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Research Article

Psychiatric Morbidity among Hijra group of people in Dhaka City of Bangladesh: Observational Study

Dr. Fahmida, F[1*], Dr. Dionéia, M. M.S[2], Dr. Md, F. A[3], Dr. Md. S A[4]

[1]Assistant Professor, Department of Psychiatry, Z H Sikder Women's Medical College, Dhaka, Bangladesh
[2]Assistant Ph.D. Professor at Post-doc in Computation and Mathematics, FFCLRP-USP, University of Ribeirao Preto,UNAERP,Collaborating Researcher IEL-UNICAMP,Faculty Member at UNAERP, Brazil
[3]Professor at the Department of Psychiatry and Directorof the National Institute of Mental Health (NIMH), Sher-E-Bangla Nagar, Dhaka
[4]Associate Professor, Department of Psychiatry, Bagabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh

***Corresponding Author**
Fahmida Ferdous

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Abstract: ***Background*:** Hijra community is a distinct community exists in Bangladesh and often degraded by the society. They are specifically recognised as third gender in South Asian countries like India, Bangladesh and considered as Tran's female in all over the world. Most of the psychiatric prevalence done in Bangladesh earlier was considered about male and female gender ignoring the third genders. ***Objective:*** To find out the psychiatric morbidities among Hijra community. ***Method*:** This cross-sectional study was conducted over a period of one year in the treatment centres of the Non-Governmental Organization, from February 2019 to February 2020 ***Sample size*:** In order to get fixed sample of 50 clients we had to approach 63 clients among them 13 clients refused. ***Result*:** The mean age of the respondents was 32.94 ± 6.68 years and the range was 25 – 52 years. Almost two-thirds of the respondents were illiterate and only completed their primary education were 20.0%.Maximum of the respondent did not live either with their family or parents due to social stigma when hijras identified at the adolescent age that they were different from the male and female gender. 84.0% of the respondents lived with their Guru (Hijras are living in a group, in the group they have a leader elected by all hijras every body called the elected person' Guru') 14% with friend/partner. The respondents occupation was: begging40%; singing and dancing30%; working as a sex worker 24% and others gets the change to work in the main stream of the population. As a sex partner, most of the respondents preferred males and the most preferable route was anus, and 18.0% of the respondents had a selective client.The average monthly income was more than 23000taka(U$ 271). According to DSM-5, Major Depressive Disorders was observed in 62% respondents, Substance/medication-induced psychotic disorder 20%; HistrionicPersonality Disorder was observed in 14.0% respondents; and Anti-Social Personality Disorder 4%.

Keywords: Psychiatric morbidity, Hijra, Bangladesh

INTRODUCTION

Hijra is understood as a special group of people born with "absent" or ambiguous. The iconic figure of the gender hijra is sexually different in people of the male body and people with female identification, although for a long time they exist as culturally recognized third gender. Recently in several South Asian countries hijra have been recognized as a third gender including Bangladesh. The international community views that the recognition of a hijra group of people as a third gender necessities to progress socio-legal rights obtaining basic as well as sexual rights [1].However, in the world of the hijra group of people there is a treatment with brutality, in the sense that they would not be human beings, as they would not have the gender identity recognized by society and would not have literacy and social support, which makes

them private from their basic rights [2] to earn money by integrating professional careers, leading them to survive through alternative activities such as singing and dancing at ceremonies and also as sex workers [3].

Hijras are observed as victims of the sexual desire of men, who use hijra for the purpose of sexual gratification through the practice of anal sex, which occurs in countries with Muslim majority such as Bangladesh. It is added that this is a practice strongly prohibited by Islam, a religion adopted by that country. The work of some non-governmental organizations (NGOs) in the hijra started in the late 1990s. The NGO *Bandhu Social Welfare Society* and *SusthoJibonBadhon*, another NGO focused on hijra,reveal the growing interest of civil society in addressing issues related to alternative sexualities, focusing especially on sexual health in the context of the global HIV epidemic [1]. Social and health inequities in relation to the Hijra population are much greater when compared to social inequities and health related to the general population. There is a treatment gap regarding the evidence in broader general health issues, including psychiatric illnesses [4], internalized stigma, isolation from society, discrimination and victimization that predisposes hijras to psychiatric illnesses, such as depression, anxiety disorders and substance related disorders [5].

Therefore the objective of this study is to observation of psychiatric morbidity among hijra group of people in Bangladesh to develop evidence-based Psychiatric interventions and to reduce their impact on their well-being.

METHODOLOGY

This cross-sectional study was conducted in an NGO out patient facility in Dhaka city where clients came for the treatment of Sexually Transmitted Infection (STI) also General health check up. Study period was one year from February 2019 to February 2020. These treatment centres, funded by different non-governmental organizations, are situated in different part of the city. One register person from the NGO assigned as informer to inform hijra community in that particular area for STI/RTI treatment. The treatment facility is designed to treat STI/RTI of the hijra group of people by a female doctor. Whenever hijaras visited the centre for STI/RTI treatment first author approached them with the study. Objective of the study, anonymity of the participants and detail of confidentiality were explained to each hijra. They were also explained that even after the consent they can withdraw themselves any time from the study. After taking written and verbal consent from fifty hijra's, Socio-demographic data were obtained. Data were collected through face-to-face interviews using a semi-structured questionnaire and the diagnosis of psychiatric disorders was assigned according to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, text review (DSM-5). The collected data were classified, cleaned and analyzed.

RESULT

The duration of study was one year. Client we had to approach 63% (Thirteen Hijras were refused to enroll in this study) in order to get fixed sample of 50 clients. Mean age of the respondents was 32.94 ± 6.68 years within the range of 25 – 52 years. Half of the respondents were in age group 20 – 30 years. Most of the respondents were Muslim (98.0%). Almost two third of the respondents were illiterate just completed their primary education were 20.0%. Most of the respondents did not live with their parents, 84.0% of the respondents lived with their Guru. Very few of the respondents had good relationship with their respective parents.

Table-1: Demographic profile of the respondents (N=50)

Age (years)	Frequency (n)	Percentage (%)
20-30	21	42.0
31-40	19	38.0
41-50	9	18.0
>50	1	2.0
Mean ±SD	32.94 ± 6.68	
Min - max	25 - 52	

Education	Frequency (n)	Percentage (%)
illiterate	38	76.0
Class VIII	2	4.0
Primary	10	20.0

Religion	Frequency (n)	Percentage (%)
Islam	49	98.0

Hindu	01	2.0

Addiction	Frequency (n)	Percentage (%)
Ganja	13	26.0
Alcohol	09	1.0
Yabba	22	44.0
Phencydil	06	12.0

Occupation	Frequency (n)	Percentage (%)
Begging	20	40.0
Singing and Dancing	15	30.0
Sex worker	12	24
Service(Garments, Beauty Parlour)	03	06

With whom hijra group of people living	Frequency (n)	Percentage (%)
Parents	01	2.0
Friend	07	14.0
Group	42	84.0

Table-2: Respondents' monthly income (N=50)

Monthly income	Frequency (n)	Percentage (%)
10000-15000	13	26.0
>23000	37	74.0

Here most of the respondent's (74%) income was more>23000(U$ 271), 44% of the hijras are involved inSubstance use. Substance use is a common practice among hijras during singing, dancing also work as a sex worker due to earn more money and entertain people and clients.

Table-3: Order among brothers and sisters (N=50)

Order	Frequency (n)	Percentage (%)
1 st	16	32.0
2nd	14	28.0
3rd	15	30.0
4th	04	8.0
5th	01	2.0

Most of the32.0% respondents were 1st in order among brothers and sisters.

Table-4: Liking of the respondents (N=50)

	Frequency (n)	Percentage (%)
Like as a sex partner		
Male	39	78.0
Female	11	22.0
Preferred route		
Anus	31	62.0
Mouth	12	24.0
Hand	05	10.0
Between thigh	02	4.0
Barrier method(Condom) used by the respondents	09	18.0
Selective partner	06	12.0

As a sex partner most of the respondents' preferred male and most preferable route was Anus 62.0%. Barrier method (Condom) used by the respondents18% and the respondents had selective client 12.0%

Table-5: DSM 5 diagnosis (N=50)

	Frequency (n)	Percentage (%)
Major depressive disorder	31	62.0

Substance induced psychotic disorder	10	20.0
Histrionic personality disorder	07	14.0
Antisocial personality disorder	02	4.0

Multiple Responses

Data were collected through face-to-face interview using a semi structured questionnaire and diagnosis of psychiatric disorders was assigned according to DSM- 5. Major depressive disorder was observed in 62.0% respondents. Substance induced psychotic disorder was 20.0%. Anti-social personality disorder was observed in 14.0% respondents, and Histrionic personality disorder was observed in 04.0% respondents.

DISCUSSION

The recognition of the international community of the hijra group as a third gender removes the view of deviance or disease giving more visibility to non-hegemonic sexual behavior patterns. Although this visibility exists [6-8], the persistence of a pathological and negative discourse leading to discrimination as a learned behavior is observed. The prejudiced social mechanism in relation to hijra establishes a group differentiation that leads to even more discrimination materializing taboos, unilateral views that implement situations of inequality, social exclusion and restricted access to social rights. According to Foucault there is a preconceived 'truth' about what makes up the individual as 'subject of a sexuality', so that there is control over his body, demarcating what are deviations and what is standard, imposing control on hijra's life [9-10].

The view that society has about the hijra group of people, through this study, is not positive, as it considers that the profession of singing and dancing is disrespected and of lesser value. Although in Bangladesh, a country that adopts Islam as a religion, which strongly prohibits anal sex for most of its Muslim citizens, prostitution is considered legal. There is a shortage of data on psychiatric morbidities among hijra in Bangladesh. Due to cultural and religious barriers, gathering information and disseminating information obtained from the Hijra group of people has been extremely challenging.

In the present study, psychiatric disorders were detected through face-to-face interviews attributed using the DSM-V among the interviewees. The Major Depressive Disorder among hijras was 62% due to poor family, social support and leading a disrespectful life. In India, mental health research indicates that the burden of mental illness was high, lifelong psychiatric morbidity was 14% and 8% in Assam. The highest proportions reporting symptoms of major depressive disorders, such as psychomotor agitation (46.1%), fatigue or loss of energy (19.5%), decreased ability to think or concentrate (16.9%), Insomnia (20 , 8%) while depressed mood almost every day 29-33%, marked decrease in interest or pleasure in all or almost all activities was 20% in Manipur. The overall score for depression and anxiety was significant, the average age of respondents was 29.53 years and most of them were Hindus [11-13]. In this study, 20.0% of the participants had psychotic disorders induced by substances / drugs. Substance use is a common practice in the hijra group of people during singing and dancing and also when working as sex workers, substance use among hijra was 44%. The rationale use of substances is to make more money by entertaining customers. Histrionic personality disorder was found in 14.0% of cases and antisocial personality disorder in 4.0% of cases.

In this study, the mean age of the hijra was 32.94 ± 6.68 years, ranging from 25 to 52 years. Most respondents were in the 31 to 40 age group. 94% of respondents were Muslims because the survey was conducted in Bangladesh, a country with a Muslim majority. Most respondents did not complete high school. Almost 76.0% of respondents were illiterate and 20.0% of respondents completed elementary school. In New Delhi, India the Hijra population (46%) was involved in begging and the traditional culture of singing and dancing (38%); as a sex worker was reported by (28%), most commonly substance abuse26% [14] in this study maximum hijra 36% involved in begging, 28% involved in singing and dancing that is traditional hijra culture, 24%work as a sex worker , work in a garments,beauty parlor(6%), maximum hijra did not live with their parents, only 14.0% of the respondents lived with their friends. More than half of the respondents lived withGuru, among brother and sister's respondents were 1st order.Most of the hijra's monthly income was over 23,000 (U$ 271), which was more than Bangladesh's per capita (78.0%). In Bangladesh, per capita income per month is U$ 107.3 [15].

As a sexual partner, most hijra prefer men and the most preferred route is the anus, 31.0%, and mouth 24%; had a selective partner 12.0%. Only 12.0% used a barrier method (condom), at risk of contracting sexually transmitted diseases that also generate psychological stress in their lives. Hijras are not health conscious, so public health policy makers need to know about their psychiatric illness. Lack of safe sex practice can be the trigger for high STD transmission and also trigger psychiatric

illnesses in society. More than 1 million sexually transmitted infections (STIs) are acquired every day worldwide. Each year, there are about 376 million new infections with 1 of 4 STIs: anal warts, gonorrhea and syphilis [16, 17]. The hijras are an integral part of our society but they have continued to be marginalized in terms of basic need such as education, economic opportunity and quality of health care.

CONCLUSION

In addition to health treatment, special attention must be given to the psychiatric treatment of hijras, so that they can reconstruct their identity in a new structure. The prevalence of psychiatric morbidity among the Hijra group of people is notable in Bangladesh. For their well-being, it is necessary to work intensively on the cause of these morbidities, that is, work so that they are not discriminated against and excluded socially. Finally, there is an immediate need to improve their well-being by developing evidence-based assessments and diagnosing psychiatric morbidities, through governmental and non-governmental agencies, and also through mental health professionals and preventive agents in Bangladesh. This will allow the service provider to better understand the hijra's social barriers to plan interventions on the factors that negatively affect them in their psychiatric illness.In addition to health treatment, special attention must be given to the psychiatric treatment of hijras, so that they can reconstruct their identity in a new structure. The prevalence of psychiatric morbidity among the Hijra group of people is notable in Bangladesh. For their well-being, it is necessary to work intensively on the cause of these morbidities, that is, work so that they are not discriminated against and excluded socially. Finally, there is an immediate need to improve their well-being by developing evidence-based assessments and diagnosing psychiatric morbidities, through governmental and non-governmental agencies, and also through mental health professionals and preventive agents in Bangladesh. This will allow the service provider to better understand the hijra's social barriers to plan interventions on the factors that negatively affect them in their psychiatric illness.

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