

Psychological Distress and Sexual Health Concerns among Gender and Sexually Diverse Populations in Dhaka

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Background

Sexual Health Concerns (SHC) are subjective experiences related to sexual function, shaped by cultural norms and social expectations, and perceived as concerns rather than clinically diagnosed diseases or dysfunctions^[1,2]. In contrast, Psychological Distress (PSD) refers to a state of emotional suffering characterised by symptoms of depression (e.g., loss of interest, sadness, hopelessness), anxiety (e.g., restlessness, tension), and stress (e.g., life adversity, trauma) that impair daily functioning^[3,4]. In severe and persistent cases, PSD increases the risk of psychological disorders such as major depressive disorder, generalised anxiety disorders, schizophrenia, and somatisation^[5]. Importantly, global evidence demonstrates that Gender and Sexually Diverse Populations (GSDP) disproportionately experience PSD^[6] as well as biomedically defined sexual dysfunctions (e.g., premature ejaculation, erectile dysfunction) compared with heterosexual counterparts^[7]. Moreover, studies on heterosexual men suggest that culturally shaped SHC are linked to PSD and risky sexual behaviors^[8,9].

Sexual and Reproductive Health and Rights (SRHR)

related research and interventions for GSDP, such as Men who have Sex with Men (MSM), Male Sex Workers (MSW), and hijra, remain narrowly focused on Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infection (STI) prevention across the global contexts, including Bangladesh. This limited scope positions GSDP primarily as agents of disease transmission, overlooking their broader SRHR needs. Furthermore, evidence also indicates that unaddressed psychological distress contributes to maladaptive coping, unsafe sexual practices, and poor SRHR health-seeking^[10]. Nevertheless, comprehensive data remain scarce on culturally influenced SHC and their intersections with PSD among GSDP, despite their heightened vulnerability. Therefore, a comprehensive understanding of the intersections between SHC and PSD was crucial to address the unmet SRHR needs of GSDP, informing inclusive and culturally sensitive interventions, and strengthening the existing HIV/STI prevention efforts in heteronormative contexts like Bangladesh.

Study Objective

The study aimed to explore and understand the burden of PSD and SHC, their associations, health-seeking behaviors, and the dynamics shaping these concerns across GSDP in selected areas of Dhaka, to inform a culturally sensitive, comprehensive intervention model.

Methodology

The study employed a mixed-methods design, beginning with a quantitative survey to assess the burden of SHC and PSD, their associations, and health-seeking

behaviour for these issues, followed by a qualitative exploration to explain and contextualise the findings. The survey was conducted among:

469 members of GSDP recruited through a first-come, first-served approach of convenience sampling at two Drop-in-Centres (DICs) in Dhaka

142
MSM

180
MSW

147
Hijra

A semi-structured questionnaire, adapted from literature and incorporating locally validated psychometric tools (PHQ-9, GAD-7, PSS-10), was used for data collection. The qualitative component included:

24 in-depth interviews with MSM, MSW, and hijra (via maximum variation sampling)

11 key-informant interviews with experts and stakeholders

2 focus group discussions with DIC service providers (both via purposive sampling)

Key findings

Burden of the PSD and SHC

Nearly two-thirds (63%) of participants reported at least one (Fig 1).

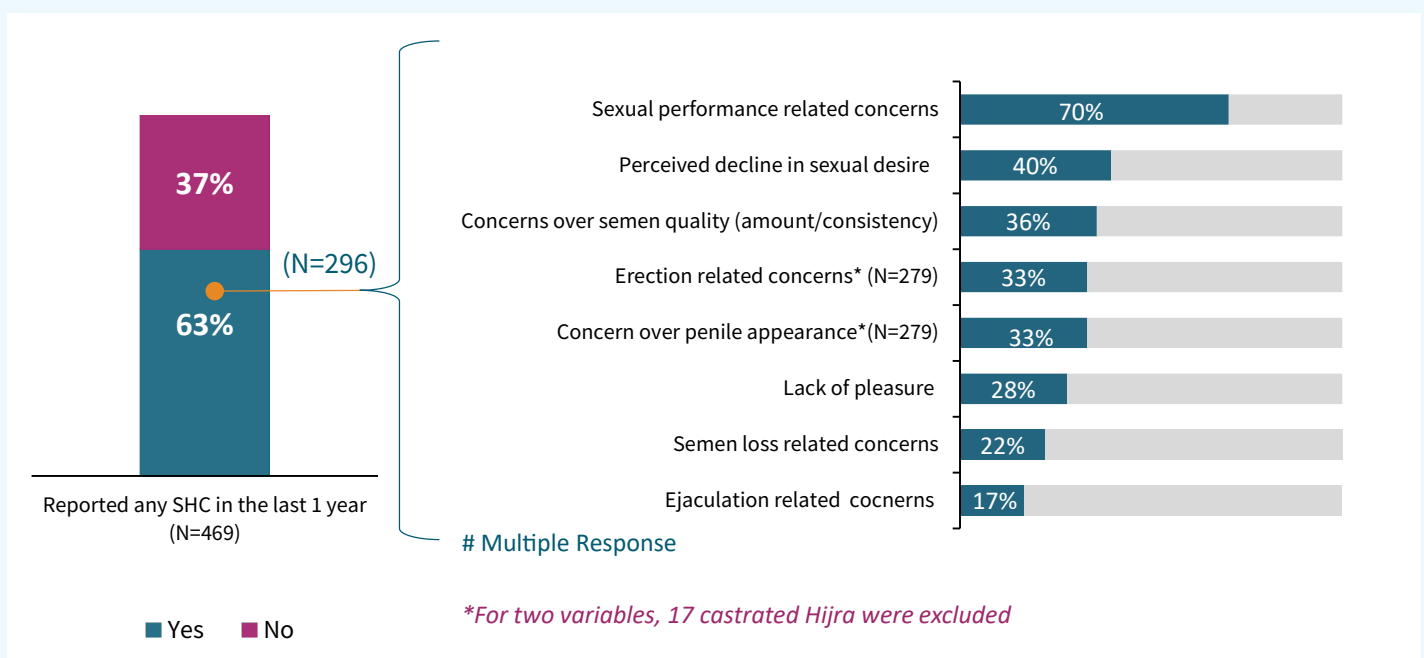


Fig 1: Pattern of SHC among the participants

37% of all participants reported depression, 43% anxiety in the last two weeks, and 86% moderate to high stress in the last month (Fig 2). Hijra experienced significantly more depression, anxiety, and stress than other participants.

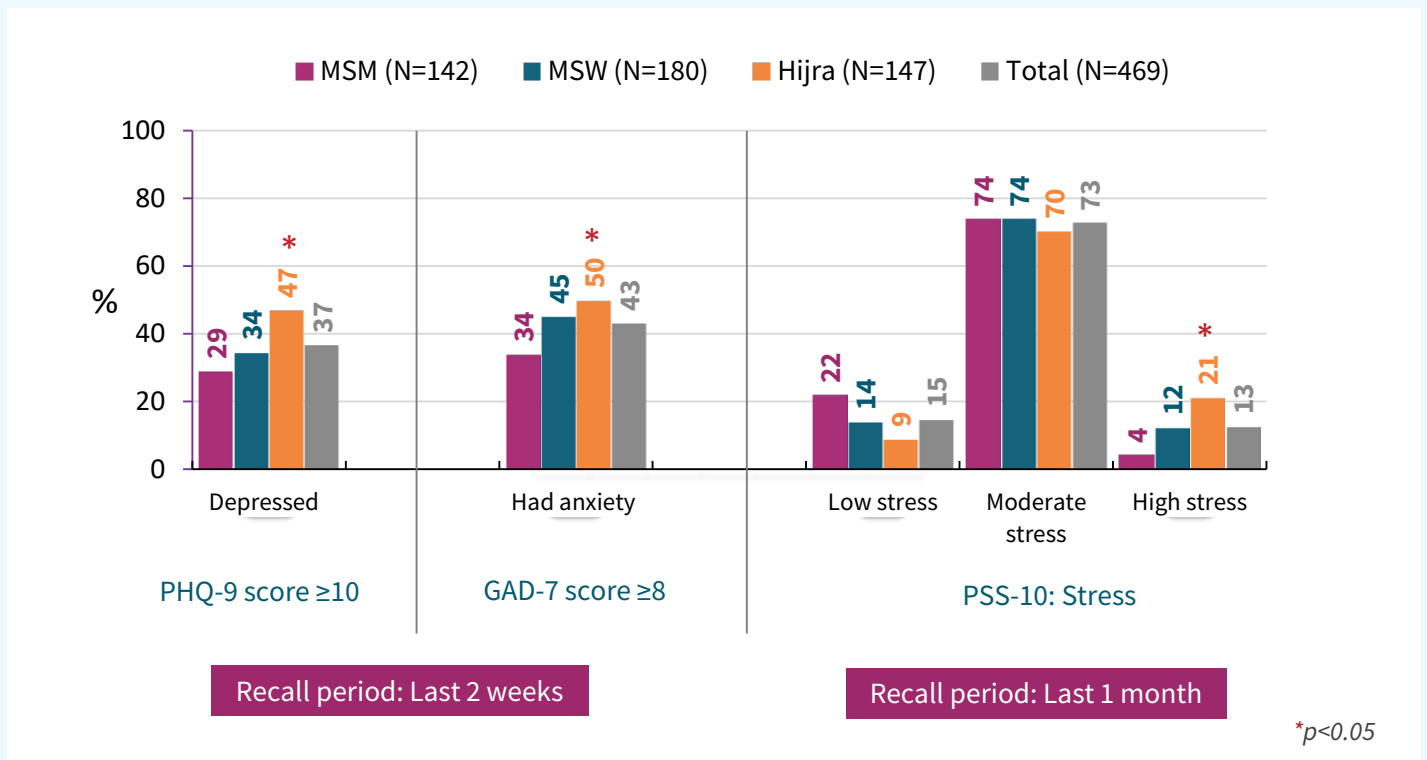


Fig 2: Patterns of PSD among the participants

Association between SHC and PSD

Multivariate logistic regression analysis showed that those who reported any SHC in the past year were 2.2 (95% CI: 1.4-3.4; p=0.001) times more likely to have depression, 2.0 (95% CI: 1.3-3.0; p=0.001) times more likely to have anxiety, and 2.1 (95% CI: 1.2-3.7; p=0.009) times more likely to have stress than those who did not report any SHC in the past year.

Health-seeking behavior for SHC and PSD

- Among those who had any SHC in the past year, only 35% sought healthcare.
- In the case of PSD, only 5% sought professional psychological services.
- Qualitative data from FGD and IDI revealed that, although participants prefer DIC as a safe and reliable space to seek healthcare for their SHC and PSD. However, during FGD, DIC staff mentioned that their capacity to handle these issues needs to be increased.

Public health implications of SHC

Participants engaged in various risky behaviors to address their SHC. For example, 20% changed their sex partners frequently, 19% had condom-less sex, 19% tried non-prescribed sexual stimulant pills/products (oil, lotion, spray, etc.), 12% used illicit drugs to improve SHC, thus engendering a public health concern (Fig 3).

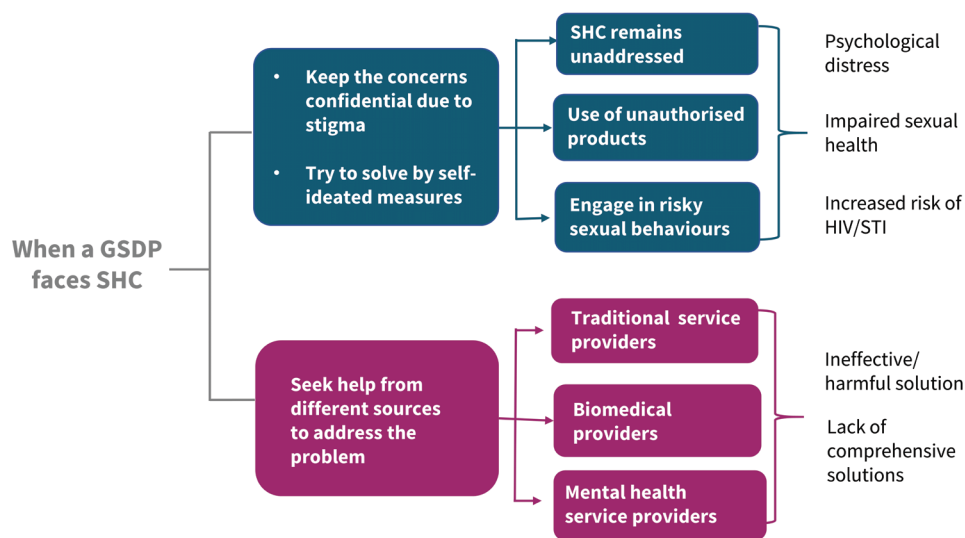


Fig 3: How GSDP responds to Sexual Health Concerns (SHC) and the resulting impact on their well-being

Conclusion

This study underscores the importance of not viewing sexual health concerns and psychological distress as separate issues, but as deeply intertwined experiences, especially for deeply marginalised populations like MSM, MSW, and hijra. Therefore, to advance SRHR equitably, we must bring visibility to what remains invisible and extend care to those who are too often overlooked.

Way forward

- Develop community-based screening tools to identify individuals at risk of SHC and PSD to routinely screen GSDP.
- Capacity building of DIC staff members for screening, delivering primary counseling, basic sex education, and mental health awareness as the first-line support.
- Establishment of a referral mechanism linking GSDP with SHC and PSD to sensitised and multidisciplinary experts (e.g., psychologists, psychiatrists, and other sexual health experts) for culturally tailored comprehensive care.

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