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Burden of self-reported mental health among key populations in Dhaka and Jashore: A silent killer

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Background

Key populations (KPs)[θ], such as men who have sex with men (MSM), Male Sex Workers (MSW), hijra, and Female Sex Workers (FSW), have always been perceived as synonymous with HIV and Sexually Transmitted Infections (STIs). As a result, these two disease concerns have remained the sole focus of KP-related research and interventions, neglecting broader health concerns, including their Sexual and Reproductive Health and Rights (SRHR).

The programme for HIV and AIDS by icddr,b has pioneered the first-ever SRHR surveillance for KPs in Jashore for FSW and Dhaka for MSM, MSW, and hijra. Both rounds of data collection were completed in Round 1 (2023) and Round 2 (2025). The SRHR surveillance included 22 individual-level outcome indicators drawn from the globally acclaimed SRHR literature. The indicators combine biomedical and behavioural measures, including self-reported mental health.

Examples of SRHR indicators:

- HPV and other STIs
- Unintended pregnancies
- Abortion
- SRHR service coverage
- Sexual health concerns
- **Mental health (self-reported)**

Why mental health?

The existing yet limited global evidence demonstrates the rising mental health burden among various KPs. For instance, a systematic review based on Low- and Middle-Income Countries (LMICs) among FSW revealed that the pooled prevalence rates of depression, anxiety, and psychological distress were 42%, 21%, and 41%, respectively[1]. A systematic review revealed a pooled prevalence of 39% for mental health difficulties, such as depression, anxiety, stress, and suicidal ideation, among young gender- and sexually diverse populations, which also include MSM (including MSW) and transgender people (known as hijra in South Asia)[2]. Mental health research remains scant in the Southeast Asian region. KPs are at elevated risk of compromised mental health outcomes due to internalised and enacted homophobia, criminalisation of same-sex behaviours and sex work, gendered power differentials, poverty, and lack of sensitisation about these populations. Thus, it is the demand of the time to measure the situation of mental health among the KPs and introduce evidence-based mental health-focused research and intervention.

Why is mental health among KPs a concern?

- Stigmatisation
- Criminalisation Gendered power dynamics
- Poverty
- Legal challenges
- Lack of sensitisation

[θ]*Key populations include males having sex with males (MSM), male sex workers (MSW), hijra, and female sex workers (FSW) but exclude people who inject drugs (PWID) in the AdSEARCH project as they do not present sexual health-related complexities as other KP*

Capturing the mental health burden: Methodological adaptation for KPs

The SRHR surveillance has examined the self-reported mental health concerns of MSM, MSW, hijra, and FSW using a single-item mental health assessment instead of using validated psychometric scales. The use of a single-item dependent health assessment scale has gained prominence in population health research, especially since it is challenging to collate a comprehensive set of measures within a limited timeframe. Though effective for clinical settings, they are deemed impractical for community surveys[3]. Therefore, this approach has been adopted in the American Journal of Public Health and the Behavioural Risk Factor Surveillance Survey mandated by the Centres for Disease Control (CDC)[4,5].
Moreover, a recent study indicated moderate levels of specificity and sensitivity in a study examining mental health among cancer patients. Single-item measures have successfully assessed depressive moods among adolescents[6], showcasing their adaptability across various demographic groups. As our SRHR surveillance examines a lot of SRHR indicators, this calls for quantitative measures of self-reported feelings of depression, anxiety, and stress among KPs, leading to the development of a single-item questionnaire in line with established population studies. Although standardised questionnaires are conventionally recommended for an accurate assessment of mental health symptoms, the decision was to adopt a simplified approach, motivated by the intricate nature of the issue, time constraints, and the primary study goal of capturing KPs' feelings without the obligation to perform a clinical diagnosis.

Key Findings

An overview of the burden of various mental health concerns: Quantitative findings

A considerable percentage of MSW/hijra/FSW reported depression/anxiety/stress:

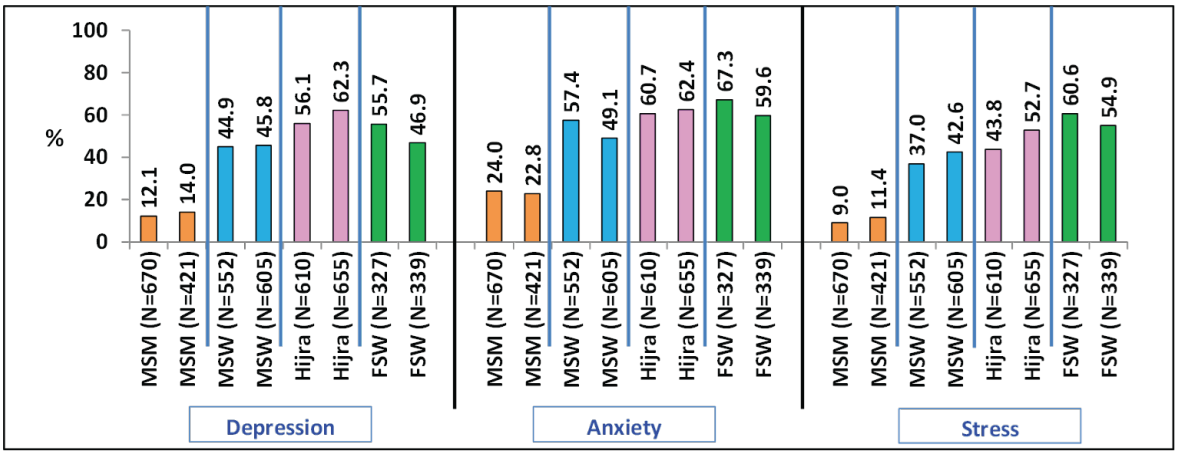


Figure 1: Single-item community-based mental health assessment during the last 12 months: Round 1 vs. Round 2

Both suicidal/attempt and self-harm were significantly higher among FSW than other KPs ($p<0.05$):

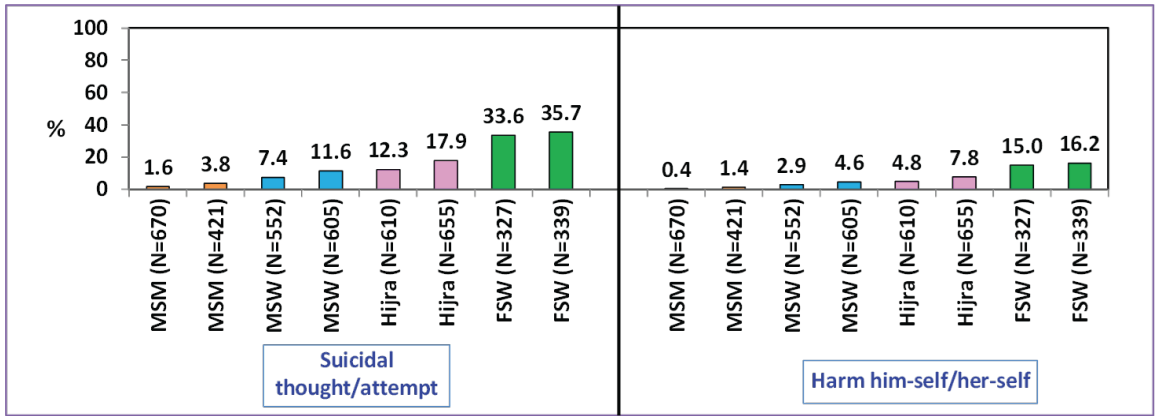


Figure 2: Prevalence of suicidal thought/attempt and harm him-self/her-self during the last 12 months: Round 1 vs. Round 2

Exploring the underlying contexts of mental health concerns: Qualitative findings

Qualitative data were collected to explain insights from quantitative data. Therefore, a set of qualitative in-depth interviews was conducted on selected SRHR indicators. This also included the self-reported mental health of all KPs (Figures 1 and 2).

MSM, MSW, and hijra

- Gender dysphoria: Some participants felt frustrated about the disconnect between their sex assigned at birth and their preferred gender expression.
- Gender identity crisis: Participants struggled to attach meaning to their gender identity within the heteronormative context of Bangladesh.
- Lack of familial and societal acceptance: Participants felt emotionally distressed as they could not pursue a family life with a socially accepted job.
- Fear of identity disclosure: Many participants fear their double lives would be exposed.
- Anxious about risky sexual behaviours: Many participants are aware that their sex lives are dangerous and are, hence, worried about contracting STIs.

> *"Why did I end up like this (hijra)? If I were actually born as a girl, I would have been able to take care of my parents, I would have been able to get married, and I would have had a partner, children and a normal family life. but I am a hijra, that is why I am stuck in this community. That's why I feel bad"*
>
> - Hijra, 38 years, IDI

FSW

- Hopelessness and despair associated with sex work: Participants noted that they often entered this profession out of despair and economic hardship, where they could not find any other viable income-generating source. They also felt depressed due to navigating difficult client relationships.
- Intimate partner violence and conflict: Difficult relationships, violence, physical assault, and infidelity, which were all rooted in gendered power differentials.
- Fear of exposure: Many FSW felt wary about their sex work careers being exposed.

> *"I raged out of my home, and then my mother-in-law brainwashed my husband into divorcing me, and he ultimately agreed to it. After hearing that, I broke down a lot because I love him so much. So, then I hung myself with a rope because at that moment I just wanted to end my life."*
>
> - Street FSW, 24 years, IDI







Way Forward: Identifying priority areas for further research and intervention

This SRHR surveillance raised specific concerns about the overall self-reported mental health of KPs. This exploration was crucial in the context where mental health was a relatively neglected component among KPs. Considering the substantial rates of depression, anxiety, stress, and suicidal thoughts/attempts (Figures 1 and 2) and concerning gaps in mental health service uptake (Table 1), the situation demands further mental health assessment using locally validated psychometric scales. Such assessment could guide the development of a contextually appropriate and culturally competent intervention targeting mental health needs of diverse groups of KPs.

The Program for HIV and AIDS, icddr,b provides HIV/STI prevention services to MSM/MSW/hijra via 64 service centres in 23 districts. Recent size estimation data indicate that 23% of the FSW, 50% of the MSM (including MSW), and 55% of the hijra are covered by interventions, serving as their first line of care. Yet, they have always prioritised HIV and STI prevention and management; therefore, mental health issues received less attention. In existing interventions, most cases and counselling episodes are handled by medical assistants or outreach supervisors cum counsellors, who are paraprofessional healthcare providers and community-based service providers, respectively. However, considering the gravity of the self-reported mental health burden, it is urgently needed to deploy a dedicated counsellor position with the appropriate academic and clinical background.

Types of services received during the last 12 months (among those who received services during the last 12 months)*	MSM (N=267)	MSM (N=274)	MSW (N=331)	MSW (N=464)	Hijra (N=401)	Hijra (N=475)	FSW (N=290)	FSW (N=301)
Received psychosexual counselling	3.0%	6.6%	7.3%	14.2%	5.2%	16.4%	0%	3.7%
Received psychosocial counselling	0.4%	1.8%	0.9%	8.6%	0.5%	12.4%	0%	15.3%

*Multiple responses

Table 1: Uptake of mental health counselling services by all KP groups during Round 1 and Round 2

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