

Facilitators and Barriers to Health Seeking Behavior Among Sex Workers and Drug Addicts in Lusaka District, Zambia

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Received: April 10, 2026; Accepted: April 15, 2026; Published: April 23, 2026

ABSTRACT

Introduction: The behavior of seeking health services among sex workers and drug addicts is a complex concept shaped by diverse factors on a global scale. They also confront heightened levels of stigma, discrimination, social exclusion, violence, human rights abuses, and legal prosecution. This study aimed to assess the facilitators and barriers to health-seeking behavior among sex workers and drug addicts in Lusaka district of Zambia.

Methods: Ethical approval for this study was obtained from the Lusaka Apex Medical University Biomedical Research Ethics Committee (LAMUBREC), IRB number 00001131, as well as from participating brothels, nightclubs, and bars. A cross-sectional study design was utilized in this study to assess the facilitators and barriers to health seeking behavior among sex workers and drug addicts in Lusaka district of Zambia. Also 100 study participants aged 18–45 years were selected through simple random sampling to take part in the study. The total sample size for this study was 100 respondents. The study participants were also informed that participation in the study was completely voluntary and that they were free to opt out of the study at any point without any coercion or consequence. Other than that, a written informed consent was also obtained from the respondents before the researchers proceeded with data collection exercise. Primary data was collected from respondents using structured questionnaire with closed ended questions and was analyzed using SPSS version 28 and MS Excel. Multivariate logistic regression analysis examined associations between socio-demographic factors and health-seeking behaviors parameters, with significance set at $p < 0.05$.

Results: The study found that, most of the respondents (81%) had high awareness of available health services, and 92% knew services' locations. Perceptions of healthcare quality and accessibility were favorable in that; a significant majority of study participants (75%) expressed their belief in the good quality of healthcare services within the district. The study also uncovered that an overwhelming majority of participants (75%) concurred that healthcare services were adequately tailored to meet the specific needs of key populations. Nevertheless, a substantial proportion of respondents (78%) acknowledged encountering financial barriers to accessing healthcare services within the district. The study also revealed that a significant majority of key populations (68%) agreed that healthcare services are readily available in health care facilities when needed. The study further revealed that, cultural and social factors, stigma, and discrimination significantly influenced health-seeking behaviors (80.8%) among sex workers and drug addicts. Also 75% of respondents agreed that existing programs effectively promoted positive health-seeking behaviours among this population. Age and education were significantly associated with cultural and societal factors towards health-seeking behaviours among sex workers and drug addicts ($p < 0.05$). These associations imply that interventions should be tailored according to demographic characteristics, with more focused strategies for younger and less-educated individuals who may be more vulnerable to negative influences.

Conclusion: Community engagement and sensitization, strengthened social mobilization, supportive public health policy reforms, and ongoing health education for healthcare providers are essential for building trust, promoting dignity, reducing stigma and discrimination, fostering inclusive and non-judgmental healthcare environments, and ensuring equitable access to healthcare services for sex workers and drug users in Lusaka District, Zambia.

Keywords: Facilitators, Barriers, Health-Seeking Behavior, Sex Workers, Drug Addicts, Lusaka, Zambia

Citation: Tinkler Saul Simbeye, Nneoma Natalie Wosu, Charity M. Chimwala-Selico, Lee A. Selico II, Mumba Mwanza, et al. Facilitators and Barriers to Health Seeking Behavior Among Sex Workers and Drug Addicts in Lusaka District, Zambia. *J Glob Health Soci Med.* 2026. 2(2): 1-11.

DOI: doi.org/10.61440/JGHS.M.2026.v2.42

Introduction

Sex workers and drug addicts remain one of the most socially marginalized groups, often being excluded in politics, economics, social, and cultural life. The most important key population groups are sex workers and drug addicts. These are people who, by virtue of other higher risk behaviours, have a greater probability of acquiring HIV irrespective of the type of epidemic or local conditions. Their behavior also subjects them to legal and social problems on a regular basis, rendering them more susceptible to HIV. These include persons who are exposed to injecting drug use, men who have sex with men, and men and women who are involved in sex work. Evidence justifies that, people are said to be vulnerable when their living conditions are liable to change exposing them to the danger of contracting HIV. These groups are the youths, women, migrants, long-distance truck drivers, displaced populations, males in uniforms and homeless children. It also involves queer, gay, transgender, Lesbian, and bisexual people who are discriminated, criminalized, stigmatized, and not able to receive healthcare services, legal protections and social support [1-2].

In one of the studies on substance use disorder patients in Ghana, it was identified that a wide range of health issues, and they included drug dependence, malaria, respiratory diseases, cardiovascular complications, and skin problems. The participants also indicated a decline in the general quality of life and health-related wellbeing. The research studied the determinants of healthcare-seeking behavior, and the results showed that these behaviors depended on the perceived benefits of care, severity of the illness, and numerous triggering conditions. It was established that drug users obtained healthcare in various sources, the facilitators of which were effective communication, awareness of the severity of illness and expected outcomes of treatment. On the other hand, obstacles to accessing traditional healthcare services included financial constraints, dwindling social support, and poor health literacy as well as the fear of legal action. The authors recommend a multifaceted solution to the health needs of people with substance use disorders and the way they seek healthcare [3].

In another Swaziland study, the prevalence of stigma was also high with 61.7% of the people interviewed expressing concern with seeking medical attention, 44.1% practicing stigma and 73.9% being subject to social stigma by their family and friends. Healthcare practitioners were rarely reporting same-sex practices, at 25.6. Fear of accessing healthcare was largely associated with numerous things, implying the need to legalize discrimination on the basis of sexual orientation or practices, suicidal thoughts, sexual assault, inability to promote condom use among unwilling male partners, and non-Swazi birth. The researchers further discovered that reporting of same-sex activity with a healthcare provider was considerably linked to certain factors like secondary schooling or college education, condom use during the last homosexual experience with a casual male partner, and suicidal ideation [4].

A systematic review that was conducted on the health seeking behaviors of the female sex workers revealed several key findings. According to the review, there was a high prevalence of sexual and reproductive health (SRH) issues, such as sexual

diseases (STIs), unwanted pregnancy, and inaccessibility to reproductive health care services. Examples of barriers that have been noted to create a big hustle include the lack of proper access to the relevant care, lack of awareness on what is available and the social stigma attached to sex work. In addition to SRH issues, the impact of non-SRH factors such as mental health disorders, substance use, and prevalence of violence and abuse in the workplace were also recorded in the review. Together, these results demonstrate a complicated interaction of health, social, and structural determinants that influence the healthcare-seeking patterns of female sex workers [5].

In a recent study of the determinants of Gonorrhoea and Chlamydia testing among sex workers, it was found that there are several obstacles and supports that are pivotal factors. These are the stigmatization and discrimination that exists in the society and access to the social support networks at the larger community level and the financial aspects at the service provision level. The research recommends the development of interventions that can reduce the societal stigmatisation of sex workers, reduce the economic cost of testing services, and increase the extent of community participation and engagement to promote greater accessibility and acceptability of testing services among this group [6].

In a different study, female sex workers were observed to be reluctant in seeking Gonorrhoea and Chlamydia screening services because of the fear of confronting imprisonment, abuses of their rights, and verbal abuse in case their identity as sex workers was to be exposed. More efforts are necessary to improve the rights and dignity of female sex workers (FSWs) and make sure that they can access healthcare services without hindrances [7].

Besides, in another study, it was also found out that the existence of deep-rooted societal and internalized stigma of sex work is a major discouraging factor among sex workers to seek out the much-needed health care. This marginalization of sex work by society is a major barrier to health care provision. The biased views on sex work spread throughout healthcare settings and lead to the development of negative prejudice among the health professionals and the refusal to give sex workers the required treatment, which is an abuse of their duty to promote the well-being of every patient and the promotion of health, thus violating the right of sex workers to access healthcare as equals. Also, the fear of revealing their profession to healthcare providers has limited access of sex workers to the care they need, which increases the chances of misdiagnosis and poor treatment efficacy. The negative experiences with the health care professionals also hinder their use of formal medical care in the future [8].

According to the World Health Organization (WHO) healthcare services, including primary healthcare services, should be accessible, available, and culturally sensitive to sex workers, as per the principles of eradicating stigma, nondiscrimination, and the fundamental right to health [9].

Although there are these advantages, the available healthcare services to sex workers are insufficient and may not meet their various health requirements. A lot of services seem to be

inaccessible, unaffordable and culturally unacceptable. Sex workers have already voiced the need to have more holistic care, not limited to HIV and STI treatment but also to substance dependence, mental health, and reproductive health services, preferably in the same healthcare facility. Monetary challenges also increase injustices, as a significant percentage of sex workers are unable to access much-needed healthcare [8].

Materials and Methods

This study utilized a cross-sectional study design to assess the facilitators and barriers to health seeking behavior among sex workers and drug addicts (key population) in Lusaka district of Zambia. This study was carried out in selected brothels and streets in Lusaka district of Zambia where key populations (sex workers and drug addicts) are found. Ethical approval was sought and secured from Lusaka Apex Medical University Biomedical Research Ethics Committee (LAMUBREC) IRB number 00001131. The study also used simple random sampling technique with a sampling frame of 220 to select 100 respondents to participate in the study. The target population for this study were all key populations aged between 18 and 45 years old found in brothels and streets. On the other hand, the study population for this study were Sex workers, and drug addicts (substance abusers) aged between 18 and 45 years old. Apart from that, before the main primary data collection process began, a pilot study was conducted at certain selected brothels and streets in order to assess the consistency and reliability of the data collection tool. Feedback from the pilot study participants was used to fine-tune the questionnaire and make necessary adjustments to ensure the validity and reliability of the data collection instrument. Also, the data collection tool was evaluated by the faculty of nursing and midwifery sciences in order to ensure content validity. Also, Cronbach's alpha was used to authenticate the consistence and reliability of the questions in the data collection instrument on the facilitators and barriers to health seeking behavior among sex workers and drug addicts. Such brothels and streets were

not included in the final study in order to avoid selection bias. Other than that, a brief verbal explanation of the study's aim, objectives, benefits and risks was provided to study participants to ensure that they clearly understood the purpose of the research and what their participation involved before signing the written informed consent form. Efforts were also made to explain to the study participants that no harm would be done to them, neither would they gain any personal benefit by participating in the study and that their anonymity would be assured throughout the study. Similarly, study participants were given the opportunity to opt out of the study at any point without any coercion. They were also informed that participation in the study was completely voluntary. After every aspect of the study had been thoroughly explained, and the respondents demonstrated full understanding and willingness to participate, they were provided with a written informed consent form to sign. Then, all those participants who voluntarily provided and signed the written informed consent form were given structured questionnaires with closed-ended questions to complete. Other than that, the respondents were well assured that any information collected from them would remain confidential and would not be disclosed to anyone without their consent. There was no identity whatsoever of the respondents such as names, phone numbers, passport numbers, national registration card numbers or residential addresses on the questionnaires in order to maintain anonymity and confidentiality. Primary data was collected from respondents using structured questionnaires with closed ended questions from 01/04/2024 to 30/07/2024. Other than that, the authors did not have any access to information that could identify individual participants during or after data collection. The collected data was analyzed using SPSS version 28 and MS excel and was presented using tables. Multivariate logistic regression analysis was used to examine the relationships between socio-demographic characteristics and barriers and facilitators to health seeking behaviours parameters among sex workers and drug addicts with significance set at $p < 0.05$.

Results

Table 1: Demographic Data

VARIABLE	RESPONSES	FREQUENCY	PERCENTAGE
AGE	18-20	23	23%
	21-25	55	55%
	26-30	19	19%
	31-35	1	1%
	36-45	2	2%
GENDER	MALE	53	53%
	FEMALE	47	47%
MARITAL STATUS	SINGLE	69	69%
	MARRIED	27	27%
	DIVORCED	2	2%
	WIDOWED	1	1%
	SEPARATED	1	1%
SOCIAL CLASS	UPPER CLASS	23	23%
	MIDDLE CLASS	62	62%
	LOWER CLASS	15	15%

RELIGION	CHRISTIAN	77	77%
	MUSLIM	16	16%
	HINDUSM	7	7%
LEVEL OF EDUCATION	NONE	24	24%
	PRIMARY	13	13%
	SECONDARY	26	26%
	TERTIARY	37	37%
OCCUPATION	UNEMPLOYED	72	72%
	INFORMAL EMPLOYMENT	21	21%
	FORMAL EMPLOYMENT	7	7%
NUMBER OF CHILDREN	ZERO	5	5%
	ONE	56	56%
	TWO	22	22%
	THREE	9	9%
	FOUR	4	4%
	FIVE	3	3%
	SIX	1	1%

Table 1 shows that, most of the respondents (55%) were aged between 21 and 25 with a slightly higher representation of males (53%) than females (47%). A significant portion of respondents (69%) were single, while the middle class was the largest social class identified (62%) in the study. Christianity was found to be a predominant religion (77%), and a notable proportion of study participants (37%) had attained tertiary education. The majority of respondents were unemployed (72%), while 21% of study participants were in informal employment. The study also disclosed that, most of the respondents (56%) were parents, with one child being the most common.

Table 2: Awareness and Level of Knowledge of Sex Workers and Drug Addicts Towards Healthcare Services

QUESTIONS	RESPONSES	FREQ	%
Are you aware of the healthcare services available in Lusaka District?	YES	81	81%
	NO	19	19%
Do you know where to access healthcare services within Lusaka District?	YES	92	92%
	NO	8	8%
Are you aware of the specific healthcare programs or initiatives designed for key and vulnerable populations in Lusaka District?	YES	71	71%
	NO	29	29%
Do you know the types of medical services offered in Lusaka District?	YES	82	82%
	NO	18	18%
Are you familiar with the locations and contact information of healthcare facilities in Lusaka District?	YES	79	79%
	NO	21	21%
Do you know the eligibility criteria for accessing healthcare services in Lusaka District?	YES	60	60%
	NO	40	40%
Are you aware of any special support or assistance available to key and vulnerable populations when using healthcare services in Lusaka District?	YES	67	67%
	NO	33	33%
Have you received information or education regarding available healthcare services in Lusaka District in the past year?	YES	76	76%
	NO	24	24%

Table 2 demonstrates that most of the respondents (81%) exhibited a high level of awareness regarding the healthcare services accessible at health facilities within Lusaka district, Zambia. This study further revealed that a substantial proportion of respondents (92%) possessed knowledge about the locations where healthcare services could be obtained. Additionally, a significant number of respondents (71%) demonstrated familiarity with specific healthcare programs or initiatives tailored to key and vulnerable populations in Lusaka District. Moreover, the study uncovered that a large proportion of key and vulnerable populations (82%) held an adequate level of understanding about the types of medical services offered in Lusaka district, Zambia. Furthermore, the study indicated that a considerable number of key populations (79%) were acquainted with the locations and contact information of

healthcare facilities where they could readily access health services in Lusaka District of Zambia. The study also highlighted that a substantial majority of study participants (76%) acknowledged receiving information about available healthcare services in Lusaka District within the preceding year.

Table 3: Perception of Key Populations Towards Quality and Accessibility of Healthcare Services Among Sex Workers And Drug Addicts

QUESTIONS	RESPONSES	FREQ	%
Do you believe that healthcare services in Lusaka District are of good quality?	YES	75	75%
	NO	25	25%
Have you experienced any difficulties in accessing healthcare services in Lusaka District in the past year?	YES	65	65%
	NO	35	35%
Do you feel that healthcare services in Lusaka District are readily available when needed?	YES	68	68%
	NO	32	32%
Have you or someone you know encountered discrimination or stigma when seeking healthcare services in Lusaka District?	YES	66	66%
	NO	34	34%
Are you satisfied with the overall accessibility of healthcare services in Lusaka District?	YES	66	6%
	NO	34	34%
Have you had to travel a significant distance to access healthcare services in Lusaka District?	YES	68	68%
	NO	32	32%
Do you think that healthcare services in Lusaka District adequately address the specific needs of key and vulnerable populations?	YES	75	75%
	NO	25	25%
Have you or someone you know faced financial barriers to receiving healthcare services in Lusaka District?	YES	78	78%
	NO	22	22%

Table 3 shows that most of the study participants (75 percent) said they believed in the overall good quality of healthcare services in the district. Moreover, the analysis revealed that the vast majority of the respondents (75%) agreed that the healthcare services are sufficiently customized to address the unique needs of the most important and vulnerable groups in the Lusaka district. In spite of these favorable attitudes, a significant percentage of the respondents (78%) admitted that they faced financial obstacles to receiving healthcare services in the district. It was also found that a huge majority of important and vulnerable groups (68%) believed that healthcare services in Lusaka District are easily accessible when they are needed. This observation indicates that access to healthcare services among these populations in the district is relatively high. Nevertheless, the researchers also concluded that a significant number of the respondents (66%) had been exposed to discrimination and stigmatization when accessing healthcare services in Lusaka District. This means that although services are available there are still major obstacles to accessing quality care amongst sex workers and drug addicts.

Table 4: Role of Cultural and Social Factors; Stigma and Discrimination in Shaping Health Seeking Behaviors and Willingness of Sex Workers and Drug Addicts

QUESTIONS	RESPONSES	FREQ	%
Do cultural and societal factors play a significant role in shaping healthcare seeking behaviors?	YES	87	87%
	NO	13	13%
Does stigma and discrimination affect the willingness of key populations to access healthcare services?	YES	88	88%
	NO	12	12%
Are key population more reluctant to seek healthcare due to cultural factors?	YES	77	77%
	NO	23	23%
Is societal influence a factor that can deter key populations from accessing healthcare services?	YES	76	76%
	NO	24	24%
Does stigma associated with certain health conditions impact healthcare-seeking behavior?	YES	77	77%
	NO	23	23%
Are cultural factors a significant barrier for vulnerable populations in accessing healthcare?	YES	77	77%
	NO	23	23%
Do societal factors influence the willingness of key populations to seek healthcare services?	YES	78	78%
	NO	22	22%

Does discrimination affect the health seeking behaviors of vulnerable populations?	YES	86	86%
	NO	14	14%

Table 4 reveals that, majority of the respondents (87%) confirmed that, cultural and societal influences play an important role in informing healthcare-seeking behaviours among sex workers and drug addicts. Also, stigma and discrimination significantly influence the desire of key populations to receive health care services, as reported by 88% of the respondents. The research also found that 77% of the respondents confirmed the unwillingness of sex workers and drug addicts to access healthcare services because of cultural factors, with 76% confirming that societal influence was a significant reason why key populations would not access healthcare services. Moreover, 77% of the respondents indicated that stigma related to some health conditions is a major determinant of healthcare-seeking behavior, and the same proportion (77%) indicated that culture is a major determinant of vulnerable populations accessing healthcare. Furthermore, it was established that the social parameters affected the readiness of the populations to use healthcare services, and 78% of interviewees admitted that it had an impact. Lastly, discrimination was also cited as a major determinant to the health seeking behavior of the key populations with 86% of the respondents agreeing with this.

An association between effectiveness of existing healthcare programs and interventions and socio-demographic variables is shown in Table 5 below. Age and level of education were found to have significant association with role of cultural and social factors; stigma and discrimination in shaping health-seeking behaviors and willingness among sex workers and drug addicts in Lusaka District of Zambia ($P < 0.05$).

Table 5: Association between role of cultural and social factors; stigma and discrimination in shaping health seeking behaviours and willingness and Socio-Demographic Variables

Socio-demographic Variables	χ^2 value	Df	p-value
SEX	24.312	4	0.301
AGE	22.152	2	0.000**
MARITAL STATUS	23.471	4	0.420
RELIGION	23.422	6	0.301
OCCUPATION	21.359	4	0.201
LEVEL OF EDUCATION	22.432	5	0.000**
SOCIAL CLASS	24.721	3	0.410
NUMBER OF CHILDREN	25.112	5	0.341

**Significant at $P < 0.05$.

**Discussion of the Findings
Demographic Data**

The findings of the current study reveal complex patterns of healthcare access and utilization among key populations in Lusaka District, Zambia, and both align with and diverge from existing literature in several important ways. The age distribution, with 55% of participants aged 21–30 years, is consistent with patterns reported in studies across Sub-Saharan Africa, where

young adults constitute the majority of vulnerable and high-risk populations due to increased social and economic mobility and exposure to risk factors. Similarly, studies such as highlight that individuals in this age group are more likely to face structural barriers to healthcare access, reinforcing the representativeness of the current sample [10,11].

However, the slight male dominance (53%) observed in this study contrasts with findings from other regional studies, which often report a higher proportion of females within vulnerable populations, particularly in research focusing on reproductive health and service utilization. This discrepancy may be attributed to differences in study design, recruitment settings, or the specific populations targeted, suggesting that contextual factors in Lusaka District may influence gender representation differently compared to other settings. The high unemployment rate (72%) among participants is strongly aligned with broader socioeconomic trends in Zambia and Sub-Saharan Africa, where limited formal employment opportunities push many individuals into informal or unstable livelihoods. This finding supports existing evidence that economic vulnerability is a key determinant of limited healthcare access and utilization, as financial constraints often restrict the ability to seek and sustain care [12-14,11].

In contrast, the relatively high level of education observed in this study, with 37% of participants having attained tertiary education, differs from trends reported in similar populations, where lower educational attainment is more common. This variation may indicate the influence of the urban setting of Lusaka, where access to educational institutions is greater, or it may suggest potential sampling bias, as individuals with higher education levels may be more likely to participate in research studies [15,16].

Awareness and Level of Knowledge of Sex Workers and Drug Addicts Towards Healthcare Services

The findings of this research indicate that drug addicts and sex workers are aware and know much about the health care services available at different health facilities in the Lusaka district of Zambia. Most of the respondents (81%) demonstrated a high degree of awareness concerning the healthcare services available in the health facilities in the Lusaka district in Zambia. This research also found that a big percentage of the respondents (92%) had information regarding the places where they were able to access healthcare services in the district. Also, many respondents (71%) were familiar with certain healthcare programs or initiatives that address such key populations as sex workers and drug addicts in Lusaka District. In addition, the research revealed that a high percentage of sex workers and drug addicts (82%) had a satisfactory level of knowledge on the nature of medical care they get in Lusaka district in Zambia. Moreover, the research revealed a significant proportion of sex workers and drug addicts (79%) who were familiar with the names and contact details of the health care services where they could easily access health services in Lusaka District of Zambia. Another finding reported in the study was that a significant proportion of

respondents (76%) were informed about the healthcare services availability in Lusaka District during the previous year.

The findings of the current research have shown that the sex workers and drug addicts have a fairly high awareness and knowledge level concerning the availability and accessibility to healthcare services in Lusaka District of Zambia. The reason behind this is that the study has established that a very big proportion of the study participants (81%) reported that they knew about the health care services that were offered at the local health facilities. Not only that, the study further revealed even higher percentage (92) of the study subjects who knew where such health care services could be availed and used. Such results do not resemble the findings of the study conducted by Avais et al (2014) which was carried out in the city of Larkana, in Parkistan where it was established that merely 46% of male sex workers were aware of HIV/AIDS and only 35% were aware of centers where they could receive HIV testing clinical services. Scaringly, no respondent in the said situation had been subjected to any medical or HIV testing services. This contrast shows that Lusaka has undertaken serious significant progress in health service awareness initiatives and community outreach activities through health education, health communication and community engagement as well as social mobilization. However, in other areas, it has been found that, key populations are drastically underserved and ill-informed about the availability and accessibility of the health services.

In addition, the findings of this research also indicated 71% of the respondents were knowledgeable about healthcare programs that were appropriately designed to meet the needs of sex workers and drug addicts. These are similar to those findings of a study conducted by, who also found that sex workers in South Africa valued the convenient access and ease of using specialized truck-stop clinics that offered primary healthcare services, as well as HIV and STI prevention services to such populations. Both of the findings emphasize the significance of focused and specific educational interventions in increasing vulnerability and key society awareness and confidence in the healthcare systems. On the other hand, these findings are not comparable to those reported by the study which discovered that sex workers in Kenya, Zimbabwe, Uganda and South Africa were exposed to severe unmet health needs, substandard access to lubricants and condoms accessibility. They were also exposed to frequent denial of diagnosis and treatment of infections, and unfriendly attitudes exhibited by healthcare providers in the health facilities. Such discrepancies are a stark indication that even as the beleaguered educated health services support the knowledge and uptake of health services among sex workers and drug addicts, different structural obstacles like stigma, criminalization, and discrimination still demoralize or undermine access to healthcare services in most African countries. The author suggested that there was a necessity to undertake massive sensitization and capacity building of the frontline healthcare providers and public health experts on the significance of good or positive attitude towards sex workers and drug addicts in the workplace setting during health service delivery [17,18].

Other than that, the study also revealed that, a fair share of respondents (82%) possessed a sufficient degree of awareness

regarding the kind of health services provided within the health facilities. These findings are aligned with the work by who emphasised the importance of developing sex work-specific health services in South Africa and Kenya. According to Richter, judgmental, disrespectful and uncompassionate providers are not the key considerations in fostering confidence and awareness among sex workers. Results of this study indicate that these principles are already affecting the process of healthcare delivery, which has led to an increase in the level of knowledge and awareness of the services compared to other areas. In addition, the researchers revealed that, an overwhelming number of the participants (79%) were familiar with the addresses and phone numbers of medical centers. This conclusion resembles the results from the study by who found that the accessibility, convenient location, and appropriate operating hours of wellness clinics were important to sex workers in South Africa. Both articles emphasize that geographical accessibility and availability of services is important in enhancing awareness and uptake of healthcare services by key population. Nevertheless, this result is contrary to, who explained that stigma, the sense of guilt and shame and deprivation of self-respect because of discrimination by frontline healthcare providers were significant obstacles to the access to and use of health services among key population. The research also found that in South Africa, healthcare workers were inadequate to capacity build on the management of sex workers which usually leads to resistance by major populations to access care and also to report behavioural risks. This implies that even with awareness, there might not be effective service utilization as long as there is sporadic discrimination and stigmatization [19-21].

Moreover, the study also found that 76% of the respondents had been informed on the healthcare services in the past one year, and 24% of the respondents had not been provided with health education on the available services in the health facilities. The current finding is comparable to positive experiences among sex workers in the North Star Alliance clinics mentioned by [20], where it was established that, the continuous growth in the number of health services provided and the communication activities contributed to the high-satisfaction levels among users. However, the findings of this study are not comparable to the results of the study by that reported the presence of invisible networks of exclusion and systemic discrimination that put sex workers in South Africa off seeking healthcare services in the health facilities. These contradicting experiences effectively demonstrate how legal, social and structural contexts can have a major bearing on the level to which awareness would be decoded into meaningful accessibility and use of the available health services within the health facilities [22].

Perception of Sex Workers and Drug Addicts Towards Quality and Accessibility of Healthcare Services in Lusaka, Zambia

The results of the current study found out that a considerable percentage of the participants in the study (75%) had good perception on the good quality of healthcare services provided in the health facilities in Lusaka district. Besides that, the research also revealed that a huge percentage of the research respondents (75%) agreed that the healthcare services are sufficiently designed to address the particular identified needs of sex workers and drug

addicts in the Lusaka district. However, irrespective of these positive impressions, a significant number of the respondents (78%) admitted that they had faced some financial obstacles when seeking healthcare services in the district. It was further found that a large proportion of these key populations such as sex workers and drug addicts (68%) were of the opinion that healthcare services in the Lusaka District is readily accessible whenever required. The finding indicates that the populations in the district have a relatively high accessibility to healthcare services. Nonetheless, the results of the study also revealed that a significant percentage of the respondents (66%) experienced discrimination and stigmatization during the process of seeking healthcare services within Lusaka District. This implies that even if health services are available and accessible in the district, there are major obstacles to accessing and utilizing quality health care services to the key populations. The findings of this paper describe an overall positive attitude to the quality and availability of healthcare services by sex workers and drug users in Lusaka District of Zambia. Interestingly, a large number of the research participants (75%) felt that the quality of healthcare services they obtained was high and well-designed to address their needs, and 68% of respondents gave an affirmative response that services are easily accessible whenever they are needed. These results can be compared to the overall data that show that marginalized groups can positively perceive the services that are designed in an inclusive way. As an illustration, the North Star Alliance appraisal in South Africa revealed that sex workers considered truck-stop clinics to be available, appropriately placed, and well-adapted by welcoming frontline health workers [23].

In the same way, the accessibility, availability, confidentiality, good organization, and patient-centred approach to community-based ART services delivery in Tanzania were highly rated as important by the female sex workers (FSWs). Therefore, this means that consideration of the key populations such as sex workers and drug addicts could lead to positive perceptions among this population. Nevertheless, even with these good perceiving, the financial barriers were still considered as major barriers, and 78% of the respondents indicated that they had faced challenges related to the cost in accessing healthcare services in the health facilities. This fact resonates well with the results of the Seek, Test, Treat, and Retain (STTR) initiative, during which the authors found that drug users and hazardous drinkers were always facing barriers to covering medical costs, lack of social support, and transportation when attempting to seek and utilize the existing health services in the hospitals and clinics. These structural obstacles merely serve to point out that despite the perceived availability, accessibility and high quality of the healthcare services, economic barriers may continue to prevent the unrestricted access and use of such services among the key population groups like sex workers and drug addicts in the district [24,25].

Besides that, the research also found that 66% of the research participants were discriminated and stigmatized when they sought healthcare services in the health facilities within the district. It is a finding that is in line with reports in Zambia that stigma, issues of confidentiality, and fears of legal punishment still remain a barrier to health services uptake among key populations [26].

In the same way, occupational stigma was also found to have direct relationship with increased healthcare access barriers to street-based sex workers in Canada. This highlights that discrimination is not localized, but rather a universal deterrence to healthcare accessibility among sex workers. These trends indicate that stigma has deep roots in healthcare systems and it has been one of the most hard obstacle to bend despite the advancements in the provision and customization of services to the needs of the patients and clients. The other aspect of comparison is the research on patient satisfaction in Malaysia that concluded that the quality of health care services was closely correlated with the efficiency of administration, quality of medical services, and nursing support [27,28].

Even though this study was not devoted to any priority population, the given work offers clear guidelines on why respondents in Lusaka city of Zambia are satisfied with the quality, accessibility and availability of healthcare services. The administrative and clinical areas are the domains that possibly led to positive quality perceptions of health services among this population. Even though the Lusaka results have indicated that in spite of acknowledging the technical quality, discrimination is still a severe impediment to the accessibility and quality of health services in most cases. Therefore, this implies that perceived quality and perceived inclusiveness might not necessarily align very well or converge. Nevertheless, the ambivalent character of these findings is also enlightened with the studies of marginalization and health outcomes. Similarly, Ziegler (2021) in his work postulated that social exclusion is a determinant of health that produces downstream barriers to health service accessibility and emphasized the need for contextualized interventions, such as self-testing and integrated social services. It was further illustrated that, the fact that sex workers and drug users in Lusaka reported both satisfaction with service availability, accessibility, and frustration with discrimination and stigma suggests that health systems improvements alone are insufficient without broader efforts to reduce marginalization or social exclusion in the health care settings.

Role of Cultural and Social Factors; Stigma and Discrimination in Shaping Health Seeking Behaviors and Willingness

Table 4 shows that, most of the respondents (87%) affirmed that cultural and societal determinants have a significant impact on seeking healthcare among key populations. Moreover, stigma and discrimination were also observed to significantly reduce interest in seeking healthcare services by the key populations, which was supported by 88% of respondents. The research also found that 77% of the respondents identified cultural unwillingness of major populations to receive medical attention and 76% cited society as a strong discouraging factor. Furthermore, 77% of them reported that stigma associated with certain health conditions significantly hinders healthcare-seeking behaviour and the same percentage of them recognised cultural factors as major obstacles to vulnerable populations as well. However, it was also found that societal determinants influenced the inclination of key populations to seek healthcare and 78% of the respondents agreed with this. Finally, discrimination was also one of the key determinants hindering the health-seeking behaviour of vulnerable groups, as 86% of respondents affirmed that it had an impact. The current

study also concluded that cultural and societal determinants have a negative impact on the healthcare-seeking behaviours of key populations, namely sex workers and drug users, with 87 per cent of the respondents supporting the impact of the determinants. This finding is consistent with who found that sex workers have an ingrained stigma and stereotypes in society that hinder the access and use of mental health services in health facilities. The observed significant hesitation amongst 77 percent of the participants in the current study to access healthcare services because of cultural factors is a reflection of observation that street-level sex workers in Vancouver, Canada, faced cultural and social stigma that determined poor access to both health and social services. As a result, the current findings are in line with the available literature that suggests that societal organizations and perceptions of the community play a critical role in influencing health-seeking behaviours and patterns among the marginalized groups. These results highlight that vulnerable population healthcare choice cannot solely be understood in the context of the cultural and traditional contexts that permeate it. Thus, it is crucial to acknowledge that within the contexts where the cultural discourses portray specific groups of people as deviant or morally suspect, healthcare avoidance is not only a personal decision but also a group response to system exclusion [28,29].

In addition, stigma and discrimination came up as major barriers in this study, as 88% and 86% of participants, respectively, agreed that the presence of these factors affected the number of sex workers and drug addicts seeking healthcare in health facilities. These findings are in agreement with, who found that stigma was a major obstacle which precluded female sex workers in Switzerland from seeking mental-health care, despite a high degree of need. The findings have also been closely echoed by who discovered that substance use and sexual-minority identity stigma significantly played a role in discouraging key populations from seeking treatment and other health services provided in health facilities. In line with both studies, the present investigation shows that stigma is not just an attitudinal barrier, but directly translates into less access and utilization of healthcare services by sex workers and drug addicts. In this sense, stigma is more than a passive social perception; it is actually an active force of exclusion that discourages or dissuades sex workers and drug addicts from seeking health services even when they are available. This strongly suggests that the power of stigma lies not only in its psychological effects and impacts, but also in its potential to influence health-care accessibility, utilization, and impact on health as a social determinant of health [30,31].

In addition, the researchers established that most of the respondents (77%), confessed that stigma associated with certain health conditions had a great impact on health-seeking behavior. This conclusion can be compared to who disclosed that negative therapeutic experiences were frequently characterized as being based on negativity and stigma by sex workers, being part of the reason why they do not receive healthcare settings. Similarly, reported that marginalization and exclusion of sex workers and drug addicts justified the stigma and, therefore, led to further deterioration of health outcomes and the impossibility to receive sexual and social health services. These findings therefore resonate with findings from other studies regarding

the importance of stigma as instilled in both clinical and social systems, and, therefore, restricting access to and use of services. Significantly, in this context, it is implied that not everyone experiences stigma in the same manner but instead it overlaps with certain health conditions and identities, which makes certain groups more susceptible to stigmatization. This study affirms that stigma is a barrier that is entrenched in the fabric of care to offer health-care services because of the conceptualization of stigma as a structural and a relational phenomenon [32,33].

Moreover, the process of societal impact on readiness to seek healthcare with the confirmation of 78% of those interviewed is parallel to the findings by, who demonstrated that discrimination of illegal drug users was strongly related to adverse mental and physical health outcomes, as well as the decreased use of healthcare in the health facilities. Similarly, the results can also be aligned with the work by the Illicit Drug Reporting System that found that the discrimination in various social spheres, such as families and public institutions, was directly linked to the poor health and diminished well-being of people who inject drugs. These results also demonstrate the effects of discrimination on the life course and in various sites of interaction that subsequently perpetuates the disadvantage cycle and entrenches health disparities in these populations. Discrimination, in the present study and in the literature at large, has not been an isolated instance, rather a series of exclusion in which one faces in the private, communal and institutional realms[34].

The findings also emphasize the fact that cultural and societal contexts together with stigma and discrimination, which pervades the society, have a systematic negative influence on the willingness of the vulnerable groups of people such as sex workers and drug addicts to access healthcare services in health facilities. The results also coincide with, who argued on how health professionals reinforce the deviant labels thus amplifying stigma and deterring healthcare-seeking behaviour among such population. This is a clear indication that on top of structural constraints, there is professional attitudes and cultural narratives that keep repeating the exclusion or marginalization of the various important populations. When healthcare professionals replicate and reflect the stigma in the rest of society, healthcare systems are complicit in perpetuating the same injustices that they are supposed to address. Therefore, the issue of enhancing healthcare access and utilization among key and vulnerable populations needs a policy-based intervention. As a matter of fact, it requires cultural change, sensitization of health care providers and intentional attempts to demolish the discourses that make some populations appear as undeserving of health care [35-38].

Limitations of the Study

The study had several limitations such as small sample size of 100 participants which potentially compromised its ability to fully capture the diverse perspectives and experiences of sex workers and drug addicts in Lusaka District of Zambia which in turn limited the generalizability of its findings. Moreover, the study's focus on urban populations also limits its applicability to rural vulnerable and key populations, who may face different barriers and facilitators to healthcare accessibility and utilization.

Conclusion

All in all, the research reveals that in Lusaka District, Zambia, sex workers and people who use drugs demonstrate high awareness and knowledge of available healthcare services, along with positive perceptions of service quality and accessibility. Nevertheless, structural, financial, and socio-cultural factors such as stigma, discrimination, and entrenched cultural beliefs continue to impede equitable access to health services and influence health-seeking behaviors and intentions among this population. Age and educational level also shape perceptions of program effectiveness, highlighting the limitations of one-size-fits-all approaches and the need for context-specific interventions. Although current programs and informational outreach efforts provide a foundation for engagement, they remain insufficient without integrated plans that address both healthcare delivery and the broader social determinants of health. Sustainable progress requires culturally sensitive care, targeted strategies to reduce stigma and discrimination, financial support mechanisms, and expanded services addressing mental health, substance dependence, and other acute health needs beyond HIV and STI treatment. Moreover, community participation, policy reforms, and provider education are essential for building trust, promoting dignity, and ensuring equitable access. Through differentiated, multi-sectoral, and culturally responsive strategies, healthcare systems in Lusaka District and beyond can improve service delivery to diverse key populations, reduce health inequities, and advance the overarching goal of health equity for society's most vulnerable members.

Recommendations

1. The investigator suggests that awareness creation efforts should be maintained through health education, social mobilization, and community-based engagement activities aimed at eliminating societal stigma and discrimination against sex workers and drug addicts when accessing and utilizing healthcare services in the health facilities in Zambia.
2. It is also recommended that the Ministry of Health in Zambia together with World Health Organization is encouraged to engage in ongoing capacity-building of healthcare providers to equip them with skills and knowledge required to develop positive and nonjudgmental attitudes towards sex workers and persons with substance use disorders to ensure that all people have equal, respectful and inclusive access to healthcare services.
3. The author further recommends that, there is need for Lusaka District Health Office to adopt the differentiated service delivery models (DSD model) that consider the various needs and nature of sex workers and drug addicts within Lusaka district.
4. The researcher also suggests that Lusaka District Health Office should incorporate mental health and substance abuse treatment provision activities into the primary healthcare setting so as to effectively meet the complex health needs of sex workers and drug addicts.

Conflict Of Interest: The authors state that no conflicts of interest regarding the conduct of this study existed.

Acknowledgement: We would like to thank everyone who made this research a success. The study was carried out as an initiative to build strategies on how to manage barriers and enhance

facilitators influencing the health-seeking behaviours among the sex workers and drug addicts in Lusaka district of Zambia.

Funding: This research was undertaken without any financial support from any funding agency, organization, institution, or individual. The authors conducted the study independently and received no external or internal funding for the design, data collection, analysis, or publication of the findings.

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