Diversity & Inclusion Research

WILEY

RESEARCH ARTICLE OPEN ACCESS

The Female Sex Workers' Experiences of Accessing Healthcare Services in Bangladesh: A Qualitative Investigation

Shaharior Rahman Razu[1,2] | Kim Usher[1] | Rikki Jones[1] | Md. Shahidul Islam[1]

[1]School of Health, University of New England, Armidale, Australia | [2]Sociology Discipline, Khulna University, Khulna, Bangladesh

Correspondence: Shaharior Rahman Razu (srazu@myune.edu.au)

Received: 9 May 2025 | **Revised:** 9 May 2025 | **Accepted:** 12 May 2025

Funding: The study was supported by the Australian Commonwealth Government at the University of New England, Australia.

Keywords: access | Bangladesh | female sex workers | healthcare | hospitals | qualitative

ABSTRACT

The female sex workers (FSWs) are vulnerable to different health problems due to the nature of the profession. There is a major concern regarding their healthcare access and the quality available to them particularly in developing countries. This study investigated the experiences of female sex workers seeking healthcare in the southwestern region of Bangladesh. We used a qualitative research approach and the data were collected from February 1 to August 31, 2023 using a semistructured interview guide. Interviews were undertaken with 20 participants selected through purposive sampling from Khulna, Satkhira, and Jessore districts through in-depth interviews. We employed inductive reasoning and thematic analysis techniques in this study. Findings indicate FSWs seeking healthcare were subjected to stigma and harassment. There was a lack of affordable specialized healthcare services including general physical, mental, and reproductive and sexual care, and a shortage of personnel and healthcare equipment in the healthcare centers. At the same time, corruption and bad management resulting suboptimal healthcare services being delivered, along with subpar in and out-patient conditions experienced by the participants. We conclude that discrimination against the FSWs in healthcare centers need to be addressed and offering specialized healthcare services to meet their specific needs at an affordable cost for them can be helpful. Increasing well-trained manpower, and improving the accountability and infrastructure are necessary to improve the healthcare experiences and outcomes for this vulnerable community.

1 | Introduction

The female sex workers (FSWs) are marginalized group who need special medical attention (Makhakhe et al. 2019; Davey et al. 2019). Although important, the healthcare necessities are often ignored and the FSWs struggle to access the basic healthcare services (Krüsi et al. 2021; Singer et al. 2021). It is evident that the choice of and access to healthcare services for the FSWs are affected by different factors including socio-economic, cultural, and legal related matters which often creates a complex set of intersectionality for them (Singer et al. 2021; Platt et al. 2018). However, these factors are often not limited to this particular community, rather is an omni-prevalent feature of developing countries such as Bangladesh (Hinata et al. 2024; Coombs et al. 2022).

The healthcare system in Bangladesh is under a tremendous pressure due to its affordability and availability. The COVID-19 pandemic has further exacerbated the vulnerability of health-care systems for all people including the marginalized FSWs. The financial hardship of FSWs has been a key impediment to their ability to access quality healthcare services in particular

(Singer et al. 2021). Most of the FSWs suffer from poverty and struggle to meet their basic needs, which leads to healthcare becoming a lower priority (Platt et al. 2018; Jana et al. 2014). Adequate allocation of financial resources is needed as a priority to address the healthcare needs for FSWs (Socías et al. 2016).

In addition to economic barriers, the FSWs in Bangladesh experience additional problems in accessing healthcare due to the legal and cultural contexts (Reza et al. 2023). Professional sex work is criminalized by laws and the presence of a conservative religious culture, which forces FSWs to operate secretly, making it difficult for them to get important healthcare services. Often, the prospect of being arrested or harassed by law enforcement officials deters FSWs from seeking timely healthcare services (Wahed et al. 2017), frequently choose to hide their identity to avoid social stigma and public disgrace, particularly in settings like healthcare clinics (Birger et al. 2024; Sawicki et al. 2019). Although necessary, there is a lack of dedicated healthcare services for FSWs, hindering their access to vital healthcare services, especially those related to sexual and reproductive health (Langenbach et al. 2023, Shapiro et al. 2021).

The COVID-19 pandemic intensified existing limitations in both public and private healthcare systems, resulting in a nationwide disruption of healthcare services that were already vulnerable (Parveen et al. 2024; Ahmed et al. 2020). Public hospitals were compelled to prioritize COVID-19 cases, resulting in the neglect of routine and essential healthcare for non-COVID patients while private healthcare facilities faced operational reductions and increased service costs attributed to supply chain challenges. This has exacerbated the unaffordability of healthcare for vulnerable populations, such as FSWs, resulting in substantial barriers to accessing these services. The reliance of FSWs on informal clinics or NGOs for medical support has been significantly impacted by pandemic-related lockdowns and a decrease in funding, exacerbating their already vulnerable situation (Brooks et al. 2023). The overall situation has affected the fragile healthcare system significantly hindering access to essential services such as STI testing, contraception, and mental health support for FSWs nationwide (Sarker et al. 2023).

A lack of specialized services tailored to address the unique healthcare needs of FSWs, such as HIV testing and treatment, reproductive health services, and mental health support, impairs their access to comprehensive care (Beattie et al. 2020; Nnko et al. 2020; Tokar et al. 2018). The inadequate healthcare infrastructure, characterized by a limited number of healthcare facilities in both urban and rural areas, presents difficulties for FSWs in obtaining prompt and suitable healthcare services, particularly during the COVID-19 pandemic (Al-Zaman 2020). Given the context, our study aims to investigate the experiences of FSWs in Bangladesh when obtaining healthcare services. We sought to gather in-depth knowledge about the experiences and difficulties faced by FSWs in accessing healthcare services, particularly during the COVID-19 pandemic. This study is important for understanding how to reduce and prevent health associated risks in this vulnerable group, especially in terms of proactive prevention and ongoing monitoring of their health. The findings of this study will serve as a significant reservoir of knowledge that will be advantageous to both local and national entities, including policymakers, governmental bodies, and nongovernmental organizations.

2 | Methods and Materials

2.1 | Study Design and Setup

To gain a comprehensive understanding of the experiences of FSWs in accessing healthcare services, we applied a qualitative research approach that enables us to capture and analyze the attitudes, beliefs, perceptions and experiences of the FSWs and the key sector workers (KSWs) regarding the object of investigation (Tenny et al. 2022; Hammarberg et al. 2016). Khulna, Satkhira, and Jessore districts, located in the southwestern region of Bangladesh, were chosen by the researchers as the research area based on account of its distinct socioeconomic and geographical vulnerability to prostitution (Hossain et al. 2015; Siddiqua and Matin 2012). The widespread dissemination of prostitution, coupled with the degree of intensity of prostitution in this locality, and serves as an indication of an importance of studying the healthcare issues of FSWs in this region (National AIDS/STD Program 2016) also suggests. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used to guarantee the quality of the research (Tong et al. 2007)

2.2 | Study Area

In examining the healthcare challenges faced by FSWs, it is crucial to consider the unique socioeconomic, cultural, and geographic factors that influence their lives in this region. Jessore encompasses its historical significance as a component of the ancient Janapada of Vanga and Pratapaditya, subsequently influenced by British governance and the enduring legacy of the Bangladesh liberation war. Benapole serves as a significant transit hub located near the India-Bangladesh border, recognized as the largest land port in Bangladesh, and the region's distinctive heritage contributes to a notable prevalence of sex work, influenced by patterns of cross-border movement. This situation places FSWs at heightened risk for trafficking, exploitation, and the transmission of sexually transmitted infections within this region.

Satkhira, characterized by extensive rural coverage, is situated in proximity to the Sundarbans, which is recognized as the largest mangrove forest globally. The district, while bordering India, experiences significant challenges related to poverty and inadequate healthcare infrastructure. The remoteness of certain areas further restricts access to essential services, exacerbating health disparities within the population. Social conservatism and discrimination stemming from adverse economic conditions create barriers for FSWs in obtaining quality healthcare in this region. Khulna, on the other hand, recognized as a significant divisional city, historically known as an “industrial city” due to its port, is inherently a more active region for FSWs. Khulna provides comparatively superior healthcare services in relation to the other two districts mentioned; however, the pervasive stigma surrounding FSWs, coupled with a declining

economy that once thrived on the 'golden fiber' jute mills, continues to hinder their access to essential health services.

Key medical facilities in Khulna comprise Khulna Medical College Hospital, Khulna Sadar Hospital, and various private hospitals, including City Medical College Hospital, Ad-din Akij Medical College Hospital (AAMCH), and Gazi Medical College Hospital. Additionally, there are NGO clinics operated by organizations such as Marie Stopes, BRAC, Khulna Mukti Seba Sangstha (KMSS), and Christian Service Society (CSS) Bangladesh. Jessore is home to Jessore General Hospital, private clinics such as Ibn Sina Diagnostic & Consultation Center and Ad-din Sakina Medical College Hospital (ASMCH), as well as healthcare centers funded by NGOs, including Ashar Alo and Lighthouse. Satkhira, on the other hand, possesses facilities, including the Satkhira Medical College Hospital serving as the primary public hospital, supplemented by several private clinics and NGO projects, such as Islami Bank Community Hospital and China Bangla Hospital. Although a combination of government, private, and NGO-operated facilities offers general healthcare, specialized services for FSWs are still limited. Despite their limitations, certain NGOs, such as Dhaka Ahsania Mission, Lighthouse, Save the Children, Marie Stopes, and Bandhu Social Welfare Society, provide regular STI screenings, reproductive health care, and awareness initiatives for these at-risk women.

2.3 | Participants and the Research Team

The study comprised a total of 20 participants, consisting of 14 FSWs and six KSWs such as health care professionals, NGO workers etc. We recruited hotel, residential, brothel, and street-based FSWs residing in the Khulna, Jessore, and Satkhira regions of Bangladesh. The inclusion criteria for FSWs included, 18 years of age or older, currently engaged in sex work, and a permanent resident of the study area. The inclusion criteria for KSWs included, direct experience working with or being involved with FSWs. We tried to incorporate individuals from different fields and socioeconomic backgrounds to ensure a diverse range of experiences were collected as presented in Tables 1 and 2.

The research team possess extensive knowledge and experience in qualitative research methods as well as gender and health research background (KU, RJ, and MSI) and the student researcher (SRR) is currently pursuing a PhD, holds a post-graduate certificate in Social Sciences and is being mentored by senior researchers on the team. The results of this study represent the findings of larger doctoral research study. The interviews were performed by trained data collectors who had Bachelor (Honors) and Master's degree qualifications in relevant social sciences background, while the main research team comprised of academics from the Faculty of Medicine and Health at the University of New England, Australia.

2.4 | Recruitment

A purposive sampling was employed to ensure individuals from a variety of backgrounds, experiences, and opinions working as either FSWs or KSWs, in the southwestern region of Bangladesh. This technique facilitated our ability to readily engage with FSWs, a population that is typically challenging to connect with in Bangladesh due to distinct societal and legal circumstances (Shewly et al. 2020).

The recruitment strategies involved engaging with NGO workers, healthcare professionals, administrative staffs who had direct contact with FSWs. To enlist the target population, the researchers also reached out to professional networks and healthcare clinics that cater to FSWs. The potential participants were primarily invited using targeted advertisements in non-governmental organizations (NGOs) that offered healthcare

TABLE 1 | Background information of the female sex workers.

Sl.	Name*	Age	District	Type of sex worker	Type of engagement
1.	Rabeya	30	Khulna	Residential-based	Full-time
2.	Sadia	25	Satkhira	Residential-based	Part-time
3.	Parvin	38	Jessore	Street-based	Part-time
4.	Rashida	34	Satkhira	Street-based	Full-time
5.	Shamima	36	Khulna	Hotel-based	Full-time
6.	Parul	45	Satkhira	Hotel-based	Part-time
7.	Jamila	36	Satkhira	Hotel-based	Full-time
8.	Abida	26	Satkhira	Residential-based	Full-time
9.	Anima	45	Jessore	Brothel-based	Part-time
10.	Rehana	39	Satkhira	Hotel-based	Full-time
11.	Lota	30	Satkhira	Street-based	Part-time
12.	Nabila	34	Jessore	Residential-based	Part-time
13.	Nasrin	38	Satkhira	Hotel-based	Full-time
14.	Shima	25	Khulna	Residential-based	Part-time

*All names displayed in the table are pseudonyms.

TABLE 2 | Background information of the key sector workers (KSW).

Sl.	Name*	Age	District	Profession	Type of engagement
1.	Dr. Dilara	38	Khulna	Medical officer	Full-time
2.	Dr. Rafi	36	Jessore	Medical officer	Full-time
3.	Nila	35	Khulna	NGO worker	Full-time
4.	Rokeya	32	Khulna	SACMO	Full-time
5.	Rakhi	43	Khulna	NGO worker	Full-time
6.	Kusum	42	Satkhira	NGO worker	Full-time

*All names displayed in the table are pseudonyms.

assistance. The advertisement included some basic information regarding our research, the privacy-related considerations and how to contact the research team to participate. The contact details researchers were included in the advertisement and prospective participants who contacted the researcher via phone were contacted for potential involvement. Participants who expressed interest were evaluated for final interviews after being provided with initial information about our research and their responsibilities. The potential participants were provided with a comprehensive description of the study's objectives, methodologies, potential risks, and benefits following an institutionally approved information sheet. Both the participants and the KSWs were mainly recruited from the city areas of Jessore, Satkhira and Khulna districts due to proximity to operational areas and the FSW-targeted healthcare facilities.

2.5 | Data Collection

In-depth interviews were undertaken in face to face modality, using a predeveloped semi-structured interview guide containing relevant study questions to collect the FSWs' narratives on their experiences accessing healthcare services. The technique widely used in data gathering to obtain information from individuals who have direct experience and expertise about the subject matter, including relevant attitudes, opinions, and perspectives (DeJonckheere and Vaughn 2019; Allen et al. 2019). The data collection team which consisted of both male and female trained data collectors visited the study area several times to get to know the FSWs before collecting data. Casual conversations were used to build rapport with participants before the in-depth interview. Once the rapport was built, the participants were requested to provide their preferred interview time and venue to assure their safety and comfort. To further mitigate the impact of gender dynamics on participants' interviews, we implemented ethical training and offered participants the choice to select the gender of their interviewer, in addition to fostering rapport.

After choosing a mutually agreeable location, data collection. The locations mostly consisted of NGO drop-in facilities, which are frequented by FSWs for regular health check-ups, or the workplaces of the participants. The participants were briefed about the subject matter and the study topic before starting the interviews. Audio recordings following ethical guidelines were incorporated during the data collection to enhance the precision and reliability of our findings by mitigating the influence of memory or focus better on the interview (DeJonckheere and Vaughn 2019). The interview took approximately 30–45 min and the participants were allowed to provide interpretation accuracy feedback if they wished as the data collector summarized the findings at the end of each interview. The data was collected from February 1 to August 31, 2023 until saturation, when no new information or themes emerged (Saunders et al. 2018).

2.6 | Data Analysis

The collected data were transcribed in the next step and the transcriptions were finalized by SRR. The main research team did a comprehensive analysis of the data using both manual techniques and the NVivo (version 14) software. We used NVivo 14 to help us organize, manage, and code our data systematically. The software aided in developing preliminary codes that later built up thematic clustering., We manually analyzed our data to ensure a deeper level of immersion in it. Line-by-line reading of the transcripts and manual theme refinement were part of the process to identify any subtleties that software-based coding might have missed.

The data analysis was performed using the six-step thematic analysis method as outlined by Clarke and Braun (2017) and Nowell et al. (2017). The six-step thematic analysis were used to identify the patterns, themes, and meanings of our qualitative data following a structured process which included, familiarized and immersing ourselves in the data, construct preliminary codes by identifying salient segments, categorizing these codes into potential themes, which are thoroughly scrutinized and refined to verify their coherence and pertinence. The themes were combined to create a coherent story that accurately captures the essential essence of the data. SRR initially encoded the data using an inductive approach, systematically analyzing the transcripts line by line after gaining a comprehensive understanding of the interviews. Subsequently, the research team engaged in a discussion to ultimately determine the group codes and consolidate them into themes, reaching a consensus.

2.7 | Ethical Considerations

We obtained the ethical clearance from the Human Research Ethics Committee of the University of New England, Australia (Approval number: HE22-199) to conduct this study before conducting the field data collection. The process incorporates

obtaining participants' informed consent, safeguarding confidentiality and anonymity, and mitigating any potential harm or discomfort that participants may experience during the interviews. Informed consents were obtained during the process and they participants were free to quit the interview anytime if they wished.

3 | Results

There were five key themes identified through analysis of the data. These include (1) lack of affordable and specialized treatment, (2) stigma and harassment, (3) inadequate hospital staff and logistics, (4) corruption and mismanagement, and (5) clinic in- and out-patient conditions. A total of 20 interviews were undertaken, 14 with FSWs and six with KSWs. Data was obtained for 420 min, averaging 21 min each interview and the interviews lasted 8 to 43 min. Participants averaged 35 years old, ranging from 25 to 45. Nine contestants were from Satkhira, seven from Khulna, and the rest from Jessore. On the 14 FSWs, five worked in residential areas, five in hotels, three on the streets, and the rest in brothels. Of the 20 participants, 13 individuals worked full-time and the rest part-time as Table 1 shows.

3.1 | Lack of Affordable and Specialized Healthcare Services

The matter of healthcare for FSWs is complex. Despite being highly economically disadvantaged, they require specialized healthcare treatments which is often costly. This has placed them in a juxtaposition for which they are unable to find a straightforward resolution when they need specialized care. A significant number of our participants expressed that the healthcare centers they visited were both unaffordable and lacking in specialized design for their needs. Frequently, the elevated expense of treatment served as an obstacle to accessing essential healthcare treatments in times of greatest need. While acknowledging that public hospitals, such as Khulna Medical College and Hospital, offer reduced treatment costs compared to private ones, FSWs expressed concerns about the quality and accessibility of healthcare services at these facilities. These hospitals typically lacked specialized services such as pathology and pharmaceutical facilities that were necessary for FSWs. As a result, women had to travel to access health care services. This also escalated the expense of medical care and the overall inconvenience. Notwithstanding these issues, a significant number of individuals were unable to select any alternate options.

> *The main factor that I consider here is the cost. So even if the environment, management and the behavior of the people working in the public hospital is not satisfactory, I still go to these hospitals because I cannot afford the treatment cost of private clinics.*
>
> (IDI 12)

Many of participants shared that the treatment cost raised in recent times and their economic condition has got worse since the onset of COVID-19. Most of the FSWs could not continue working as they were unable to go to work because of the lockdown and social distancing measures. This affected their economic situation under the crisis. Nevertheless, they often preferred the private facilities if money were not the issue as they consider the private clinics for quality healthcare services.

> *Look, the main issue is money here. If you have money, you can afford good healthcare services, as simple as that.*
>
> (IDI 3)

Many of the participants in this study asserted that the FSWs did not have access to comprehensive healthcare treatments. Because of their susceptibility to sexually transmitted illnesses, including the life-threatening HIV/AIDS, they required tailored healthcare interventions. These services may include regular examinations, availability of birth control methods, teaching on preventing HIV, support for mental health, and treatment for substance misuse. Providing a wide range of services customized to meet their specific needs will not only enhance their physical well-being but also treat mental health problems originated from stigma and discrimination.

> *We need specialized healthcare services especially focusing the FSWs. They shouldn't be in constant fear of being stigmatized when seeking necessary healthcare services. We (the NGOs) provide some routine check-ups for HIV/AIDS and STDs, but that is not sufficient. Currently, I don't know of any such services provided by a government (public) hospital that offers any extra facility for them (the FSWs), but we badly need it.*
>
> (IDI with KSW 5)

Our participants reported that although several NGOs offered screening services, these services were insufficient to meet all of their healthcare requirements. The FSWs faced a lack of access to specialized healthcare treatments, which worsened their overall physical and mental well-being. Several individuals were clueless on what actions to take, resulting in heightened levels of worry and anxiety. By prioritizing comprehensive healthcare for FSWs, we can enhance their health equity and overall well-being.

> *The NGOs provide some routine health check-ups each 6 months, but we need a comprehensive healthcare service. For example, I had a fracture in my leg for some time, and I could not walk properly. However, I had no idea where to seek help. I wish someone helped me with these problems other than providing supports for STDs only.*
>
> (IDI 7)

A KSW (Physician) we interviewed expressed a similar concern regarding the lack of specialized services to prevent health problems for the FSWs.

> *Though there are some issues of mismanagement and lack of specialists, and tools for examining the STDs, the doctors always try to handle their patients sincerely.*

3.2 | Stigma and Harassment

One important aspect that affects FSWs when they seek healthcare services is the negative societal judgment and mistreatment they face, regardless of their personal characteristics or the specific healthcare facilities they go to. Our participants indicated a preference for seeking healthcare services from public hospitals due to the affordability of their healthcare solutions. However, they also reported negative encounters with private clinics. The FSWs reported that the hospital staff exhibited discrimination based their identities. Particularly, once the hospital workers became aware of their professional identity, their behavior changed.

> *Whether it is a hospital or any other public space, people treat us differently if they come to know our identity. They look at us with despise. I think this happens because of the stigma associated with our (sex work) profession. Most of the people are Muslims in this country and Islam prohibits this profession. Funnily, people who take services from us also blame and hate us. They give us advice whenever they get a chance. Once I disclosed my profession to a doctor when seeking healthcare in a public hospital, the doctor scolded me a lot. Since then, I never disclose my professional identity in these circumstances.*
>
> (IDI 11)

A positive attitude and collaboration are fundamental expectations for patients receiving healthcare services. FSWs frequently experience misfortune in this aspect. They frequently had negative experiences with the hospital workers. Regardless of their identity, the majority of participants expressed dissatisfaction with the nurses, maids (ayahs), and ward boys at the hospitals.

> *Harassment and misbehavior are pretty common in these hospitals. Some* ayahs *and ward boys are not cooperative at all. They are generally abusive and tend to misbehave with the patients and their attendants. This attitude couples if they come to know our professional identity. I felt humiliated a couple of times and stopped visiting the hospital for any medical purposes. I would rather stay ill instead of tolerating such treatment.*
>
> (IDI 7)

One FSW recounted a comparable incident and conveyed her inclination to refrain from seeking medical assistance at healthcare facilities due to her previous encounter with harassment.

> *When I went to a hospital with my colleagues for some treatment last year, they (hospital authority) treated us very disrespectfully. They said it is better to commit suicide instead of living as a sex worker. Since then, I avoid disclosing my identity to the doctors and nurses. Even the pharmacy people scolded us when I went to buy contraceptives. They look at us differently. I can feel the hatred in their eyes. This is how the society treats us.*
>
> (IDI 11)

The FSWs expressed a persistent fear of being judged and embarrassed which compelled them to conceal their identity from doctors, so withholding crucial information and putting their health at risk. This denial is not limited to their healthcare rights alone; rather, it is evident in every part of their daily existence, as they have expressed. This maintains a cycle of marginalization for them.

> *If we disclose our identity, we would not get the basic services for the children such as school and health care, or even a house for rent. The society despises us. They take our service, but deny our contribution. Isn't it a hypocrisy?*
>
> (IDI 7)

A doctor we interviewed mentioned how the situation aggravated during the COVID-19 pandemic and the FSW were victimized with stigma and harassment in her experience.

> *Well, in my opinion, accessing the public hospitals was particularly difficult if you did not have a connection or reference. You'll suffer a lot, particularly with the FSWs' professional identity, they are not treated well at all. The situation was even worse during the pandemic. They were more despised and neglected. The services were being operated in small scale to prevent infection, there were clearly scarcity of staffs and PPEs. They were relying on Almighty and, you see the Almighty saved them!*
>
> (IDI with KSW 6)

3.3 | Lack of Manpower and Logistics

Some of our participants reported the healthcare centers they visited frequently experienced a scarcity of personnel. The persistent scarcity of personnel frequently placed significant pressure on healthcare systems, pushing them to their maximum capacity, and compromising the quality of patient care. Staff burnout was prevalent due to the overwhelming number of patients in both the in-patient and out-patient departments. Additionally, there were complaints about the way some staff members treated patients.

> *There is an extreme shortage of doctors, nurses and other staffs in these hospitals. The staffs in both OPDs (outpatient departments) and in-patient services usually lack manners. Some of the staffs are recruited through outsourcing for a short term. These staffs are not in permanent contract with the government, hence they do not get full wages and fringe benefits. These people tend to misbehave a lot as they lack accountability and responsibility.*
>
> (IDI 11)

Several FSWs reported experiencing prolonged waiting times for medical treatment at these facilities. The influx of patients in hospitals queue for testing and medical appointments, especially following the COVID-19 epidemic, has considerably

exacerbated their suffering, and has persistent over time. Our participants reported that they frequently visited medical facilities but occasionally left without completing the required diagnostic procedures.

> *You have to wait for a very long time usually, but the service they provide after that will also frustrate you. There are specific counters for specific services in public hospitals. For each service, the patient has to stand in the ques in front of the counter and has to wait for a long time. Ultimately, the duty time of the doctor's end, and patients go home without treatment in many cases. There is no accountability, no transparency of what's going on. They don't even bother to notify early that the patient will not get the desired service on a given day.*
>
> (IDI 1)

In addition, the FSWs disclosed that the primary constraints of hospital pathology included insufficient equipment support to perform required tests, as well as a scarcity of proficient professionals to carry out such tests. The materials used were frequently antiquated, and this absence of contemporary machinery occasionally impeded the accurate diagnosis of specific health issues for the FSWs. The hospitals frequently lacked sufficient quantities of essential medications in their pharmacies, even during the COVID-19 pandemic.

> *I went to the pathology section of a nearby (public) medical college hospital a few years back. They said they don't offer some of those medical tests I required. Then I had to go to a private diagnostic center to complete those tests. I could make it in half of what I spent there if those services were available in that hospital. Even during the COVID-19 pandemic, I visited that hospital for vaccines, but I was disappointed. We never found any oxygen cylinders, masks or sanitizers although I heard that the government provided these abundantly.*
>
> (IDI 3)

A KSW working in NGO sector mentioned the scarcity of services and emphasizes the lack of logistics during COVID-19 pandemic in her statement.

> *During pandemic, the public hospitals were mostly closed. There was not enough equipment for the treatment of COVID-19. Patients of other diseases also did not get treatment since there were less doctors and nurses in that time.*
>
> (IDI with KSW 5)

3.4 | Corruption and Mismanagement

The FSWs in our study reported corruption and mismanagement where issues with healthcare delivery in Bangladeshi hospitals, which affected well-being of the people accessing. A key feature of corruption is bribery or illegal transection under-the-table to get services that are often supposed to be provided free of cost. Such behavior often originated from a lack of wages and job insecurity, inadequate monitoring, administrative inefficiency and nepotism. Our participants shared the predominance of *dalals* (brokers) and representatives in the public and private healthcare facilities which hampered the system.

> *You can see* dalal *(brokers) everywhere when you go to a public hospital. As soon as a patient enters into the hospital outdoors,* dalals *surround you, and tries to convince you that they can provide you with quality treatment at a cheaper cost. They offer you to go to the private clinics where it costs much, but you don't have to wait in the ques for a long time. Many people fall into these traps and ends up with faulty treatments. Although the hospital administration knows it, there hasn't been any effective measures to stop this.*
>
> (IDI 2)

Our participants reported that patients who have good relationships with hospital staffs may receive special benefits. Nepotism was found to have an impact on the quality of healthcare services delivered in hospitals, as reported by the FSWs in this study. Besides, the FSWs agreed that their hassles were less if they partook in the bribery as it made assessing and receiving treatment a lot quicker. Our participants complained a lack of supervision of the overall system and blamed the hospital authority for not taking any action against corruption.

> *If you pay some tips to the third or fourth grade employees for every single service you take from these hospitals, your job will be done quickly. Maybe they have a connection to the upper authorities. Sometimes you go to a counter and wait for hours, but you will find nobody is there to serve you. Sometimes, they are hesitant to perform their duties, and tries to transfer the tasks to others. Everything is happening in daylight, but nobody is there to look after these issues.*
>
> (IDI 13)

Poor administration in healthcare services ultimately diminished the quality of care provided to FSWs seeking healthcare assistance. The absence of sufficient financial resources is frequently caused by corruption and leads to insufficient staffing and a shortage of medical supplies, as previously mentioned. Subsequently, the patients are subjected to extended periods of waiting, as well as substandard medical care, which ultimately undermines their health outcomes.

> *If the challenges faced by the FSWs in these hospitals can be reduced, and if the hospital authorities are not strict with them, that would really help them. If the picture inside the hospital can be improved and the necessary arrangements are properly organized, the poor people may not have to suffer from long queues, extra costs and harassments.*
>
> (IDI with KSW 5)

During the interview, healthcare professionals provided their explanation, citing limited resources and a heavy workload as factors during the COVID-19 epidemic.

> *We had to take care of a huge number of patients each day, both general and COVID-19 infected ones. It was a difficult situation and we experienced an inhumane pressure on us. Doctors, nurses and staffs had to work overtime, still we couldn't do enough at times. The number of seats were limited, but the demand was sky-high. This, of course, affected the overall quality of services provided to everyone including any vulnerable groups. However, the situation is improving now with COVID-19 strains waning day by day.*
>
> (IDI with KSW 2)

4 | Poor In- and Out-Patient Conditions

Ensuring cleanliness and maintaining good hygiene in hospitals is crucial to preventing the transmission of infectious diseases. However, participants in this study reported that they did not perceive hospitals, especially public ones, to prioritize cleanliness and hygiene. The FSWs reported that the level of hygiene in the hospitals varied from one ward to another. They regarded both floors and toilets as the most unsanitary areas, believing that they were not regularly cleaned. The participants who had experiences with in-patient services also expressed that the management of waste disposal was inadequate and did not adhere to necessary healthcare standards.

> *I was once admitted in a hospital for several days when I went through a tumor surgery. My contract included admission to the general beds where I had to share the room with several other patients. There was too much noise in the general beds and I couldn't take a good nap up until midnight in those general beds. The toilet was dirty, and nurses were unwilling to assist in the days, and unavailable at nights.*
>
> (IDI 2)

Some participants reported that maintaining hygiene in hospitals and clinics was a significant difficulty due to a lack of awareness. This was particularly complicated during the COVID-19 pandemic as many individuals visiting hospitals were apathetic towards following adequate cleanliness measures, despite being urged by hospital authorities. Initially, during the early stages of the COVID-19 outbreak, there were protocols in place to promote social distance and cleanliness. However, with time, these protocols became less of a priority in both the areas where patients were treated within a healthcare facility and receive care outside of a healthcare facility. Individuals exhibited diminished concern for upholding hygienic practices and adhering to social distancing measures, both of which are crucial in mitigating the transmission of the disease. This greatly raised the likelihood of contracting COVID-19 and other contagious illnesses, particularly in such a crowded place like hospitals.

> *It is quite difficult to get a desired service from these local hospitals. The out-patient departments are always full of patient and noise. These problems coupled during the COVID-19 pandemic. This is why I always tried to avoid going there in recent times. I was afraid that I might contact COVID-19 if I visit such a crowded place.*
>
> (IDI 10)

We noted that the hospital personnel indicated that they were making every effort to maintain a clean and healthy environment to the best of their ability. However, they acknowledged that there are financial and management concerns that need to be addressed to enhance the quality of their services. They stressed the need for further investment in the healthcare sector to enhance this scenario.

> *The hospitals try to keep it clean as much as possible, but we (the hospital staff) acknowledge that there are funding and other issues. There are NGOs that also provide healthcare services for the FSWs. Funding in those NGOs come from foreign countries, so it is normal that they can offer better environments.*
>
> (IDI with KSW 1)

5 | Discussion

This study examines the experiences of FSWs accessing healthcare services in the Southwestern region of Bangladesh. During this investigation, we identified that FSWs faced a shortage of financial means to access high-quality healthcare services. The fact that women face higher economic vulnerability which affects their health outcomes is also outlined in some of the existing literature (Hallett et al. 2023; Abdella et al. 2022; Yang et al. 2021). We believe the economic fragility of the FSWs is profoundly entrenched in multidimensional sociological, political, and legal factors. This further marginalizes them and renders them susceptible to poor health, creating a vicious cycle of ill health and poverty. Many FSWs enter the profession due to limited job opportunities, low educational attainment, or the absence of viable economic alternatives (Abdulla et al. 2024). We argue that implementing policy reforms that empower FSWs to achieve financial independence, enabling them to afford necessities such as decent healthcare is important to tackle this issue.

This study reported a lack of specialized healthcare provision specifically tailored for FSWs. The women in prostitution are often uncertain about where to find assistance in times of health needs (Tomko et al. 2021; Lafort et al. 2016), if dedicated services were targeting them, the FSWs would be able to readily obtain quick support during any medical emergency, eliminating the need for them to endure the prolonged medical crisis. Another important factor that affected help-seeking was social stigma. Many of our participants reported that stigma worked as a significant barrier to accessing necessary medical services. This finding is consistent with number of previous studies (Birger et al. 2024; Ruegsegger et al. 2021; Singer et al. 2021; Stangl et al. 2019). This study reported FSWs faced discrimination when

accessing healthcare services due to their professional identity which affected adversely their health outcomes. The negative attitude toward the FSWs frequently stems from cultural biases and moral assessments that marginalize those engaged in sex work within a society that tends to be more conservative. As a consequence, these women are perceived primarily as morally deviant rather than as individuals who should be treated with respect and care which leads to negative health outcomes for FSWs (Martín-Romo et al. 2023; Benoit and Unsworth 2022; Kim et al. 2018).

The healthcare facilities in Bangladesh suffer from acute shortage of staff and equipment (Rahman et al. 2024; Shahjalal et al. 2023; Darkwa et al. 2015). The required doctors and nurses in proportion to the patients needing services remain a constant challenge in a densely populated country, more than 170 million (Islam et al. 2014 Bangladesh Burden of Disease Collaborators 2023). Consequently, the excessive workload leads to burnout among healthcare workers, which in turn reduces the quality of treatment delivered to patients (Rizwan et al. 2023; Rashid et al. 2022; Chowdhury et al. 2022). This study reported that participants frequently waited for long hours to visit the doctors and faced challenges in accessing the necessary equipment support for conducting medical diagnoses. The FSWs also highlighted the widespread occurrence of corruption and mismanagement in healthcare centers, especially those that are publicly funded. The findings are in line with some previous studies that reported similar concerns (Khanam et al. 2023; Hossain 2021). We noted that corruption and mismanagement were widespread in various forms, such as bribery and inefficient administrative practices, within these hospitals. These factors greatly diminished the effectiveness of the healthcare system and had a negative impact on the quality of patient care.

While it is of the utmost importance to address the detrimental impacts of corruption and poor management in Bangladeshi hospitals to restore the quality of service and accessibility for patients, improving the physical environment of the hospitals are equally important. Our findings indicate that both in- and out-patient environment such as hygiene standards in the healthcare centers they visited were not up to the mark which is indicated in some previous studies (Dihan et al. 2023; Harun et al. 2022). These service facilities suffered from unsatisfactory conditions due to insufficient infrastructure, overcrowding, inadequate hygienic measures to avoid infectious diseases, and poor waste disposal management caused by poor monitoring and a lack of critical resources (Rahman et al. 2024; Rahaman et al. 2023; Unicomb et al. 2018). The unfavorable conditions in the hospital premises not only worsened medical diseases but also led to severe psychological stress, culminating in total dissatisfaction with the healthcare system. A well-equipped facility with necessary supplies and adequate staff is necessary for an improved outcome under the circumstances.

The livelihood and healthcare access of FSWs in southern Bangladesh are influenced by a multitude of social, economic, religious, and political issues. A significant issue of this study is the social stigma encountered by FSWs in getting health services, which is profoundly entrenched in the conservative cultural and religious standards of the region under investigation. This may have resulted in discrimination and social marginalization, causing FSWs to be reluctant to pursue healthcare in public and private facilities (Wahed et al. 2017). Economic difficulties compel many individuals into sex work, but insufficient financial resources hinder their ability to access quality healthcare, especially in private institutions (Tomko et al. 2021; Ma and Loke 2019). On the other hand, inadequate management policies and corruption inside healthcare facilities, especially public ones, politically hinder access to essential services for FSWs. Moreover, there are apprehensions about healthcare personnel' biased attitudes stemming from societal stereotypes, leading to sentiments of neglect and harassment (Langenbach et al. 2023). The convergence of these structural variables exacerbates the adverse experiences and inadequate services for FSWs while seeking healthcare.

6 | Limitations

Although we made efforts to maintain a high level of methodological consistency in performing this study, we acknowledge the possible limitations of our study. The scope of our study was restricted to a specific number of participants, and one may argue that it could have been advantageous to include a bigger sample size to obtain a more comprehensive viewpoint. However, it is worth emphasizing that qualitative research does not necessarily demand a huge participant pool, but instead prioritizes the thoroughness of the information and the depth of the data, and we used data saturation technique to overcome this. Additionally, the ongoing research is a component of a mixed-method approach that integrates qualitative and quantitative data from the first author's PhD project. Hence, the quantitative portion of the project addresses specific topics that are not included in this study. We also acknowledge the potential bias and subjectivity in interpreting the experiences revealed by our participants. However, we have taken diligent efforts to mitigate this by fostering empathy and creating rapport. The focus of our study was primarily on the participants, giving them the opportunity to express their concerns and act in addressing the challenges they encounter when trying to access healthcare services. Our intention is to further develop the conversation surrounding the healthcare rights of vulnerable FSWs that will arise from the release of this study.

7 | Conclusion

The healthcare experience for FSWs is marked by several challenges, and effectively managing these challenges necessitates a comprehensive strategy. Our research suggests that it is crucial to allocate funding to provide affordable and tailored services for marginalized FSWs as a top priority. In light of the findings, we propose the implementation of clear anti-discrimination policies and the provision of sensitivity training to facilitate healthcare access for vulnerable FSWs in Bangladesh. Well-trained healthcare professionals, along with adequately equipped facilities and essential diagnostic tools, will effectively address the specific needs of FSWs, thereby minimizing the gaps in healthcare services. It is advisable to conduct independent audits to promote transparency and accountability within the system.

Author Contributions

All authors contributed to the article and approved the final version for submission.

Acknowledgements

The authors acknowledge the Australian Commonwealth Government and the University of New England for providing the first author with RTP International Scholarships for conducting the study. Open access publishing facilitated by University of New England, as part of the Wiley - University of New England agreement via the Council of Australian University Librarians. The first/corresponding author is a recipient of RTP International Scholarships funded by the Australian Commonwealth Government at the University of New England, Australia, however this does not cover the APC for any publications.

Ethics Statement

Approved by the Human Research Ethics Committee, University of New England, Australia (Approval Number: HE22-199).

Consent

Written informed consent was obtained from the participants.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data for this study are not open access but can be made available on reasonable request to the Principle Investigator and after consideration of ethical approval.

References

Abdella, S., M. Demissie, A. Worku, M. Dheresa, and Y. Berhane. 2022. "HIV Prevalence and Associated Factors Among Female Sex Workers in Ethiopia, East Africa: A Cross-Sectional Study Using a Respondent-Driven Sampling Technique." *EClinicalMedicine* 51: 101540. https://doi.org/10.1016/j.eclinm.2022.101540.

Abdulla, F., M. N. Huq, and M. M. Hossain. 2024. "Mental Health Challenges Among Biologically Female Sex Workers." *npj Women's Health* 2, no. 1: 9. https://doi.org/10.1038/s44294-024-00013-3.

Ahmed, S. A. K. S., M. Ajisola, K. Azeem, et al. 2020. "Impact of the Societal Response to COVID-19 on Access to Healthcare for non-COVID-19 Health Issues in Slum Communities of Bangladesh, Kenya, Nigeria and Pakistan: Results of Pre-Covid and COVID-19 Lockdown Stakeholder Engagements." *BMJ Global Health* 5, no. 8: e003042. https://doi.org/10.1136/bmjgh-2020-003042.

Allen, J., R. King, S. K. Goergen, et al. 2019. "Semistructured Interviews Regarding Patients' Perceptions of Choosing Wisely and Shared Decision-Making: An Australian Study." *BMJ Open* 9, no. 8: e031831. https://doi.org/10.1136/bmjopen-2019-031831.

Al-Zaman, M. S. 2020. "Healthcare Crisis in Bangladesh During the COVID-19 Pandemic." *American Journal of Tropical Medicine and Hygiene* 103, no. 4: 1357–1359. https://doi.org/10.4269/ajtmh.20-0826.

Beattie, T. S., B. Smilenova, S. Krishnaratne, and A. Mazzuca. 2020. "Mental Health Problems Among Female Sex Workers in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis." *PLoS Medicine* 17, no. 9: e1003297. https://doi.org/10.1371/journal.pmed.1003297.

Benoit, C., and R. Unsworth. 2022. "COVID-19, Stigma, and the Ongoing Marginalization of Sex Workers and Their Support Organizations." *Archives of Sexual Behavior* 51, no. 1: 331–342. https://doi.org/10.1007/s10508-021-02124-3.

Birger, L., E. Peled, and Y. Benyamini. 2024. "Stigmatizing and Inaccessible: The Perspectives of Female Sex Workers on Barriers to Reproductive Healthcare Utilization–A Scoping Review." *Journal of Advanced Nursing* 80, no. 6: 2273–2289. https://doi.org/10.1111/jan.16010.

Brooks, S. K., S. S. Patel, and N. Greenberg. 2023. "Struggling, Forgotten, and Under Pressure: A Scoping Review of Experiences of Sex Workers During the COVID-19 Pandemic." *Archives of Sexual Behavior* 52, no. 5: 1969–2010. https://doi.org/10.1007/s10508-023-02633-3.

Chowdhury, S. R., H. Kabir, M. R. Chowdhury, and A. Hossain. 2022. "Workplace Bullying and Violence on Burnout Among Bangladeshi Registered Nurses: A Survey Following a Year of the COVID-19 Pandemic." *International Journal of Public Health* 67: 1604769. https://doi.org/10.3389/ijph.2022.1604769.

Clarke, V., and V. Braun. 2017. "Thematic Analysis." *Journal of Positive Psychology* 12, no. 3: 297–298. https://doi.org/10.1080/17439760.2016.1262613.

Coombs, N. C., D. G. Campbell, and J. Caringi. 2022. "A Qualitative Study of Rural Healthcare Providers' Views of Social, Cultural, and Programmatic Barriers to Healthcare Access." *BMC Health Services Research* 22, no. 1: 438. https://doi.org/10.1186/s12913-022-07829-2.

Darkwa, E. K., M. S. Newman, M. Kawkab, and M. E. Chowdhury. 2015. "A Qualitative Study of Factors Influencing Retention of Doctors and Nurses at Rural Healthcare Facilities in Bangladesh." *BMC Health Services Research* 15: 344. https://doi.org/10.1186/s12913-015-1012-z.

Davey, C., J. Dirawo, P. Mushati, S. Magutshwa, J. R. Hargreaves, and F. M. Cowan. 2019. "Mobility and Sex Work: Why, Where, When? A Typology of Female-Sex-Worker Mobility in Zimbabwe." *Social Science & Medicine* 220: 322–330. https://doi.org/10.1016/j.socscimed.2018.11.027.

DeJonckheere, M., and L. M. Vaughn. 2019. "Semistructured Interviewing in Primary Care Research: A Balance of Relationship and Rigour." *Family Medicine and Community Health* 7, no. 2: e000057. https://doi.org/10.1136/fmch-2018-000057.

Dihan, M. R., S. M. Abu Nayeem, H. Roy, et al. 2023. "Healthcare Waste in Bangladesh: Current Status, the Impact of Covid-19 and Sustainable Management With Life Cycle and Circular Economy Framework." *Science of the Total Environment* 871: 162083. https://doi.org/10.1016/j.scitotenv.2023.162083.

Hallett, N., C. Christie, J. Docherty-Smith, et al. 2023. "Healthcare Interventions for Sex Workers: Protocol for a Scoping Review." *BMJ Open* 13, no. 8: e074983. https://doi.org/10.1136/bmjopen-2023-074983.

Hammarberg, K., M. Kirkman, and S. de Lacey. 2016. "Qualitative Research Methods: When to Use Them and How to Judge Them." *Human Reproduction* 31, no. 3: 498–501. https://doi.org/10.1093/humrep/dev334.

Harun, M. G. D., M. M. U. Anwar, S. A. Sumon, et al. 2022. "Infection Prevention and Control in Tertiary Care Hospitals of Bangladesh: Results From Who Infection Prevention and Control Assessment Framework (IPCAF)." *Antimicrobial Resistance and Infection Control* 11, no. 1: 125. https://doi.org/10.1186/s13756-022-01161-4.

Hinata, H., K. S. Lwin, A. Eguchi, C. Ghaznavi, M. Hashizume, and S. Nomura. 2024. "Factors Associated With Barriers to Healthcare Access Among Ever-Married Women of Reproductive Age in Bangladesh: Analysis From the 2017-2018 Bangladesh Demographic and Health Survey." *PLoS One* 19, no. 1: e0289324. https://doi.org/10.1371/journal.pone.0289324.

Hossain, F. 2021. "Moral Distress Among Healthcare Providers and Mistrust Among Patients During COVID-19 in Bangladesh." *Developing World Bioethics* 21, no. 4: 187–192. https://doi.org/10.1111/dewb.12291.

Hossain, Q. Z., Q. Azad-uz-zaman, and S. K. Roy. 2015. "Lives of Brothel Based Sex Workers in Khulna, Bangladesh." *International*

Journal of Social Work and Human Services Practice 3, no. 4: 131–136. https://doi.org/10.13189/ijrh.2015.030401.

Islam, A. 2014. "Health System in Bangladesh: Challenges and Opportunities." *American Journal of Health Research* 2, no. 6: 366–374. https://doi.org/10.11648/j.ajhr.20140206.18.

Islam, S., R. Uddin, S. Das, et al, 2023. "The Burden of Diseases and Risk Factors in Bangladesh, 1990-2019: A Systematic Analysis for the Global Burden of Disease Study 2019." *Lancet. Global Health* 11, no. 12: e1931–e1942. https://doi.org/10.1016/S2214-109X(23)00432-1.

Jana, S., B. Dey, S. Reza-Paul, and R. Steen. 2014. "Combating Human Trafficking in the Sex Trade: Can Sex Workers Do it Better?" *Journal of Public Health* 36, no. 4: 622–628. https://doi.org/10.1093/pubmed/fdt095.

Khanam, M., N. S. Shuchi, R. S. Kamal, and S. M. Ahmed. 2023. "Health Sector Corruption in the Times of COVID-19 Pandemic in Bangladesh: Newspapers as Mirrors of Society." *Heliyon* 9, no. 12: e22318. https://doi.org/10.1016/j.heliyon.2023.e22318.

Kim, H. Y., A. Grosso, O. Ky-Zerbo, et al. 2018. "Stigma as a Barrier to Health Care Utilization Among Female Sex Workers and Men Who Have Sex With Men in Burkina Faso." *Annals of Epidemiology* 28, no. 1: 13–19. https://doi.org/10.1016/j.annepidem.2017.11.009.

Krüsi, A., K. D'Adamo, and A. Sernick, 2021. "Criminalised Interactions With Law Enforcement and Impacts on Health and Safety in the Context of Different Legislative Frameworks Governing Sex Work Globally." In *Sex Work, Health, and Human Rights*, edited by S. M. Goldenberg, R. Morgan Thomas, A. Forbes, S. Baral. Springer. https://doi.org/10.1007/978-3-030-64171-9_7.

Lafort, Y., R. Greener, A. Roy, et al. 2016. "Where Do Female Sex Workers Seek HIV and Reproductive Health Care and What Motivates These Choices? A Survey in 4 Cities in India, Kenya, Mozambique and South Africa." *PLoS One* 11, no. 8: e0160730. https://doi.org/10.1371/journal.pone.0160730.

Langenbach, B. P., A. Thieme, R. van der Veen, S. Reinehr, and N. R. Neuendorff. 2023. "Attitudes Towards Sex Workers: A Nationwide Cross-Sectional Survey Among German Healthcare Providers." *Frontiers in Public Health* 11: 1228316. https://doi.org/10.3389/fpubh.2023.1228316.

Ma, H., and A. Y. Loke. 2019. "A Qualitative Study into Female Sex Workers' Experience of Stigma in the Health Care Setting in Hong Kong." *International Journal for Equity in Health* 18, no. 1: 175. https://doi.org/10.1186/s12939-019-1084-1.

Makhakhe, N. F., A. Meyer-Weitz, H. Struthers, and J. McIntyre. 2019. "The Role of Health and Advocacy Organisations in Assisting Female Sex Workers to Gain Access to Health Care in South Africa." *BMC Health Services Research* 19, no. 1: 746. https://doi.org/10.1186/s12913-019-4552-9.

Martín-Romo, L., F. J. Sanmartín, and J. Velasco. 2023. "Invisible and Stigmatized: A Systematic Review of Mental Health and Risk Factors Among Sex Workers." *Acta Psychiatrica Scandinavica* 148, no. 3: 255–264. https://doi.org/10.1111/acps.13559.

National AIDS/STD Programme. (2016). 4th National Strategic Plan for HIV and AIDS Response, 2018–2022. Directorate General of Health Services. Ministry of Health and Family Welfare.

Nnko, S., D. Nyato, E. Kuringe, et al. 2020. "Female Sex Workers Perspectives and Concerns Regarding HIV Self-Testing: An Exploratory Study in Tanzania." *BMC Public Health* 20, no. 1: 959. https://doi.org/10.1186/s12889-020-09105-6.

Nowell, L. S., J. M. Norris, D. E. White, and N. J. Moules. 2017. "Thematic Analysis: Striving to Meet the Trustworthiness Criteria." *International Journal of Qualitative Methods* 16, no. 1: 1–13. https://doi.org/10.1177/1609406917733847.

Parveen, S., M. S. Mahbub, N. Nahar, et al. 2024. "The Impact of COVID-19 on Healthcare Services in Bangladesh: A Qualitative Study on Healthcare Providers' Perspectives." *Journal of Preventive Medicine and Public Health* 57, no. 4: 356–369. https://doi.org/10.3961/jpmph.24.081.

Platt, L., P. Grenfell, R. Meiksin, et al. 2018. "Associations Between Sex Work Laws and Sex Workers' Health: A Systematic Review and Meta-Analysis of Quantitative and Qualitative Studies." *PLoS Medicine* 15, no. 12: e1002680. https://doi.org/10.1371/journal.pmed.1002680.

Rahaman, M. A., A. Kalam, and M. Al-Mamun. 2023. "Unplanned Urbanization and Health Risks of Dhaka City in Bangladesh: Uncovering the Associations Between Urban Environment and Public Health." *Frontiers in Public Health* 11: 1269362. https://doi.org/10.3389/fpubh.2023.1269362.

Rahman, K. M. T., S. E. Rayna, F. A. Khan, et al. 2024. "Challenges Faced by Medical Officers in Providing Healthcare Services at Upazila Health Complexes and District Hospitals in Bangladesh–A Qualitative Study." *Lancet Regional Health - Southeast Asia* 24: 100398. https://doi.org/10.1016/j.lansea.2024.100398.

Rashid, F., R. A. M. Erfan Uddin, H. M. H. Mehedi, et al. 2022. "Burnout Syndrome Among Frontline Doctors of Secondary and Tertiary Care Hospitals of Bangladesh During COVID-19 Pandemic." *PLoS One* 17, no. 11: e0277875. https://doi.org/10.1371/journal.pone.0277875.

Reza, M. M., G. Sarwar, S. D. Irfan, et al. 2023. "Establishing a Surveillance System on Sexual and Reproductive Health and Rights (SRHR) of Key Populations (KPs) at Risk of Compromised Outcome of SRHR- A Protocol for a Mixed-Method Study." *PLoS One* 18, no. 7: e0289010. https://doi.org/10.1371/journal.pone.0289010.

Rizwan, F., F. Monjur, M. Rahman, et al. 2023. "Burnout Risks in Bangladeshi Physicians: A Multicenter, Cross-Sectional Study." *Heliyon* 9, no. 12: e22386. https://doi.org/10.1016/j.heliyon.2023.e22386.

Ruegsegger, L. M., M. Stockton, V. F. Go, et al. 2021. "Stigma, Social Support, and Sexual Behavior Among Female Sex Workers at Risk for HIV in Malawi." *AIDS Education and Prevention* 33, no. 4: 290–302. https://doi.org/10.1521/aeap.2021.33.4.290.

Sarker, M. R., M. A. Rouf Sarkar, M. J. Alam, I. A. Begum, and H. Bhandari. 2023. "Systems Thinking on the Gendered Impacts of COVID-19 in Bangladesh: A Systematic Review." *Heliyon* 9, no. 2: e13773. https://doi.org/10.1016/j.heliyon.2023.e13773.

Saunders, B., J. Sim, T. Kingstone, et al. 2018. "Saturation in Qualitative Research: Exploring its Conceptualization and Operationalization." *Quality and Quantity* 52, no. 4: 1893–1907. https://doi.org/10.1007/s11135-017-0574-8.

Sawicki, D. A., B. N. Meffert, K. Read, and A. J. Heinz. 2019. "Culturally Competent Health Care for Sex Workers: An Examination of Myths That Stigmatize Sex-Work and Hinder Access to Care." *Sexual and Relationship Therapy* 34, no. 3: 355–371. https://doi.org/10.1080/14681994.2019.1574970.

Shahjalal, M., M. M. Alam, M. N. A. Khan, et al. 2023. "Prevalence and Determinants of Physical Violence Against Doctors in Bangladeshi Tertiary Care Hospitals." *Human Resources for Health* 21, no. 1: 26. https://doi.org/10.1186/s12960-023-00811-x.

Shapiro, A., and P. Duff. 2021. "Sexual and Reproductive Health and Rights Inequities Among Sex Workers Across the Life Course." In *Sex Work, Health, and Human Rights: Global Inequities, Challenges, and Opportunities for Action*, edited by S. M. Goldenberg, 61–77. Springer.

Shewly, H. J., L. Nencel, E. Bal, and K. Sinha-Kerkhoff. 2020. "Invisible Mobilities: Stigma, Immobilities, and Female Sex Workers' Mundane Socio-Legal Negotiations of Dhaka's Urban Space." *Mobilities* 15, no. 4: 500–513. https://doi.org/10.1080/17450101.2020.1739867.

Siddiqua, Y., and W. M. Matin. 2012. "Risks and Vulnerabilities of Migrant and Trafficked Women Living in Jessore: A Qualitative Study." In *Sex Workers and Their Children in Bangladesh: Addressing Risks and Vulnerabilities*, edited by D. Sabet and S. Ahmad, 82–106. University of Liberal Arts Bangladesh and ActionAid Bangladesh.

Singer, R. B., A. K. Johnson, N. Crooks, et al. 2021. "'Feeling Safe, Feeling Seen, Feeling Free': Combating Stigma and Creating Culturally Safe Care for Sex Workers in Chicago." *PLoS One* 16, no. 6: e0253749. https://doi.org/10.1371/journal.pone.0253749.

Socías, M. E., J. Shoveller, C. Bean, P. Nguyen, J. Montaner, and K. Shannon. 2016. "Universal Coverage Without Universal Access: Institutional Barriers to Health Care Among Women Sex Workers in Vancouver, Canada." *PLoS One* 11, no. 5: e0155828. https://doi.org/10.1371/journal.pone.0155828.

Stangl, A. L., V. A. Earnshaw, C. H. Logie, et al. 2019. "The Health Stigma and Discrimination Framework: A Global, Crosscutting Framework to Inform Research, Intervention Development, and Policy on Health-Related Stigmas." *BMC Medicine* 17, no. 1: 31. https://doi.org/10.1186/s12916-019-1271-3.

Tenny, S., M. B. Janelle, and D. B. Grace. 2022. *Qualitative Study*. StatPearls Publishing LLC. https://www.ncbi.nlm.nih.gov/books/NBK470395/.

Tokar, A., J. E. W. Broerse, J. Blanchard, and M. Roura. 2018. "HIV Testing and Counseling Among Female Sex Workers: A Systematic Literature Review." *AIDS and Behavior* 22, no. 8: 2435–2457. https://doi.org/10.1007/s10461-018-2043-3.

Tomko, C., J. L. Glick, D. F. Nestadt, et al. 2021. "Characterizing Health Care Access Among Cisgender Female Sex Workers With Substance Use Histories in Baltimore, Maryland." *Journal of Health Care for the Poor and Underserved* 32, no. 3: 1584–1603. https://doi.org/10.1353/hpu.2021.0151.

Tong, A., P. Sainsbury, and J. Craig. 2007. "Consolidated Criteria for Reporting Qualitative Research (COREQ): A 32-item Checklist for Interviews and Focus Groups." *International Journal for Quality in Health Care* 19, no. 6: 349–357. https://doi.org/10.1093/intqhc/mzm042.

Unicomb, L., L. Horng, M. U. Alam, et al. 2018. "Health-Care Facility Water, Sanitation, and Health-Care Waste Management Basic Service Levels in Bangladesh: Results From a Nation-Wide Survey." *American Journal of Tropical Medicine and Hygiene* 99, no. 4: 916–923. https://doi.org/10.4269/ajtmh.18-0133.

Wahed, T., A. Alam, S. Sultana, et al. 2017. "Barriers to Sexual and Reproductive Healthcare Services as Experienced by Female Sex Workers and Service Providers in Dhaka City, Bangladesh." *PLoS One* 12, no. 7: e0182249. https://doi.org/10.1371/journal.pone.0182249.

Yang, L. S., S. S. Witte, C. Vélez-Grau, et al. 2021. "The Financial Lives and Capabilities of Women Engaged in Sex Work: Can Paradoxical Autonomy Inform Intervention Strategies?" *Global Journal of Health Science* 13, no. 6: 69–80. https://doi.org/10.5539/gjhs.v13n6p69.