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Mapping the provision of Sexual and Reproductive Health and Rights (SRHR) services and key populations' accessibility and affordability of SRHR services in selected districts of Bangladesh

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Background

Global studies have documented Key Populations' (KPs) health disparities in accessing available SRHR care based on their gender identity, sexual orientation, and sexual practices[3–7]. Financial inaccessibility, lack of provider knowledge and education, limited information availability, systemic and interpersonal discrimination, and cis-normative and gender biased health systems, which hinder KPs from exercising their SRHR rights[8]. Additionally, the readiness of health systems to provide SRHR services is suboptimal in South and South-East Asian regions[9–12].

This mixed-methods study aimed to assess whether SRHR services in Bangladesh are available, ready, and accessible for KPs, including Female Sex Workers (FSW), men who have sex with men (MSM), Male Sex Workers (MSW), and transgender women (hijra), who face persistent legal, social, economic and health disadvantages[13]. In Bangladesh, same-sex relations are criminalised, transgenderism and homosexuality are stigmatised, and quasi-legal sex work further reinforces stigma, fear, and avoidance of care[14–18]. Prior studies in Bangladesh identified provider bias, breaches of privacy, affordability barriers, and low facility readiness, especially in primary care, limiting SRHR service uptake[11,19,20]. Moreover, the refusal of SRHR services by healthcare providers due to religious and cultural beliefs was explored in previous research[21].

Current programmes for KPs are fragmented and HIV and STI-centric due to long-standing donor preferences despite KPs' broader SRHR needs[22].

Sexual and reproductive health and rights (SRHR)

It is an integral part of healthcare; it ensures safe, respectful sexual lives, informed reproductive decisions, and access to quality services[1].

Access to SRHR services is poor worldwide. An estimated 4.3 billion people of reproductive age lack adequate SRHR services[2].

Most previous studies in this region focused on SRHR issues of general populations or a single SRHR component for KP-sensitive services, narrowly focused on HIV and STs, without evaluating the quality of comprehensive SRHR services for KPs. Furthermore, little is known about the perspectives of both providers and KPs on the inclusivity and readiness for providing SRHR services, thus warranting research that incorporates both quantitative breadth and qualitative depth. Additionally, evidence on readiness across different types and tiers of health facilities, particularly for SRHR services tailored to KPs, remains scarce. These gaps informed this study's focus on mapping SRHR services for KPs across different types and tiers of health facilities in selected cities of Bangladesh. This study provides the first mixed-methods assessment of SRHR service availability and readiness of health facilities to provide SRHR services for KPs in Bangladesh, along with evaluation of providers' perspectives regarding SRHR services for KPs.

Objectives

To map the health facilities located in Dhaka and Jashore cities in order to assess the availability of SRHR services (in both outpatient and in-patient departments) for the selected KPs (i.e., MSM, MSW, FSW and hijra) in selected cities of Bangladesh.

To explore the scopes, challenges, and barriers to accessibility and affordability of SRHR services targeted to the KPs.

To assess and understand the readiness and willingness of the health service providers and the readiness of health facilities in providing SRHR services to the KPs.

To assess and understand the unmet SRHR needs and gaps of SRHR services targeted for the KPs and explore KPs' opinions about the available services.

To generate evidence-based recommendations for policy planners on SRHR service provisions for the KPs.

Methodology

A parallel convergent, mixed-methods study comprising of quantitative and qualitative components co-occurring in Dhaka (for MSM, MSW, and hijra) and Jashore (for FSW).

Theoretical frameworks followed

Adapted ***WHO Service Availability and Readiness Assessment (SARA)*** framework for health facility readiness

Adapted ***Donabedian model*** for the quality assessment of SRHR services for KPs

Adapted ***Levesque's conceptual framework*** to synthesise qualitative findings related to SRHR services accessibility

Adapted ***integrated behavioral model*** to thematically outline qualitative insights on willingness of HCPs to provide SRHR services to KPs

Sample size and sampling

Health facility assessment	Quantitative survey of KPs	Qualitative interviews
- **38** in Dhaka and **20** in Jashore after excluding non-existence and refusal cases - Multistage stratified random sampling	- **452** KPs in Dhaka (MSM, MSW, and hijra) and **393** FSW in Jashore - First come first serve basis	- *In-depth interviews (IDI):* **18** in Dhaka and **24** in Jashore; Maximum variation sampling - *Key informant interviews (KII):* **18** in Dhaka and **6** in Jashore; Intensity and snowball sampling - *Focus group discussions (FGD):* **3** in Dhaka and **1** in Jashore; Homogeneous sampling

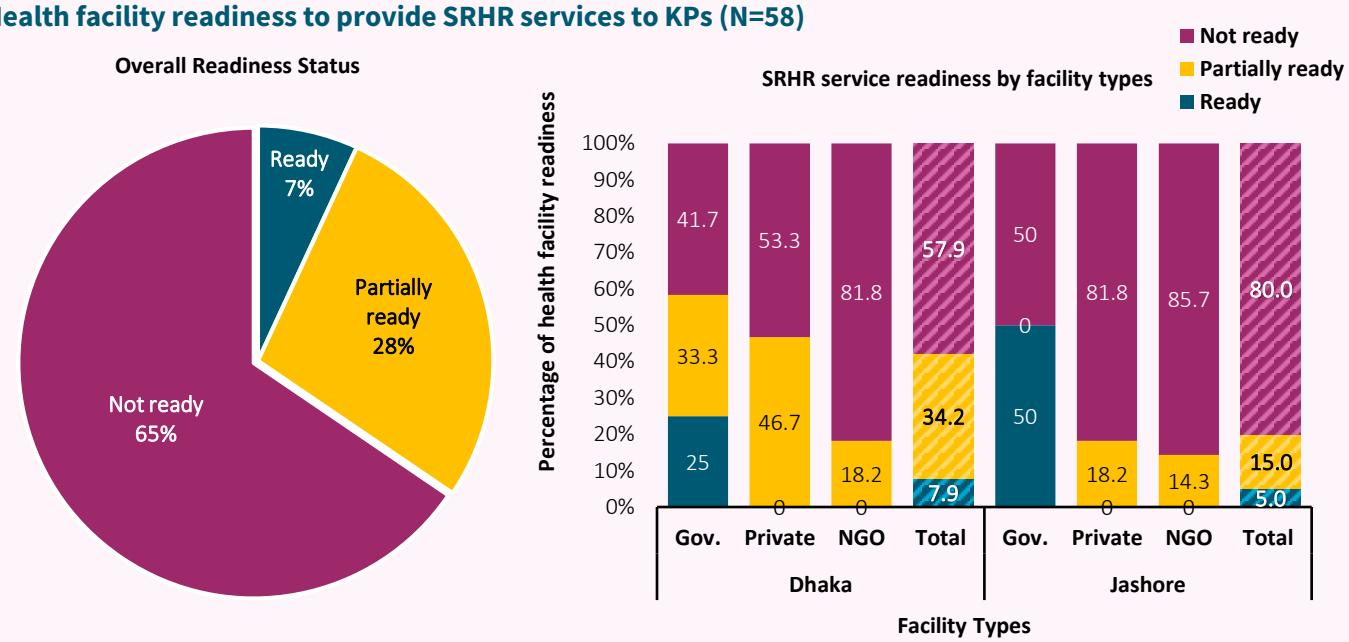
Data collection

Formative phase	Health facility Assessment	Quantitative survey	Qualitative interviews
- Document review - Field testing of data collection tools - Training for data collection	- Interview of key personnel using semi-structured questionnaire - Observation at health facilities - Simulated patient visit by peer researchers	- Enlisted KPs of 8 NGO-run DICs in Dhaka - Participant list of the icddr,b project office in Jashore - Some unlisted FSW were also recruited - Interview places: DICs in Dhaka, icddr,b field office, hotels, spots, and the residences of the FSW	- IDI: participant list of the DICs and SRHR surveillance study office along with the ongoing quantitative survey - FGD: public and DIC service providers in Dhaka and NGO workers in Jashore - KII: SRHR service providers, UN representatives, policy planners, hospital authorities, expert field workers, NGO activists and CBO leaders - At convenient places and audio-recorded with consent

Key Findings

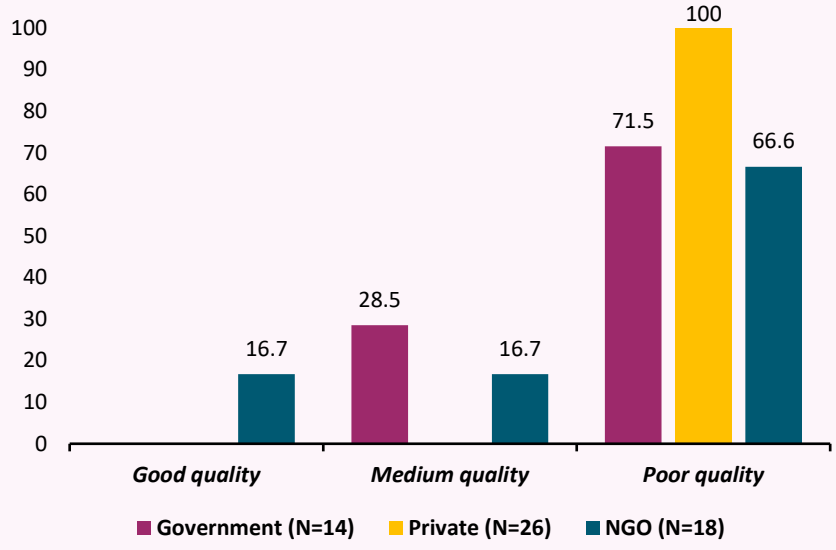
Only **7%** (**4** government facilities out of **58** health facilities) of the facilities were fully ready to provide SRHR services tailored to the needs of KPs

Health facility readiness to provide SRHR services to KPs (N=58)



** Cutoff values: >70% score = ready; 50-70% score = partially ready; <50% score = not*

Quality of SRHR services for KPs (N=58)

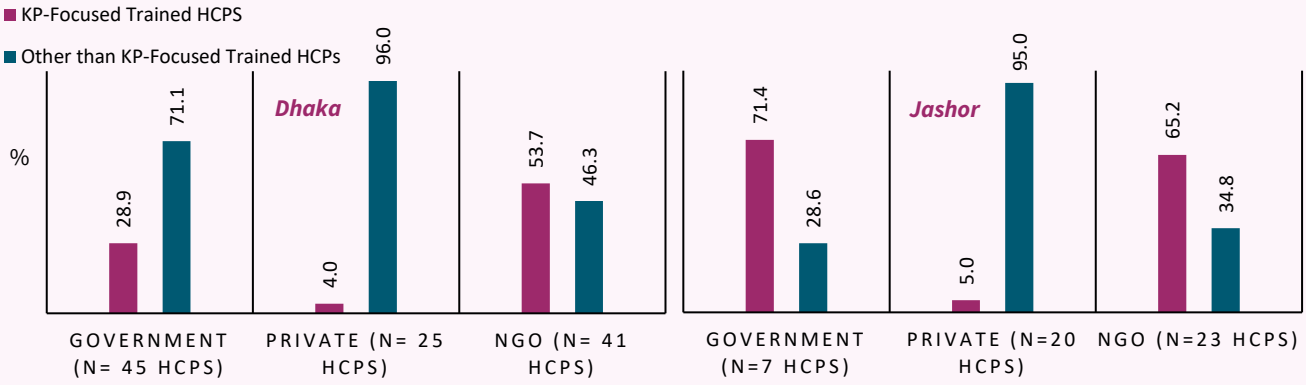


Overall, only 5.2% of the health facilities were found to provide good-quality SRH services to KPs, all of which were NGO-run centers.

Cutoff values:

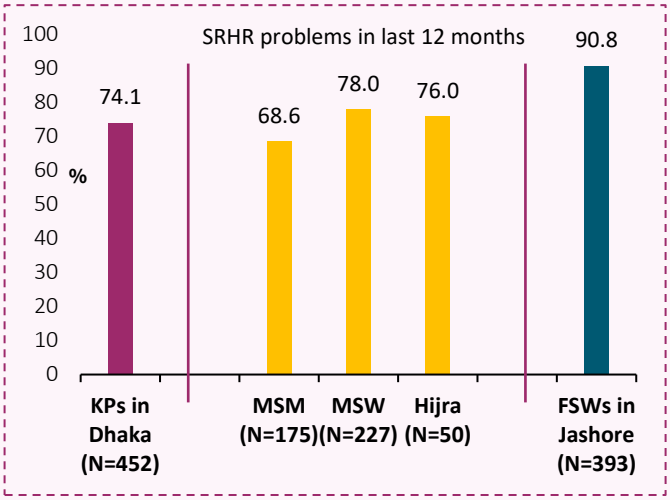
- *≥75% score = good quality*
- *50-74.9% score = medium quality*
- *<50% score = poor quality*

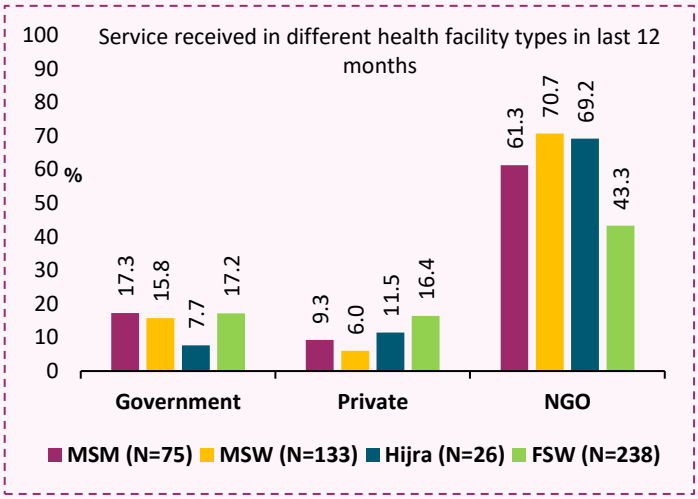
KP-focused training status among HCPs in the health facilities



SRHR problems and service received in the last 12 months

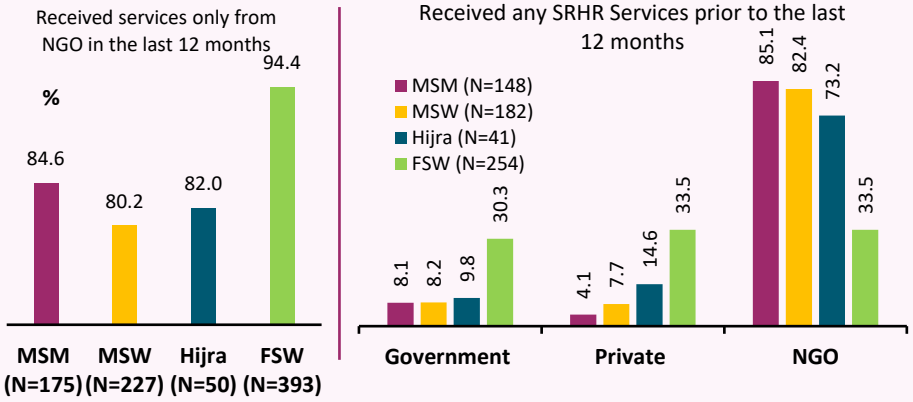
74.1% KPs in Dhaka (MSM, MSW and *hijra*) and **90.8%** FSW in Jashore reported any SRHR problems in last 12 months. The majority of the KPs sought services from NGO clinics; only **17.3%** MSM, **15.8%** MSW, **7.7%** *hijra* and **17.2 %** FSW visited government facilities.





Preference for health facilities by KPs for their SRHR problems faced during their lifetime

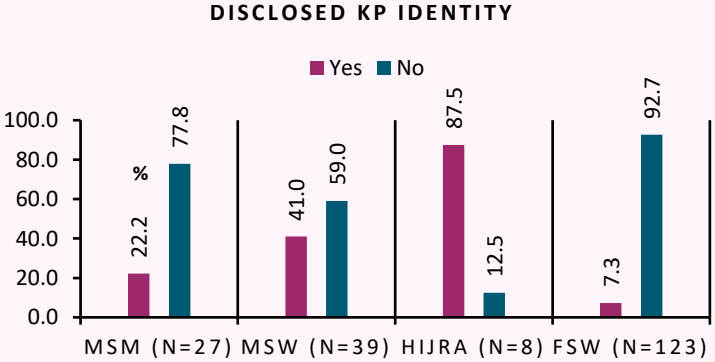
Among KPs who received SRHR services exclusively from KP-designated facilities in the past 12 months, most in Dhaka showed a strong lifetime preference for NGOs for SRHR care. Although **94.4%** of FSWs reported exclusive NGO use in the past 12 months, no strong preference existed earlier due to limited NGO-based support.

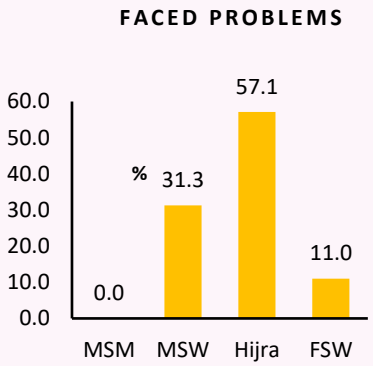


Qualitative findings revealed that, many ***hijra*** and **MSW** participants, who were visibly identifiable by their attire or feminine behavior, experienced social barriers like exclusion for being gender-diverse, made it difficult for them to access government healthcare facilities. Some hijra participants said doctors would maintain excessive physical distance in government facilities and rush through consultations, as if trying to avoid touching them.

Disclosed KP identities and faced problems in govt. and private facilities in the last 12 months

The majority of the KPs concealed their community identity while receiving SRHR services; only 39.2% in Dhaka and 7.3% in Jashore disclosed their KP identity. Among those who disclosed their identity, gender-diverse KPs primarily faced problems such as discriminatory behaviors, service refusal and other forms of misbehavior by the providers.



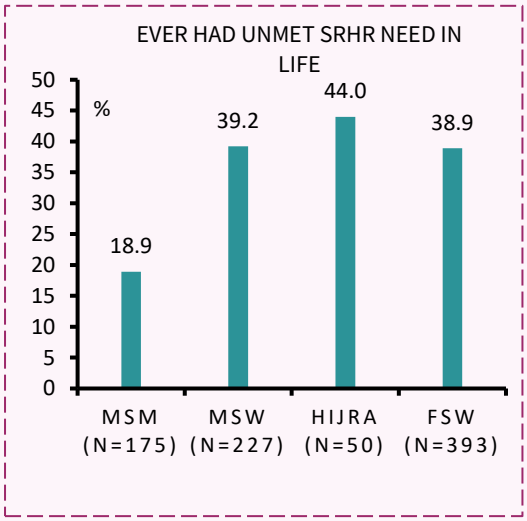


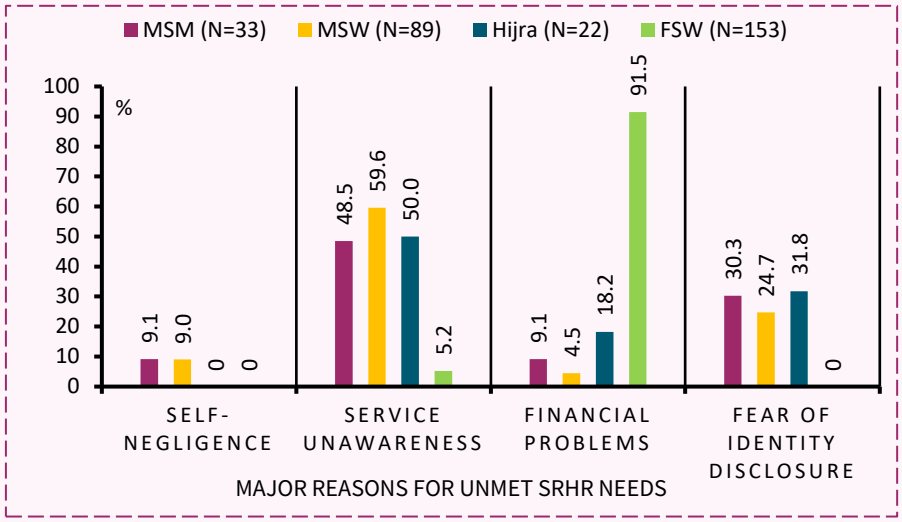
Many MSW and hijra participants were concerned about being judged, discriminated against, or stigmatised by healthcare providers, particularly in relation to anal sex practice. This fear often led to delays in seeking treatment, which in turn worsened their conditions. These negative experiences led many participants to hide their sexual orientation or gender identity during healthcare visits or to avoid government services altogether.

Most of the hijra simulated clients of our study who visited government and private healthcare facilities while wearing a chadra (female attire) faced difficulties with gender registration.

Unmet SRHR needs among KPs

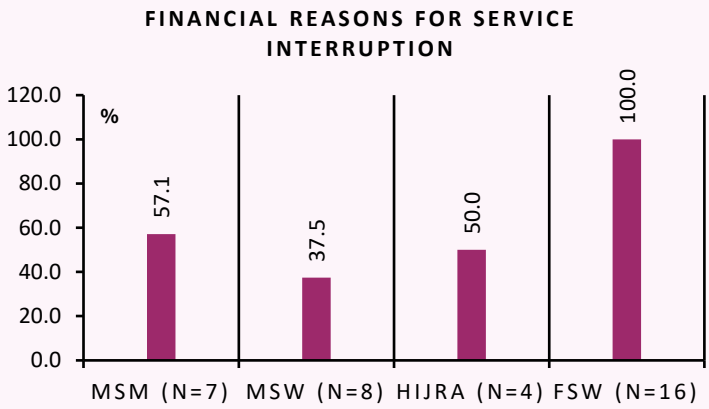
KPs who receive SRHR services from only KP-designated facilities in the last 12 months, majority of them in Dhaka preferred other NGO clinics as formal healthcare centres for their SRHR problems during their lifetime. FSWs in Jashore primarily received services from private and government centres throughout their lives, except in the last 12 months, due to the lack of KP-specific NGO support.





SRHR service interruption due to financial constraints in the last 12 months

25.7% KPs in Dhaka and **13.0%** FSW in Jashore reported experiencing SRHR service interruption due to various reasons, of which financial issues were the most prominent.

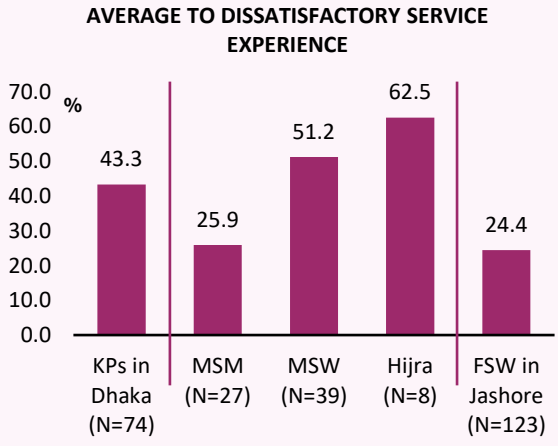


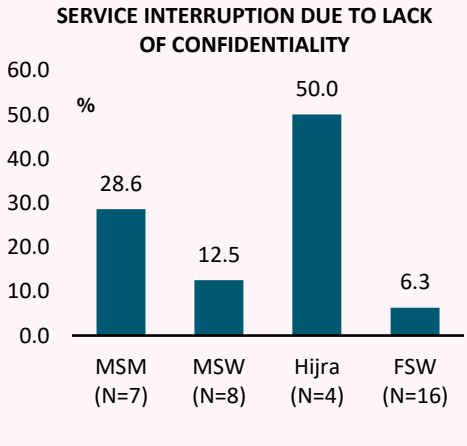
Most participants had no stable income sources, earning through informal sources. Many KPs had to avoid or discontinue treatment as they could not afford investigations, medications, or treatments. To avoid the hassles of government facilities and the high costs of private ones, some KPs went to informal providers, which ultimately worsened their condition.

"I visited many village doctors in my area; my husband took me to different local doctors for about six months, but the problem was not solved…We couldn't afford a proper doctor because of our financial situation. " (IDI, Hotel-based FSW, 46 years)

SRHR service experience in the last 12 months

KPs, mostly MSW and hijra were dissatisfied with the SRHR services they received. **26.3%** of KPs in Dhaka and **6.3%** FSW in Jashore experienced service interruption in govt. facilities due to concerns about confidentiality.



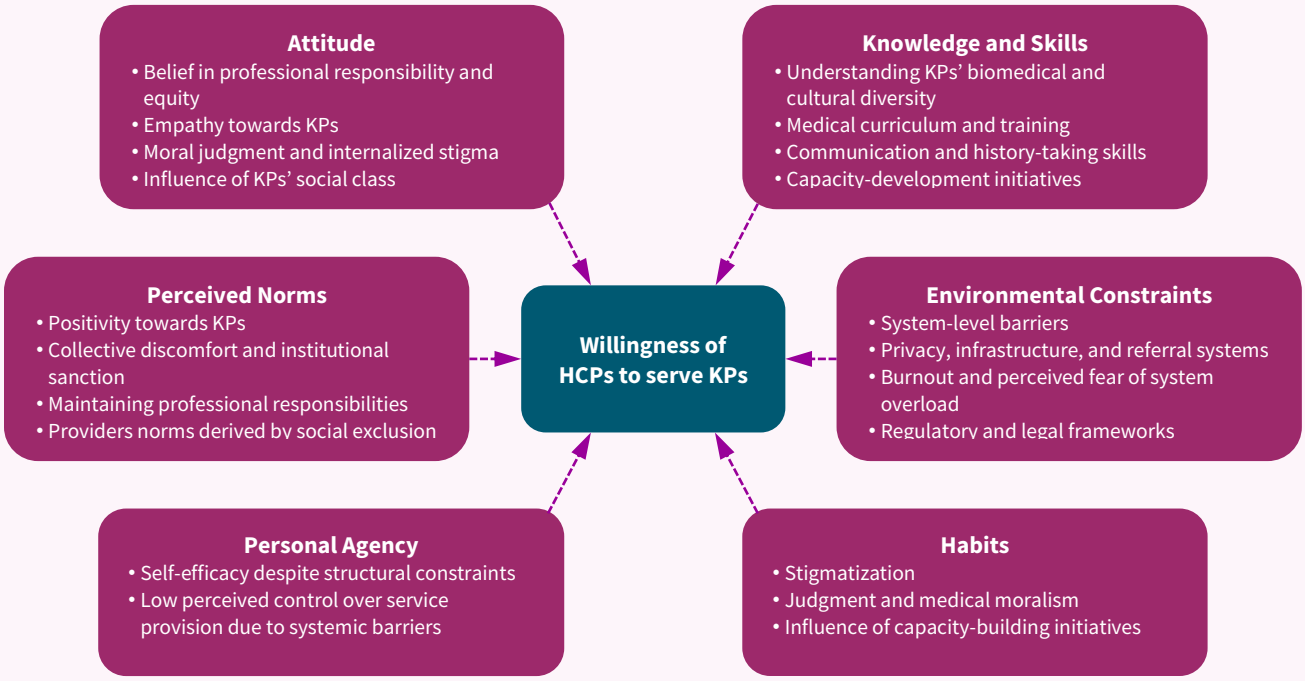


Most of the KPs who visited government healthcare facilities reported serious breaches of audio-visual privacy. In many cases, multiple healthcare providers share a common room and consult with different patients simultaneously.

"The doctor at that government medical college hospital asked questions in front of others, not in private…When I went behind the curtain for a physical check-up, I noticed that everyone was staring through the gaps…Doesn't it feel uncomfortable? I was afraid of being teased when I came out…" (IDI, MSW, 40 years old)

Drivers of HCPs' Willingness to provide SRHR services to KPs

Several HCPs demonstrated positive attitudes, driven by professional ethics and a commitment to inclusive service provision. However, it is crucial to acknowledge that not all providers exhibited favorable attitudes. Some expressed explicit or implicit discomfort with the identities and practices of KPs, fueled by religious beliefs and societal stigma.



Way Forward

Short-term (≤12 months)	Medium-term (1–3 years)	Long-term (≥3 years)
- Sensitisation of various types of HCPs - Awareness among the general population about KPs' rights by the health education department - Periodic refresher training of HCPs on KP culture and needs - Knowledge dissemination among KPs regarding existing SRHR services - Establishing a proper referral system - Listing and MoU with for subsidised lab investigations and medicines for KPs - Increase government monitoring and accountability	- National guidelines and SOPs on KP SRHR servicess - National guidelines for telehealth, e-health and m-health services for KPs' SRHR problems - Increase budget allocation for KP SRHR services - Dedicated SRHR service corner for KPs in government facilities - Alternative livelihood and earning sources for KPs; formal recognition of gender-diverse population and registration of non-binary gender norms in healthcare facilities - Sex education and awareness campaigns on SRHR at educational institutions	- Revising medical curricula for different HCPs - Integration of KP-specific SRHR services in all tiers of government facilities - Recruitment of dedicated and skill-mix-balanced SRHR service providers - Strengthen primary healthcare systems for - Strengthen all levels of government, NGO-based (DIC) and other KP-focused health facilities by incorporating integrated SRHR services - Intervention with support from the Ministry of Education to enroll KPs in formal education

Conclusion

This mixed-methods study highlights that existing SRHR services in Bangladesh are fragmented and target mainly the general population, offering minimal and suboptimal SRHR care to KPs. There are accessibility and affordability challenges faced by all types of KPs. Readiness of health facilities for KP-responsive SRHR services is poor; only a small number of facilities were completely ready, whereas the majority were not ready. Unmet SRHR needs are common across all KP groups due to financial hardship, facility-based and societal discrimination, and the lack of KP-sensitive, inclusive SRHR care. Privacy breaches, particularly in government facilities, fear of identity disclosure, and stigma discourage formal care-seeking, as reported by many participants. This negative health-seeking behavior, rooted in social barriers and exclusion, further increases risks of health-related complications. Dissatisfaction with public and private services is high, which is driven by long waiting times, discriminatory attitudes by HCPs, poor provider communication, limited diagnostics, and hidden costs in government centers, and high service costs in private facilities. A safer facility environment that ensures privacy and confidentiality, respectful and non-judgmental care, free or low-cost services, KP-sensitive training for HCPs, modified service delivery with separate consultation rooms and queues, and provision of outreach services are required for KP-sensitive, inclusive SRHR services and advancement towards Universal Health Coverage (UHC) commitment.

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