal protection of law'. As the Constitution of Bangladesh gives equal rights to every citizen, giving rise to the question, of whether the TG community is getting their rights in the police station to complain against any violence they face. This article can be marked as the successor of 'articles 6 and 7 of The Universal Declaration of Human Rights'13 and 'article 16 of the International Covenant on Civil and Political Rights.

According to article 28(3) of the constitution of Bangladesh, 'No citizen shall, on grounds only of religion, race, caste, sex or place of birth be subjected to any disability, liability, restriction or condition with regard to access to any place of public entertainment or resort, or admission to any educational institution.'

Positive Steps of Bangladesh Government for Hijra/third gender Community:

Recently the government of Bangladesh thinks positive regarding the rights and status of hijras. Thus, for the betterment of their life and to promote their legal rights and status the government takes some positive initiatives. The positive steps taken by the Bangladesh government are-

i. The government has taken primarily a persuasive to recruit hijras as traffic police.
ii. Some rehabilitation programs have been launched in different districts of the country.
iii. The Government has provided a special stipend for hijra students.
iv. Decided to provide proper training to improve their skills.
v. Ensures the old age allowance for the hijras.
vi. Government has taken some steps to create a better opportunity for the employment of hijras both in public and in private.
vii. The government is trying to enact a specific law in favor of hijras to ensure the legal rights of hijras.

Article 31 describes 'To enjoy the protection of the law, and to be treated in accordance with the law, and only in accordance with the law, is the inalienable right of every citizen, wherever he may be, and of every other person for the time being within Bangladesh, and in particular no action detrimental to the life, liberty, body, reputation or property of any person shall be taken except in accordance with

Bangladesh legally recognized them as the 'third gender' just in the year 2013 and since then a contradiction between being legally recognized and protection of their rights existed Eventually, the third gender people in Bangladesh got legal recognition in the year 2013.

2.3.1 Actions taken by the Government of Bangladesh regarding human rights among third gender:

In recent years, the has taken several progressive steps to enhance social protection and inclusion of communities with diverse gender identities.

- *In 2013, the Cabinet's decision to recognize the Hijra community and to reflect their presence in national identification documents and censuses was the first step towards legal recognition.*
- *In the meantime, in 2013, the MSW (Ministry of Social Welfare) introduced several livelihood schemes for the third gender community. While these steps highlight the Government's willingness to engage with the third gender community and ensure their constitutional rights, any other laws or policies expressly prohibiting discrimination on the basis of gender identity, are yet to be enacted.*
- *Some good practices have emerged in Bangladesh including changes in the passport application form which permit an applicant to state 'other' in the entry for gender.*
- *Following the 2014 Cabinet declaration for recognizing Hijras, members of the Hijra community have been provided with National Identification Cards (NIDs) under the Election Commission. As part of the change enforced by the Election Commission, individuals are now free to identify themselves as male, female or Hijras in their NIDs. The Ministry of Social Welfare (MSW) published a gazette notification regarding the third gender community*
- *On January 26, 2014, the social welfare ministry announced the recognition of hijras in its gazette with a single sentence: "The Government of Bangladesh has recognized the hijra community of Bangladesh as a hijra sex." However, the policy has more work to do. A press release issued by the Parliament Secretariat said the committee had recommended taking necessary steps after conducting a medical examination to identify "real" third gender individuals and issue an ID card.*
- *In June 2015, the Bangladesh Bank issued a circular requesting all scheduled banks and financial institutions to include the third gender community within their SME (small and medium enterprises) loan activities. This step meant third gender individuals could apply for bank loans to set up their own businesses. At least two state-owned commercial banks, Sonali Bank Limited and Janata Bank Limited have 'third gender' ('tritiyo linggo') as an option in their account application forms.*
- *In 2018, the Voter List Act 2009 was amended, to provide 'Hijra' as a gender category in the voter registration form, in addition to 'male' and 'female'.*
- *In 2018, the Election Commission updated NID cards to include 'Hijra' as a gender identity by amending the Voter List Act 2009 and the Voter List Regulations 2012. Hijras can now hold national identity cards, where they can identify as 'Hijra'.*
- *The Office of the Registrar General, Birth and Death Registration is currently in the process of updating birth and death registration forms to include the 'others' option.*
- *The policy brief documents have taken positive measures to recognize diverse gender identities, and then outline the remaining challenges in this respect, including the process for obtaining identity documents, and the reforms required in law and practice, to ensure gender identity is not narrowly defined. The brief also recognizes the need for such reforms as a first, crucial step towards addressing other existing gaps in the law that prevent these individuals from living with dignity, protection and freedom from discrimination (https://www.blast.org.bd/content/publications/Policy-Brief-Hijra-and-GDC-Rights.pdf).*
- *The social welfare ministry has implemented numerous social inclusion programmes for third gender as part of its social safety net programme, which includes a monthly allowance for people aged 50 years and up, scholarships for "hijra children," and skills and capacity development training to engage them in income-generating enterprises.*
- *According to home ministry data, among a total of 13,000 members of the third gender community, 1,920 members have received training this fiscal year. Only those aged 50 years and above are being given an allowance of Tk. 600 per month.*

2.4 International Constitutions and Human Rights for Third Gender

In 1871, British administrators passed Criminal Tribe Act in which third gender were pictured as addicted to serious crime and indulging in gay sex. In 1949, the Act was repealed but negative attitudes about third gender remained among the people. After the Second World War, people from around the world became concerned about human rights issues irrespective of race, sex or religion. Thus, from the human rights perspective, the equal treatment of all genders has been developed gradually and people from different countries advanced their mindset to accept third gender people as human beings. It was in 1948 when for the first time, United Nations General Assembly adopted the Universal Declaration of Human Rights (UDHR, General Assembly Resolution 217A) to ensure and protect fundamental human rights universally. It declares a born free and equal rights and dignity for all human beings.

Bangladesh is currently a signatory to the following treaties and conventions which provide some protection for third gender people. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was ratified by Bangladesh in 1984. Article 16, Section 1(b) provides for all women (including lesbian and bisexual women and third fender women) to have the right to freely choose a spouse and to enter into marriage with their free and full consent. While Bangladesh is a signatory to CEDAW it is not legally obliged to implement its provisions into its own national legal framework. Instead, despite being a signatory to more than one international convention that outlines the rights of third gender, Bangladesh has not made any attempt to incorporate the protections into the national framework, which is guided by the Constitution.

On 11 November 2013, a cabinet meeting chaired by the Prime Minister of Bangladesh made a landmark decision in recognizing the Hijra gender identity. The gazette that was written and circulated by the Ministry of Social Welfare on January 26, 2014, mentioned that Hijras have been recognized as the 'Hijra lingo' (Hijra gender/sex)/third gender. The Ministry of Social Welfare (MSW) was the only Ministry to respond to this Cabinet meeting's declaration. The Hijra community in Bangladesh has been marginalized and socio-economically excluded for years, and hence, the recognition was meant to set a precedent in transforming the lives of hijras /third gender for the better.

2.5 Overview of SRH and human rights for hijra/third gender

When it comes to getting SRH healthcare, the Hijra /third gender community still experiences significant obstacles. The discriminatory behavior and practices of medical service providers and other stakeholders involved with providing healthcare have been identified by the majority of hijra/third gender people as the main challenge. Most hijra/third gender people reported avoiding going to hospitals or other types of clinics unless absolutely necessary. When they finally decide to use these services, service providers greet them with hostile demeanors and a callous attitude.

Research demonstrates that, compared with the general population, third gender people suffer from more chronic health conditions and experience higher rates of health problems related to HIV/AIDS, substance use, mental illness including depression and minority stress and sexual and physical violence, as well as higher prevalence and earlier onset of disabilities that can also lead to health issues.

Due to continued marginalization from mainstream employment, Hijras/third gender continue to practice sex work as a primary source of income. This put them at higher risk of sexually transmitted infections than other groups. Surveillance data of 2016 showed that active syphilis rates was 2.1% among TG/Hijras in Dhaka, 0-3.2% in FSWs in Dhaka, Hili and national brothel. Even though the data shows that Hijras are at a higher risk from both HIV/AIDS and from STIs, service coverage continues to be below average, with only 39.8% of the overall Hijra/third gender population under the coverage of the different services provided by the NASP. According to the surveillance overall rate of having STIs among TG is 21.3%. Studies have also highlighted that the location and distance of drop-in centres

(DICs) from Hijras affect the ways in which Hijra community members are able to seek healthcare services. Hijra/third gender individuals are also disproportionately at risk of violence and face different forms of abuse. For example, a study of male and hijra/third gender sex workers in Bangladesh found that 27.8% had been anally raped and of that 21.9% had been by regular sex partners/clients.

Key statistics provided by the NASP on the SRH situation of Hijras in Bangladesh include-

Indicator	Value/ (percentage)	Data Source _IBBS , 2015 , 2020, UNAIDS website
HIV prevalence (%)	0.9	*Source: Integrated Biological and Behavioral Surveillance (IBBS) survey, 2015*
HIV testing and status awareness (%)	43.5	*Source: Integrated Biological and Behavioral Surveillance (IBBS) survey, 2015*
The condom use rate at last anal sex	43%	*Source: Integrated Biological and Behavioral Surveillance (IBBS) survey, 2015*
HIV prevalence for Hijras	1%	*Source: Integrated Biological and Behavioral Surveillance (IBBS) survey, 2020-2021*
Prevalence of active syphilis for Hijras	11.9%	*Source: Integrated Biological and Behavioral Surveillance (IBBS) survey, 2020-2021*
The condom use rate at last anal sex	38%	*Source: Integrated Biological and Behavioral Surveillance (IBBS) survey, 2020-2021*
Ever tested for HIV	67.3%	*Source: Integrated Biological and Behavioral Surveillance (IBBS) survey, 2020-2021*

Table 1. Key SRH statistics of the Hijra community. Source: NASP, 2016, IBBS 2020-21

2.5.1 Hijra / Third Gender SRH needs in health facilities:

Hijra/third gender individuals are also disproportionately at risk of violence and face different forms of abuse. For example, a study of male and third gender sex workers in Bangladesh found that 27.8% had been anally raped and that 21.9% by regular sex partners/clients. Violence against MSM and third gender people may take numerous different forms, including intimate partner violence, rape and sexual coercion, and police abuse. According to IBBS 2020, about 23% of MSM reported being forced to have any type of sex and 5.4% were physically harassed or hurt. Similarly, more than 40% of Hijra respondents have been beaten in the last year (both physical and sexual), according to a 2011 study in Dhaka. Further research carried out by the NASP regarding vulnerable adolescents identifies that Hijra/ third gender is classified under the Especially Vulnerable Adolescents (EVA) criteria. The mean age of hijra / third gender people in the situational analysis was 21 years with a majority (67%) aged 19-24 years and 33% within the 15-19-year age range. The mean age at first sex was 12.9 years and was universal with a male partner. IBBS 2020 , reported the average age of the first anal encounter was 12 years. For a large majority (84%), their first sex was unintended or unplanned and 45% had first sex as cash or in-kind transaction. According to the IBBS 2020 research, more than half (56.9%) of transgender women reported having sold sex in the six months prior to the study's implementation, with percentages ranging from 30% in Khulna to 80.6% in Sylhet.

2.5.2 Currently where they go for the health issues:

Role of Govt in offering PPP focused STI/HIV/AIDS services:

Numerous NGO-led initiatives to provide SRH services to the Hijra/third gender community have been launched since the National AIDS STD Prevention Program (NASP) was created. These interventions

were crucial to identifying harmful sexual practices in the community and promoting behavior that would prevent sexually transmitted infections because the Hijra community is thought to be a Key Population with increased vulnerability to HIV/AIDS. For the Hijra/third gender community to be able to mobilize themselves for additional SRH knowledge and capacity building through training provided by the NGOs, DICs were established for them and Hijra/third gender CBOs were supported in their formation. These NGOs primarily received their funding for SRH and HIV/AIDS prevention from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), as well as from other donors like USAID, UNICEF, and icddr,b. The Global Fund and the government's budgetary allotment for HIV/AIDS prevention are both currently supporting the continuation of prioritized activities for Bangladesh's key populations, with a focus on HIV testing and counseling in particular. The NASP, Save the Children, and icddr,b, BRAC are some of the fund's main beneficiaries.

The national level organizations with the largest networks currently working to provide SRH services to the Hijra community are Bandhu Social Welfare Society, Light House Bangladesh and Padakhep Manabik Unnayan Kendra (PMUK). With funding from the Global Fund and other sources, more than 100 NGOs were engaged in HIV/AIDS prevention at the beginning of the new millennium. However, fewer are still in operation as funding has decreased.

2.5.3 HIV and SRH Service Expansion

The role of DGHS & DGFP:

The DGHS has 139 registered DICs where FSWs, PWIDs as well as Hijra/third gender community individuals receive different types of HIV/STI prevention and treatment support. Partnership with the NGOs and the NASP under the DGHS can be explored to expand the services being provided at the DICs to also include general health care, mental health counselling and other essential support services. There are total number of 59 service center for TG, MSM, (Male having sex with male), MSW (Male sex worker) are currently in operation through NGO services as part of GFATM and HPNSP. National AIDS/STD program started piloting to integrate the HIV service for key population in Govt facility set up.

2.5.4 Adolescent Health and SRH

Existing OPs linked to adolescent health in both DGHS and DGFP should include activities targeting Hijra/third gender dysphoric adolescents. The existing IPC training content by both DGHS and DGFP should be updated to include motivational and informational material regarding gender dysphoria in adolescents and hijra / third gender communities so that counsellors are able to engage with parents who may seek advice regarding their adolescents' gender dysphoria. Furthermore, training and awareness curricula on adolescent health issues for school clinics, teachers and other stakeholders should be updated to reflect gender-sensitive parenting and schooling techniques.

Chapter: 3:

3.1 Objective of the SOP

To raise awareness among staff working under a service public sector delivery point about the hijra / third gender community

To build the capacity of health providers to provide services for the Hijra/third gender community

To address misconceptions and information about existing laws and rights to access health services including SRH.

To consider other systems strengthening needs to ensure and continue health and SRH by the hijra/ third gender community.

3.2 The intended beneficiaries:

Hijra /third gender /Transgender community/clients of the country

3.3. Community awareness and connectivity: Community readiness Checklist to follow:

To assist the hijra / third gender community in community awareness, communicating the service offer and its availability & benefits: a group of volunteers from a health service center will go door to door. Additionally, to offer SRH-related medical services, they also carry leaflets that describe the services that hijra/ third gender clients will receive at that hospital. which will assist hijra /third gender people in integrating into society. The hijra / third gender client will be convinced by seeing the billboards, posters, and pamphlets that the health service center has something for them, which will encourage them to visit. These will also empower the hijra/third gender people to access medical facilities by going to the hospital. Additionally, these flyers will aid in promoting the targeted services widely throughout the community.

a) Billboard
b) Poster
c) Pictorial leaflets for their service packages describing what the health service offer. (Should be available to each of the clients to access the service)
d) Explaining Benefits of the leaflets

3.4 Identifying a focal person from the community to connect with the clinic as a peer leader

Peer health leader approach (third gender CHW)

A Peer Health Leader/guru will be responsible to maintain all data on hijra /third gender. Also, a Peer/guru from the hijra/third gender community needs to be elected who will help to connect them to create a link/bridge with the clinic community. The peer leaders will arrange a time-to-time group meeting with the hijra/third gender community and the clinical community to create awareness and educate them.

For the presence of the Peer/guru third gender in the corner of the medical center, information counselling will be provided until they exit and further follow-up will be maintained by the peer/guru, so that the other hijra / third gender client will feel at home/friendly care.

3.4.1 Community readiness Checklist: (need to be followed by clinic manager)

In the beginning there should be a proper plan exist in the Govt.(DGHS/ASP) with agreed consensus about the service offering for TG , from which tier of the health facilities at Govt health care system their SRH services will be offered (is it from District hospital, UHC or below level ??). So, to integrate the TG services in Govt facilities site the health facility authority will ensure the existence of that plan to follow in their service system through following each steps of the checklist below. The service manager/clinic manager will confirm the readiness **(both at clinic facility sites and community)** through putting tick on each steps

Community Readiness checklist: to put a tick on	Yes	No
1. Confirming about the availability of proper plan from (DGHS/ASP) to offer TG services at what level (districts, Upazilla, and CCs ??) of the facility sites in order to mainstream SRH service for TG clients		
2. Getting consensus among the facility sites providers regarding their roles and responsibilities including creating community connectivity through (NGOs) as per their current organogram with specified and inclusive job description		
3. Clear instructions exist at each Govt facility sites regarding which level of staff as per organogram will support community connectivity (example : Nurses/CHCP/CHW) through connecting with (NGOs /CBOs) who are currently actively engaged in TG service management through DIC approach ?		
4. The third gender are identified and connected through the NGOs & CBOs working with them		
5. Utilizing the currently available location map of the third gender community and select Guru/Peer to connect as contact		
6. Distributing Pictorial pamphlets and Leaflets for the third gender to campaign about their SRH service offer		
7. Organizing community-based SRH awareness service through linking with ongoing NGOs/CBOs working with the third gender community		
8. Train the third gender peer /Guru on basic information regarding SRH service care and where it is available as a community connector		
9. Arranging a periodical meeting with NGOs, CBOs work with third gender to obtain support in SRH service communication and client referral.		
10. Developing a smooth service management flow between the community and clinic		

3.5 Identifying TG-friendly Health Service Delivery Points and connecting with the community

Welcoming access to clinic premises:

If hijra/ third gender people are denied access to the health service center by the gatekeeper once, they will never return. There should be a hijra/third gender sensitive/responsive health care orientation (From the gatekeeper to the decision maker). Gatekeepers to the decision maker will try to create a hijra/ third gender-friendly environment.

Usual challenges third gender (TG) often encounter in the clinic:

- Discrimination (unwelcoming environment, dedicated or safe waiting space,)
- Health systems barriers
- Lack of appropriate general medical care
- Inappropriate electronic records, forms
- lab references, clinic facilities
- Lack of TG special info/counseling
- Financial barriers

3.5.1 Gatekeepers approval:

Gatekeeper's approval plays a significant role in terms of hijra/ third gender rights to know about reproductive health issues and receiving reproductive health services. Their actions create an environment that values health services and encourages third gender people to seek them out. Other health-care professionals, such as the receptionist, nurse, and doctor, will assist the third gender in finding the appropriate SRH service.

3.5.2 Third Gender Friendly environment:

The third gender -friendly environment needs to be created and visible to the third gender and they should know where they can get a friendly environment to get health service care. A visit to a SRH care facility can cause anxiety for a variety of reasons. Some people may feel uneasy about disclosing personal information to healthcare professionals who require it in order to provide certain services. Others find it difficult to discuss their personal health issues. All SRH care workers should strive to create an environment in which these conversations are more comfortable for the patient. SRH care staff should provide an affirmative, inclusive, and respectful environment for all clients, with a focus on third gender people.

3.5.3 Creating a friendly environment checklist:

To make SRH service delivery points appealing to third gender people, the physical environment and procedure of service delivery points must be comfortable for all service recipients. It has to do with client satisfaction and quality of care.

They should not have difficulty getting basic medical care, and they should not face discrimination or prejudice from medical personnel when seeking treatment. Also, the health service providers do not have proper knowledge about third gender people. The provider's attitude should be always welcoming.

3.5.4 Points to follow for developing Hijra/third gender friendly health care facility:

Following promotional services can be considered for the third gender promotional services

Third Gender community focus awareness through NGOs/CBOs
Pictorial flip chart, service offering fliers distributed through guru's/community peer volunteers
TG-friendly Billboard and sign board in the clinic entrance
Using special Mobile Apps to inspire TG SRH service
Community safe space meeting
SRH service communication through DIC
Mobile database to remind and follow up on clients
Periodical group meetings with third gender Guru's and clinic service providers

3.5.5 Advocacy checklist:

Engaging Staff and Leadership - Summary Checklist

- ☐ Early in the process, present program goals and ideas to leadership and staff and invite their input
- ☐ Show videos and movies and/or have community speakers that tell personal stories; hold a discussion afterwards

- ☐ Discuss how gender-affirming care fits within the structure of medical and public health ethics
- ☐ Emphasize the benefits of reducing health disparities in an underserved population
- ☐ Introduce colleagues to the basics of third gender health care through free resources and courses
- ☐ Discuss how serving gender diverse clients has a high potential for creating health equity as part of UHC (universal health care)

3.5.6 Creating an Inclusive Environment:

Presenting to a health care office can be stressful and anxiety-provoking for a third tender individual. Health service providers/doctors /paramedics/counsellors and office staff can create an inclusive environment for third gender patients that will encourage patients to be forthcoming with their concerns and confident that they will be able to obtain the care that they need.

Steps to create a more inclusive environment include the following

Increase health care professional knowledge of and comfort with providing care for third gender and gender nonconforming individuals. This includes avoiding making assumptions about patients' sexual orientation, sexual practices, and surgeries and being cognizant of what questions are appropriate (eg, is the question relevant to the care being provided?).

Train and empower front desk staff, nursing staff, phone staff, billing staff, and others who interact with patients on appropriate ways to ask about names and pronouns *(Box below A)*

Review the office space to ensure that images chosen for signage, educational materials, and artwork represent all individuals who may seek health care services.

Ask all patients what pronouns they use *(Box below A)*

Clearly post a sign with the office's nondiscrimination policy.

Ensure that at least one restroom is gender neutral and accessible to all patients.

Use patient forms that include check boxes for all gender and sexual orientation options, include blanks for patients to write in their responses, or both.

Create a system where names used by patients (if other than their legal names), gender markers (eg, on medical charts), and pronouns are used for every patient every time.

Examine the electronic health record system available in clinics/health facilities and hospitals to determine a universal process to ease the communication process for all staff. The patient's name, if different from the individual's legal name, and the pronouns used should be noted in the electronic health record.

Train employees on how to apologize for mistakes if they happen.

3.5.7 Friendly environment set up for third gender checklist:

Friendly environment set up for third gender checklist	Yes	No
▪ Health-care orientation that is third gender sensitive and responsive. (From the gatekeeper to the decision maker)		
▪ A billboard describing the trans gender's services that will entice them to visit the medical facility for health care.		
▪ Pictorial leaflets and videos for them		
▪ Specific corners for them, clean premises, light and ventilation, drinking water, a functional bathroom, instructional literature, and chairs in the waiting area have all been provided at a minimum. *(If resources allowed, such as a third gender peer/guru, can be incorporated.)*		

▪ From entry to exit, procedures are in place to ensure a smooth and efficient client flow.		
▪ When third gender persons visit the medical center, they should feel at ease with the surroundings and procedures		
▪ The waiting place should be decorated in a way that portrays a third gender friendly environment		
▪ Ensuring that waiting rooms and public areas of the facility are safe for trans patients		
▪ If requested by a hijra/ third gender patient, offer a separate and private space to wait for services		
▪ Provide access to safer sex commodities such as condoms (both male and female) and lubricants		
▪ Making all facilities accessible for people with disabilities		

3.6 Facility Readiness checklist for clinic manager to follow: TG-friendly SH checklist

3.6.1 Checklist for the clinic manager to follow:

Checklist for the clinic manager	Yes	No
▪ Confirming about the availability of proper plan from (DGHS/ASP) to offer TG services at what level (districts, Upazilla, and CCs ??) of the facility sites in order to mainstream SRH service set for TG clients		
▪ Getting consensus among the facility sites providers regarding their roles and responsibilities including clear job descriptions as per their existing organogram and integrated TG services especially , Who will do what?		
▪ Clear instructions exist at each Govt facility sites regarding the service offering modality (whether the service will be given from ongoing set up or there will be separate corner DIC kind arrangement initially for the TG clients)?		
▪ All the health care providers(Doctors/MO. Nurses, counsellor) including Facility supervisor (Civil surgeon, Hospital Director, Hospital superintendent, UHFPO,) are fully oriented on the TG SRH service operation based on the TG SRH mainstreaming SOP (standard operating procedure guideline)		
▪ All employees should avoid making assumptions regarding gender identity and sexual orientation, as well as racial identification, age, and other personal characteristics.		
▪ All service providers should have a positive attitude and will provide services with respect		
▪ All service providers should be oriented and trained to offer services		
▪ In all of their interactions with third gender people, service providers and support staff show respect		
▪ Mechanisms for monitoring performance and identifying areas for improvement are in place.		
▪ All employees' performance needs to be evaluated on a regular basis, and relevant feedback should be given		

3.7 Roles and Responsibilities of Service providers (Primary care provider/PCP):

3.7.1 Front Desk/Front-Line staff:

Front Desk/Front-Line staff Front desk, registration and other front-line staff should learn how to avoid making assumptions about gender (e.g., "How may I help you?" instead of "How may I help you madam/ sir?") and to ask clarifying questions about gender identity in a respectful manner ("We wish to be respectful. Can you tell me what your pronouns are?"). Front-line staff also must learn how to talk sensitively with patients about dissimilarities between name and gender on insurance documents/legal documents vs. medical records (for example, "Could your chart be listed under another name?" OR, "What name is your NID (national Identity card) ?" It may be helpful to offer to assist patients to change the name on NID card if they indicate they have a legal name change that is not yet registered on NID. It is important to teach all staff that a NID card, or a chart name, are not indicators of "legal" identity and should never be referred to as a patient's "legal name." Changes or differences in name and pronouns need to be updated and listed in the registration information of a chart at check-in or when new patients register for care

3.7.2 Medical Assistants and Technologists:

Medical Assistants and Technologists require the same knowledge and respectful approach as front-line staff. In addition, they ought to develop a protocol for making sure that gender and name information is passed along to the provider (e.g., when passing along vital signs).

3.7.3 Primary Care Providers (PCPs) :

PCPs should have the ability to provide gender-affirming services across the gender spectrum. Hiring staff with this experience is difficult due to a lack of hijra /third gender health training in medical education; therefore, medical staff should be provided education, clinical supervision, and mentoring through continuing education courses and other opportunities *(see box below B).* PCPs need to know how to provide routine primary care for hijra /third gender clients and to make clinical decisions based on clinical and laboratory diagnosis.

In addition, PCPs ought to discuss the patient's goals for medical or surgical affirmation treatments (if any) and learn about a patient's risk through comprehensive history-taking. Knowing that hijra /third gender have a higher risk for certain health concerns, such as depression, suicidality, trauma/violence, HIV/STIs, and substance use disorders, will also help guide PCPs to provide appropriate screening. PCPs should also learn to provide post-operative care for gender-affirming surgeries, monitor for risks associated with hormone usage, and counsel on the significant risks involved and fillers and learn how to treat those who have already used these means of gender-affirming body modifications

For first-hand primary care cases the service offering start at the front desk end where the hijra /third gender client gets registered and guidance from her next desk of care which is in most the health care counselor /paramedic who should offer a trust worthy reassuring service care which allows the client to make an open communication. Based on her sharing and the service care need she/he expressed the counsellor can reexamine /reevaluate the service need based on his/her communication and then can finally forward the client to the service care desk as per the Service flow model below.

The doctor/paramedic should also follow a reassuring service-giving environment for the hijra/third gender client. They should welcome the client with the right pronunciation *(see box below A)* and also check back the health care card and the record from counsellor to understand the specific service need which soul be further followed by directly communicating with clients about their service /care need

directly from the client and reconfirm the specific health care need. The information provided by the client should be well recorded in the history sheet and then the PCP (doctor/paramedic) should go for examining his/her as per service need. In every set of service/SRH caregiving approaches the service providers (PCP/doctor/paramedic) need to follow the service flow model. After the completion of the SRH care followed by diagnosis the appropriate prescription will be generated /made by the service providers which also needs to be clearly explained to Hijra/third gender client and also need to confirm that they have understood to follow this as part of medicine/drug compliance. Then the client should be sent to the next desk (medicine corner / or for post counselling) before they make a formal exit from the clinic with their primary service care need. However, in reality for many hijra / third gender people service need may be a step ahead and complex means they may require care for retained anatomy (for example, the cervix), which may feel very uncomfortable, frightening, or even impossible. Providers should be sensitive and competent to discuss risks and benefits around anatomy-based procedures and should be open to alternative strategies such as self-insertion of a speculum.

3.7.4 Clinical Managers:

Clinical managers should attain similar competencies to medical assistants, and should also try to create and maintain a list of local agencies that are gender-affirming so they can make referrals (*e.g., Hospitals that offer secondary and tertiary care in gender affirming way organizations that address substance use disorders, mental health problems, homelessness, and intimate partner violence).* In the many areas where there are not any local trans-competent resources, the care team will need to help patients devise plans and find support in the larger community that will help keep the patient safe and/or treated appropriately. Some national resources may be available for consultation

3.7.5 Service provider's checklist:

Checklist for the Paramedic/service provider	Yes	No
▪ Providers should avoid making assumptions regarding gender identity and sexual orientation, as well as racial identification, age, and other personal characteristics.		
▪ All service providers should have a positive attitude and will provide services with respect.		
▪ In all of their interactions with third gender people, service providers and support staff show respect		
▪ The right words can help build trust; the incorrect ones can worsen a bad situation		
▪ When communicating with others about a new patient, avoid using gender terminology and pronouns (see box below)		
▪ Use of disrespectful language, looking or showing astonishment at someone's appearance, or gossiping about a patient's looks or conduct are all obvious "don'ts." They should avoid asking unnecessary questions.		
▪ Mechanisms for monitoring performance and identifying areas for improvement are in place.		

Pronouns

The service provider /Doctor paramedic should ask patients about their name and which pronouns they use. Asking all patients routinely for their gender identity and gender pronouns normalizes the interaction and allows patients to disclose without being targeted; good practice includes reciprocal disclosure (eg, "Hello, I am Dr. X and I use she/her pronouns. Is the name on your chart what you would like me to call you? What pronouns do you use?"). The patient's pronouns should be documented in the patient chart.Common choices include (note: this is not an exhaustive list):

She/her/hers

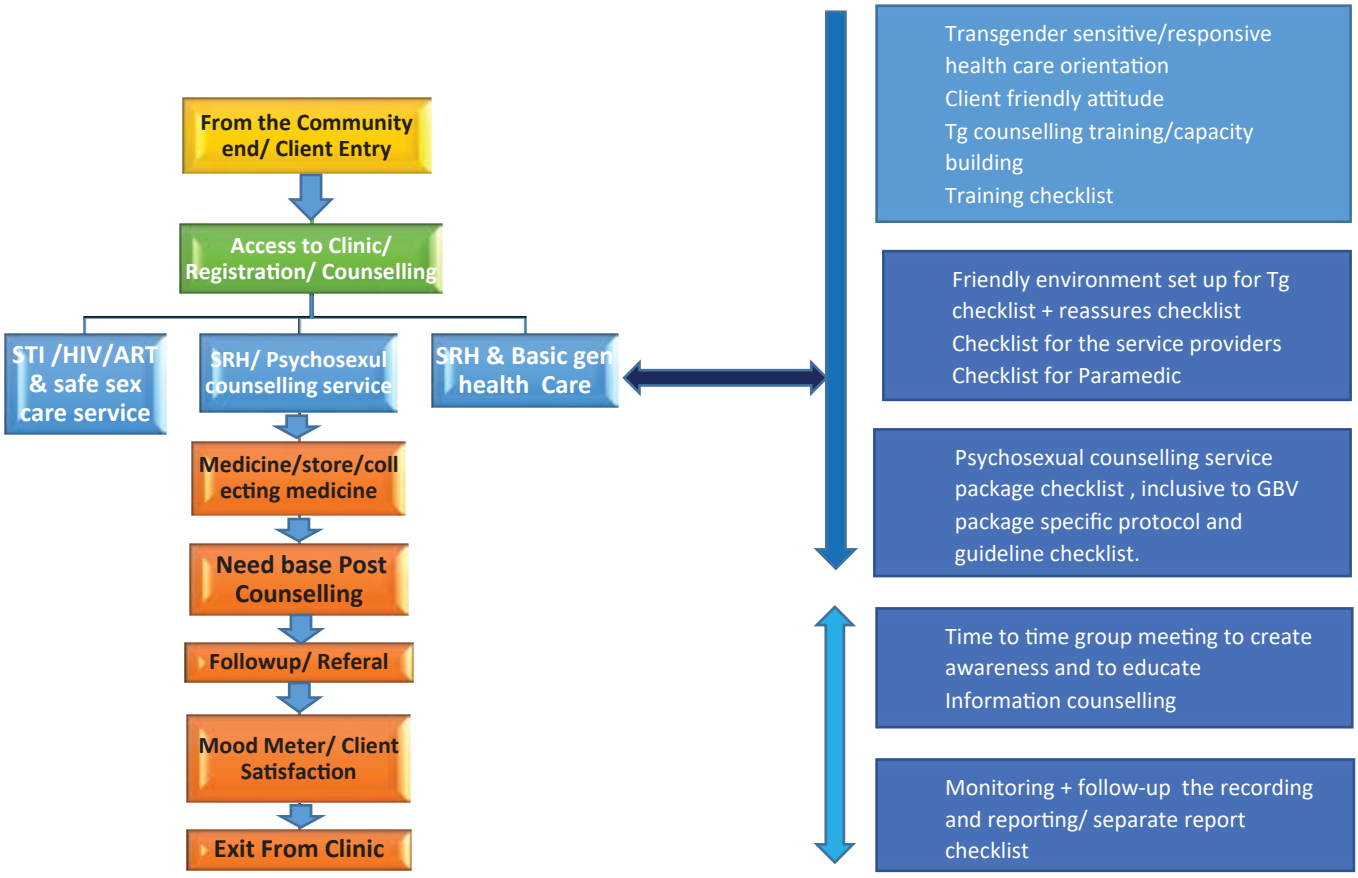
He/him/his

They/them/their: Neutral pronouns used by some who have a non -binary or diverse gender identity.

Other gender-neutral pronouns include she or her.

BOX: A

3.7.6 TG care Entry to Exit (Flow chart): with key consideration issues



3.7.7 Guiding Principles to follow by providers

- *Provider's attitude, communication and relationship with third gender are always positive, respectful and nonjudgmental, nondiscriminatory.*
- *Paying proper attention, response and time to each third gender client in SRH care including counselling and drug /medicine giving*
- *Discourage making long waiting for any third gender client*
- *Providers should maintain utmost confidentiality and quality of care*
- *The treatment and service-giving approach should follow equity and equality with all clients including third gender*
- *Providers are ready to accept open feedback on their service giving quality to the hijra / third gender clients*

3.7.8 Service Package to offer:

- Information, awareness and counselling (IAC)
- Psychosexual counselling including gender based violence (GBV)
- Mental health screening and referral considerations
- Sexual health care includes safer sex practices (condoms)
- Fertility and reproductive counseling and planning
- HIV/STI services (case management, testing, navigators/linkage-to-care, STI screening, treatment, pre-exposure prophylaxis (PrEP), and partner notification including ART service for PLHIV
- Essential drug care and compliance
- Substance use disorder treatment
- Selective general health care (Infectious disease including TB & TB HIV Co-infection)
- Cardiovascular, diabetes screening and referral considerations

3.7.9 Capacity Building (Staff In-Service – Training for Staff)

Essential Training need

Following a standardized training package, peer health leaders and other service providers who will assist in providing services to the third gender will be trained. They'll get some fundamental instruction.

General information on third gender SRH, psychological health requirements, condom care in addition to general healthcare, third gender -friendly behavior, theoretical knowledge of HIV and STI, testing methods, professional ethics, role and responsibilities, and client approach should all be covered through following the training.

3.7.10 Major training focus /issues (Box B)

Training done	Yes	No
1. Sensitizing and orientation to all staff about third gender Health care needs and human rights		
2. Training on nondiscriminatory health care and counselling for the counselor		
3. Training on Psychosexual counselling for the counsellor, paramedic and Doctor		
4. Training on managing TG care in health settings for Clinic Managers, doctors, paramedics		
5. Training on safer sex practice promotion for Counselor Paramedic		
6. Training on record keeping, reporting, supervision, monitoring and referral of third gender care: Paramedic, counselor, Clinic manager & Doctor, Statistician if any		

Additional training need

1. Training in sexual heal care Paramedic, doctor
2. Motivational training for Clinic managers, doctors and paramedics
3. Training on communication

3.8 Implementation Plan checklist: Providing Third Gender-Inclusive Services

Implementation Plan checklist: Providing Third Gender-Inclusive Services	Yes	No
Third Gender sensitive/responsive health care orientation		
• Third Gender Client-friendly attitude of all provider		
• Third Gender counselling training/capacity building of all providers		
• Training checklist (3.8)		
Service management protocol /flow chart		
• Friendly environment set up for + reassures checklist		
• Checklist for the clinic manager		
• Checklist for Paramedic/service provider		
• Psychosexual counselling service package checklist		
• Service package-specific protocol and guideline		
• From Time to time group meetings to create awareness and educate		
• Information counselling		
• Monitoring + follow-up the recording and reporting/ separate report checklist		

3.9 Recruitment /engagement of CHW /Community connector as TG /Guru.

One of the biggest challenges in third gender SRH care service giving through healthcare facilities is basically how to bring them into the clinic or redirect them from the non-formal healthcare setting to the formal healthcare facilities. Here it is very important to realize the fact that the hijra /third gender community belongs to certain communal clusters or in a group under the guru ship. These gurus are the true trustworthy leaders whom they count on mostly and always tend to be connected for their difficulties and wellbeing. In such cases, these gurus can be the best community connector to bridge the hijra/third gender groups with the clinic providers. Here, it is worth mentioning that the Gurus need to be motivated, trained and certain way incentivized by giving ID cards (identity), carrying bags, and umbrellas, so that they can volunteer as community workers to bridge the gap between the clinic and the hijra/ third gender community.

3.9.1 Following procedure /criteria should be followed in selecting Gurus as Community Volunteers:

- ✓ General acceptability by the hijra/third gender community
- ✓ Willingness and self-motivation
- ✓ Interest in Voluntary work
- ✓ Has a wider range of hijra/third gender Third Gender connectivity?
- ✓ Has general acceptability by the community
- ✓ Basic literacy and numeracy
- ✓ Attitude and communication are respectful and tolerant of the society

Chapter: 4: Monitoring, follow-up, referral, recording reporting

4.1 Privacy, confidentiality & disclosure policy in the clinic:

Every third gender client's information and privacy should be maintained while they seek care in the clinics. All health care records should be maintained with utmost confidentiality so that any information doesn't get communicated which causes them to feel offended among the other clients, their peers and the community. To aid clinicians, the useful guidance, Trans healthcare, regarding the care of third gender people. Under the section titled Disclosing gender history the guidance states:

"It is unlawful to disclose a patient's gender history without their consent."

"When communicating with other health professionals, gender history doesn't need to be revealed unless it is directly relevant to the condition or its likely treatment."

"The gender status or history of trans and non-binary people should be treated with the same level of confidentiality as any other sensitive personal information."

It is not an offence under section 22 of the Act to disclose protected information if—
(a) the disclosure is made to a health professional;
(b) the disclosure is made for medical purposes; and
(c) the person making the disclosure reasonably believes that the subject has given consent to the disclosure or cannot give such consent.

4.2 Recording, reporting, monitoring and Referral

Determine Work Flow and Electronic Health Record Format. Each team will need to establish a care system, or work flow, that functions across disciplines and departments, and that is codified within the general policies, protocols, and clinical functions of the health center. The specifics of the system will depend on the care model used. For example, a stand-alone clinic might have hijra / third gender-focused demographic and medical intake forms at registration, while an integrated program may use general population (but inclusive of all genders) demographic forms at registration, and then have service provider need to ask the hijra /third gender -focused history questions during the medical exam.

Most health centers will likely need to make modifications to their electronic health record (EHR) system to accommodate diverse gender identities specially hijra/third gender . All health centers should already be collecting sexual orientation and gender identity data that gets entered into the EHR system at registration and/or during the clinical exam. Ideally, the EHR allows for a patient's correct name and pronouns to be recorded and displayed so that they are visible to all levels of staff. In addition, health centers will want to modify the EHR to include anatomical inventories, as well as procedures, prescriptions, and medications specific to gender affirmation. Some EHRs are more limiting, and health centers have reported that inflexible EHRs are one of the greatest challenges in setting up effective programs for gender diverse patient populations. Nonetheless, most have been able to create effective work around—just be sure to build in a few months of planning to get the EHR ready for implementation.

The clinic team who work in the Health Service center will manage hijra/ third gender clients' information and files. After determining the client's identity at the entry/reception end (he/she is simply referred to as TG/third gender), then the clinic service providers (Doctors, paramedics, nurses) will initiate the following process:

Files are received at the reception here client's biographic data will be captured to create the client's unique identity number or obtain a national ID. The client's flip card will be processed and inserted in each client's file to hand to the client.

Nurse/paramedic open third gender client care file with the unique ID number. The dedicated service provider/nurse captures the client's information (clinical information) into the register using the details from the biographic data

Capture information and data on client care file and refill/ while repeated visits are made by third gender

All files are stored at the clinics with utmost confidentiality and files are delivered when needed/asked by the service provider for any related matters

Referral slips are given to the client to take with them to new sites/ designated clinics/health centers for further needed care. Here referral should be honored and cared through a properly organized referral mechanism with certain health centers that are equally sensitized and oriented about third gender health care needs. Files are segregated and transported to the referral center /respective facilities with a copy of the referral slip and the Refill encounter sheet is sent back to the clinic.

Information on referral care file is transferred to dedicated doctors and followed up

The dedicated trained nurse/paramedic will ensure that all required documents and data are captured in the referral service points and the identification number is available for every client

Client's files and referrals for outgoing clients are arranged and maintained appropriately

4.3 Client exit strategy

The third gender client after receiving his desired /expected care will exit the clinic following certain steps:

Ensure the desired care is received

Prescribe drugs if any are properly informed about dose and timing

Ensure they are clear about their follow-up or referral

If the third gender comes in a group, then they will be allowed to get their desired SRH services and leave the clinic as a group

They are free to provide any feedback/suggestion in writing /using a mood meter / or verbal communication to the receptionist

Annexure:

A. Roles and Responsibility Matrix (Govt & /NGO/INGO/Private clinics
B. Disclosure and confidentiality Policy and advice
C. All TG & gender discriminatory issues relevant words & definitions
D. Service delivery center list (Pilot center)
E. Relevant Resource link

A. Roles / Responsibility Matrix (Govt and / NGO/ INGO/ Private clinics)

Govt sector	NGO	INGO	Private clinics
▪ Taking more proactive leadership role in offering hijra /third gender friendly SRHR care as part of Universal Health care ▪ There should be hijra /Third Gender SRHR mainstreaming care specific advocacy needs to be initiated and continued from Govt end. ▪ The Govt should take a leading role to coordinate & connect all INGO, NGOs and Private initiatives to make them accountable for offering standard community care/demand side, means community-level awareness /prevention work to safe guard and prevent the SRHR vulnerability and risk exposure of the hijra /Third Gender clients ▪ The ASP as an apex organization will lead, guide, set quality and standard of SRHR care and services for hijra/third gender and all NGO, INGO, Private service will be accountable and reportable to ASP for such service offering quality and standard including the client satisfaction	▪ NGO s as in the past they have proactively taken strong and significant role in supporting and raising awareness and consciousness about hijra /third gender SRHR care and human rights, they should continue to play that role. ▪ NGOs role should be more vested on the demand side and mostly creating awareness and connecting. bridging the clients from community to mainstream care centers. ▪ NGOs should be closely connected and well coordinate with Govt specially ASP for Hijra /third gender clients service-related follow-up, monitoring and reporting matters	▪ INGOs as financial sponsor and service giver in both role as they are playing for several years, apart from continuing that role they should come forward with continued support from a diverse angle like financial, non-financial, technical support, advocacy and in many more way to make this mainstreaming SRHR attempt to turn into a reality over the years ▪ INGOs also can be strong part of advocating and establishing hijra /third gender community SRHR from a human rights angle where the mainstreaming of health care for them would be far easy and accessible to approach and offer by Govt , NGOs , and private facility sites .	▪ The private clinics and the owner of the clinics as citizen of the country are morally obligated to extend their best support to offer human friendly good care and service for the hijra /third gender, it can be possible if they really convince and motivated to offer those SRHR care and related special health care for those clients. ▪ The private sector/ Private clinics can play a complementary role alongside with Govt, NGOs, INGOs to extend mainstreaming care support through offering easily accessible, affordable and subsidized SRHR and other special care services. ▪ Private clinics can follow this SOP as a standard of SRHR service care and keep connectivity with ASP for reporting.

B. Disclosure and confidentiality Policy and advice

The Intl Gender Recognition Act 2004, at section 22 (4), also sets out those situations when it would not be an offence to disclose protected information:

"But it is not an offence under this section to disclose protected information relating to a person if —

(a) the information does not enable that person to be identified,
(b) that person has agreed to the disclosure of the information,
(c) the information is protected information by virtue of subsection (2)(b) and the person by whom the disclosure is made does not know or believe that a full gender recognition certificate has been issued,
(d) the disclosure is in accordance with an order of a court or tribunal,
(e) the disclosure is for the purpose of instituting, or otherwise for the purposes of, proceedings before a court or tribunal,
(f) the disclosure is for the purpose of preventing or investigating crime,
(g) the disclosure is made for the purposes of the social security system or a pension scheme,
(i) the disclosure is in accordance with a provision made by an order under subsection (5), or
(j) the disclosure is in accordance with any provision of, or made by virtue of, an enactment other than this section."

C. All TG & gender discriminatory issues relevant words (Glossary)

Sex

The classification of people as male or female. At birth, infants are assigned a sex based on a combination of bodily characteristics including hormones, internal reproductive organs, and genitals.

Gender Identity

One's internal, personal sense of being a man or a woman (or a boy or girl). For third gender people, their birth-assigned sex and their own internal sense of gender identity do not match exactly.

Gender Expression

External manifestation of one's gender identity, usually expressed through "masculine" or "feminine" behavior, clothing, haircut, voice or body characteristics. Typically, third gender people seek to make their gender expression match their gender identity, rather than their birth-assigned sex.

Sexual Orientation

Describes a person's physical, emotional and/or spiritual attraction to another person. Gender identity and sexual orientation are not the same. third gender people may be heterosexual, lesbian, gay, or bisexual. For example, a male who becomes a woman – and is attracted to men – would be identified as a heterosexual woman

Third Gender

An umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. third gender may include but is not limited to: transsexuals, intersex people, cross-dressers, genderqueer and other gender-variant people. Use the descriptive term (Third Gender, transsexual, crossdresser, FTM, MTF, genderqueer, etc) preferred by the third gender person. Third Gender people may or may not choose to alter their bodies hormonally and/or surgically.

Transsexual

An older term which originated in the medical and psychological communities. Just as many gay people prefer "gay" to the medical term "homosexual", many third gender people prefer "transgender" to "transsexual". However, some transsexual people still prefer to use the medical term to describe themselves. It is best to ask someone which term they prefer.

Intersex

Describing a person whose biological sex is ambiguous. There are many genetic, hormonal or anatomical variations which make a person's sex ambiguous (e.g. Klinefelter Syndrome, Adrenal Hyperplasia). Parents and medical professionals usually assign intersex infants a sex and perform surgical operations to conform the infant's body to that assignment. This practice has become increasingly controversial as intersex adults are speaking out against the practice, accusing doctors of genital mutilation. Replaces the outdated term "hermaphrodite".

Male-to-Female (MtF):

Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Gender identity:

A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964)

D. Service delivery center

Dhaka Medical College Hospital one of the pilot centers for roll out of this SOP

E. Resource link

1) Standard HIV service packages for PWID in www.asp.gov.bd (Standard Operating Procedure of DIC management)
2) Transgender Health ECHO (TransECHO)
   www.lgbthealtheducation.org/transecho/
3) Advancing Excellence in Transgender Health Conference
   fenwayhealth.org/the-fenway-institute/education/transgender-health-conference/
4) Online Course for Health Care Providers
   www.lgbthealtheducation.org/transtalks/
5) Transgender Law Center
   transgenderlawcenter.org/resources/health transgenderlawcenter.org/equalitymap
6) Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Non-binary People by The Center of Excellence for Transgender Health.
   These guidelines aim to address disparities for transgender people in accessing primary health care by equipping primary care providers and health systems with the tools and knowledge to meet the healthcare needs of their transgender and gender non-conforming patients
7) Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7 by World Professional Association for Transgender Health (WPATH).
   The WPATH Standards of Care provides clinical guidance for health professionals to assist transgender and gender non-conforming people with safe and effective pathways to achieving lasting personal comfort, in order to maximise their overall health, psychological well-being and self-fulfillment. An updated version 8 is due to be published in 2021.
8) Standards of Care by the Australian Professional Association for Transgender Health (AusPATH).

The AusPATH Standards of Care offers clinical guidelines and tips for health professionals to ensure provisions of trans-competent and sensitive health care to trans persons. While developed for the Australian context, the guidelines offer some useful information for healthcare providers operating in other geographical contexts in the Asia and the Pacific region.

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