Social Marketing Initiatives (SMI) on the Purchase and Utilization of Condoms among Female Sex Workers (FSWs) in Bangladesh

Submitted to
Dr. Md. Mahafuzer Rahman Sarker
Line Director, TB-L & ASP
Directorate General of Health Services
Ministry of Health and Family Welfare
Mohakhali, Dhaka-1212

Submitted by
Professor Abu Hasanat Mohammad Kishowar Hossain
Chairman
Department of Population Sciences
University of Dhaka
Dhaka-1000, Bangladesh

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Report Prepared By:

1. **Mohammad Bellal Hossain, PhD (LSHTM)** - Team Leader
   Department of Population Sciences
   University of Dhaka

2. **Ahbab Mohammad Fazle Rabbi, PhD** - Quantitative Research Fellow
   Department of Population Sciences
   University of Dhaka

3. **Shafayat Sultan** - Qualitative Research Fellow
   Department of Population Sciences
   University of Dhaka

4. **Abdullah Al Mamun** - Research Associate
   Department of Population Sciences
   University of Dhaka

5. **Sahadat Hossain** - Research Associate
   Department of Population Sciences
   University of Dhaka

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Acronym

HIV	Human immunodeficiency virus
KP	Key populations
NSP	National Strategic Plan
FSW	Female sex workers
ASP	AIDS/STD Programme
PR	Principal recipients
SC	Save the Children
PWID	People who inject drugs
MSM	Men who have sex with men
TG	Transgender
DIC	Drop-in center
BCC	Behavior change communication
SRH	Sexual and reproductive health
TB	Tuberculosis
HTS	HIV testing services
SMI	Social marketing initiatives
CIS	Community information system
KIIs	Key informant interviews
SSR	Sub-Sub-Recipient

Executive summary

Bangladesh, despite its low overall HIV prevalence, faces a rising epidemic, particularly among key populations (KPs). The AIDS/STD Programme (ASP) has embarked on initiatives supported by The Global Fund to combat this to end AIDS in Bangladesh by 2030. A crucial aspect of their efforts involves distributing condoms to Female Sex Workers (FSWs) through free and social marketing initiatives (SMI). However, FSWs have shown a clear preference for free condoms over purchasing them through SMI. Consequently, the ASP is compelled to evaluate the effectiveness of the social marketing approach.

This research aims to uncover the factors influencing the purchasing and utilization of condoms among FSWs, ultimately informing strategies to optimize condom distribution and enhance HIV prevention efforts targeting key populations in Bangladesh. The target was achieved using a mixed methods research design and collecting data from 1069 FSWs (for the quantitative part) from three categories: street-based, hotel-based, and residence-based FSWs residing in 9 districts of Bangladesh. Qualitative data were collected from FSWs, program officials, and other related stakeholders through in-depth interviews (IDIs). The major findings of the study are presented below.

Characteristics of the respondents

- Each type of FSW represented roughly one-third of the respondents.
- The majority of the respondents earned between 2000 and 4000 BDT weekly.
- A staggering 15.8% of the respondents started selling sex before reaching age 15, and 49% started selling sex before reaching age 20.

Prevalence of using condoms through SMI

- Almost every respondent (97.7%) reported using condoms in the last months while having transactional sex, but only 6% used them every time they had sex.
- Using condoms every time while selling sex was lowest among hotel-based FSWs (4%), and using condoms rarely was highest among residence-based FSWs (57.6%).
- 63.5% of FSWs bought condoms from peer outreach workers (POWs) at some point during the project tenure, and among them, 68.6% bought condoms from POWs in the last month.
- Condoms bought through SMI were highest in Dhaka for residence-based FSWs (62.8%) and street-based FSWs (52.2%) and in Chattogram for hotel-based FSWs (43.4%).

Facilitating and Inhibiting Factors to Implement SMI among FSWs

- FSWs reported that their most preferred source of condoms is 'free from NGO' (53.5%), and the second most preferred source is buying from POWs (SMI) (26.1%).
- Only 16.31% hotel-based FSWs boght condoms from POWs in the week preceeding the survey.
- More than three-fourths (76.4%) of FSWs knew a nearby place where they could get condoms, and another 75.1% said that POWs visit them regularly, which makes condoms available.
- The greatest advantages perceived by the FSWs of SMI condoms are that they are economically convenient (66.2%) and easily accessible (59.7%).
- Qualitative findings revealed that FSWs prefer SMI condoms as they are cheaper than other private sources, easily accessible, they get medicines or other services while buying condoms from POWs, and one of the crucial advantages is that FSWs can buy from POWs by keeping their identity hidden.
- FSWs described that they have multiple other free sources of receiving condoms, making the SMI condoms less economically convenient, and there are cheaper condoms in the market than SMI.
- 'Raja' is the most frequently bought brand through SMI (55.3%), and FSWs have to spend around 3 BDT to buy condoms through SMI.
- While reporting the reasons behind not purchasing condoms through SMI, 29.9% of FSWs reported that SMI condoms are not available when needed, and another 27.2% reported that they have multiple other free sources of condoms.

- From the demand side, qualitative findings showed that poor economic conditions, especially for street-based FSWs, and the tendency to keep the price of condoms due, are the main reason to implement SMI.
- From supply side, lack of quality condoms in SMI challenges to co-ordinate POWs visit timing with FSWs, and shortage of POWs, and storage are the barriers to implementing SMI.

Best practices and lessons learned

- The project has successfully increased awareness of unprotected sex, including HIV and other STIs and unwanted pregnancies, through community mobilization a behavior change communication program, which involved activating the participation of POWs and other DIC staff.
- Reducing the price of condoms can help increase SMI; side by side, awareness-increasing activities must be ongoing.
- DICs/outlets have proved to be safe, enjoyable places for FSWs; the health services provided along with condom distribution have been a double benefit to FSWs.
- Distributing condoms in two modalities -free and SMI has proved to be more challenging to implement SMI. The program should be implemented in only one modality in one area for better SMI performance.

Limitations

- The interviews were taken in DICs in a crowded setting, where confidentiality of the responses was difficult to ensure. This raised concerns regarding the ecological validity of the research.
- The respondents, because of their professional habits and other vulnerabilities, showed a tendency to fabricate responses while answering the questions.
- Due to the extended interview period for the quantitative data, maintaining the required number of respondents from each category regularly proved challenging for the corresponding DIC authorities.

Specific policy recommendations and conclusion

- The program should discontinue the dual modality of distributing free condoms alongside selling them through SMI.
- To improve affordability, the price of condoms sold through SMI should be reduced to either 0.50 BDT or 1 BDT per condom.
- Ensuring ‘no vacancy’ in POW and field supervisor roles at divisional headquarters is crucial for effectively reaching key populations and expanding program coverage.

The study reveals lower SMI utilization among residence and hotel-based sex workers, partly due to communication gaps with third parties like clients, pimps, and site workers. To strengthen communication and promote SMI, regular counseling meetings or workshops with these stakeholders are recommended.

Chapter One: Introduction

1.1 Background

Bangladesh is a low HIV prevalence country with less than 0.01% overall prevalence among the general population, with a much higher prevalence among the key populations (KP). But Bangladesh is one of seven countries in the region where the epidemic continues to increase (1). Overall, HIV incidence has risen 56%, and HIV-related mortality has increased 110% since 2010 (2). However, according to the 4th National Strategic Plan (NSP), HIV prevalence remains low among female sex workers (FSW), which is to be less than 0.5% (3) On the other hand, 2% of the new cases of HIV are coming from FSWs.

The AIDS/STD Programme (ASP), under the Directorate General of Health Services under the Ministry of Health and Family Welfare, has initiated different activities under the 2021-2023 grant of The Global Fund to ensure HIV-related services for the KPs and to strengthen monitoring in this regard. The program titled **'Prioritized HIV Prevention and Treatment Services for Key Populations in Bangladesh' is being implemented by the three principal recipients (PRs): AIDS and STD Program (ASP) of the Government of Bangladesh; Save the Children (SC)** and icddr, b. The SC focuses on people who inject drugs (PWID) and FSW as beneficiaries. In contrast, icddr, b focuses on MSM, TG, and PWID (particularly for OST), and ASP focuses on strengthening the enabling environment as well as gradually initiating HIV service delivery for PWID and FSW from selected government hospitals. The overall goal of this program is to reduce the transmission of HIV and the effects of AIDS on individuals, families, communities, and society to end AIDS in Bangladesh by the year 2030.

The program for FSWs aimed to reach 30,000 FSWs through Save the Children. The FSWs under this program are reached through 9 DICs and 16 outlets. The FSWs receive different service packages (intensive or minimum) based on their vulnerability. Among the total 13 districts where the program is implemented under the FSWs intervention, seven districts are categorized as most vulnerable (i.e., Dhaka, Gazipur, Narayangonj, Chattogram, Cox's Bazar, Khulna, and Sylhet), where FSWs receive the intensive package, consisting of BCC, condoms, HTS, STI diagnosis and treatment, SRH, TB screening, customized services for adolescent FSW and harm reduction services for women who inject drugs (WWID) engaging in sex work. The other six districts (Dinajpur, Jashore, Rajshahi, Satkhira, Tangail, and Comilla) have been categorized as comparatively less vulnerable. In these districts, FSWs receive the minimum package of BCC, condoms, and HTS.

1.1.1 Problem statement

One of the key activities of the HIV prevention program for FSWs is distributing condoms through outlets and DICs. The program distributed condoms among FSWs using two modalities: free and social marketing initiatives (SMI). Save the Children Bangladesh has strategized to allocate a quantity of 2,57,49,517 condoms at no charge (free) through funding from the Global Fund and to distribute 2,30,88,083 condoms to female sex workers following through the SMI approach. The distribution of free and SMI condoms was planned according to the below proportion (**Table 1.1**) among the FSWs who provide services in the streets, hotels, and residences.

Table 1. 1 Planned distributions of condoms through free and SMI modalities during the project period

Variables	Year 1 (2021)	Year 2 (2022)	Year 3 (2023)
Street	100% free	67% free+33% SMI	67% free+33% SMI
Hotel	100% free	33% free+67% SMI	33% free+67% SMI
Residence	33% free+67% SMI	33% free+67% SMI	33% free+67% SMI

However, the program implementation experience shows that most FSWs preferred free condoms as they were not willing to buy condoms. Thus, the program could distribute fewer condoms using the

SMI approach than expected, while the program distributed more free condoms than the program aimed. In addition, the SMI condoms were in demand at a few establishments - residences catering to solvent clientele and hotels with high client flow. For example, the program distributed 11010937 free condoms between January 2022 to March 2023, while the number of SMI condoms distributed in the same period was only 1310822. In this context, the program personnel are concerned about the low uptake of condom use through the SMI approach.

Table 1. 2 Free and SMI condom distribution against Target vs Achievement status (January'23 to December'23)

Particulars	Target	Achievement	Percentage (%)
Free Condom Distribution	8,455,515	8,845,160	105%
SMI Condom Distribution	9,688,485	2,042,389	21%
Total Condom Distribution:	18,144,000	10,887,549	60%

Globally, condom social marketing has historically been a significant component of HIV prevention and has been shown to increase condom sales (4). However, studies of the impact of social marketing on condom use are pretty limited, and there is also a lack of studies assessing the effects of free condom distribution on condom use. In this regard, Sweat et al. conducted two meta-analyses in 2012 and 2020 on the effectiveness of social marketing programs on condom use in low- and middle-income countries (4,5). They found that the evidence base for the effect of condom social marketing on condom use is small because few rigorous studies have been conducted. However, the meta-analysis conducted in 2012 showed a positive and statistically significant effect on increasing condom use. The meta-analysis concluded that condom social marketing could increase condom use, although such evidence comes from studies lacking sufficient rigor.

In such circumstances, the program felt it necessary to assess the effectiveness of the SMI approach. The assessment of the effectiveness of condoms requires rigorous methodology, preferably the application of an experiment design with a pre and post-test survey. However, at this juncture of the project closure, conducting a study using experimental design is not feasible as it did not have a pre-test or baseline. Thus, operation research will be carried out to understand the factors that influence the uptake of SMI among FSWs. This operation research will also explore the demand and supply side challenges of distributing condoms using the SMI approach.

1.2 Conceptual framework

The practice of purchasing condoms by FSWs through utilizing SMI can be considered to be based on four theoretical domains: life-course theories, economic security theories, health behavior change theories, and empowerment theories that focus on the interaction of structure and agency (6–8). Prior studies identified these areas as major determinants determining condom usage-related characteristics among female sex workers (8–11).

According to life-course theories, unfavorable life experiences and cumulative disadvantage impact marginalization and disempowerment (7), which could undermine intervention outcomes. Demographic background characteristics such as the age of entry into sex work, time in sex work, current age, education, current and former job history, and reason for entry into sex work (i.e., trafficking into sex work) indicate life course aspects. We hypothesize that negative life course experiences may have a long-term influence on risk perception abilities, resulting in reduced use of SMI for condom use. Economic theories that delve into expected utility, heuristics, and loss aversion in decision-making suggest that perceived economic security or insecurity—representative of the income, debt position, or savings—may impact condom negotiation and behaviors (10,11).

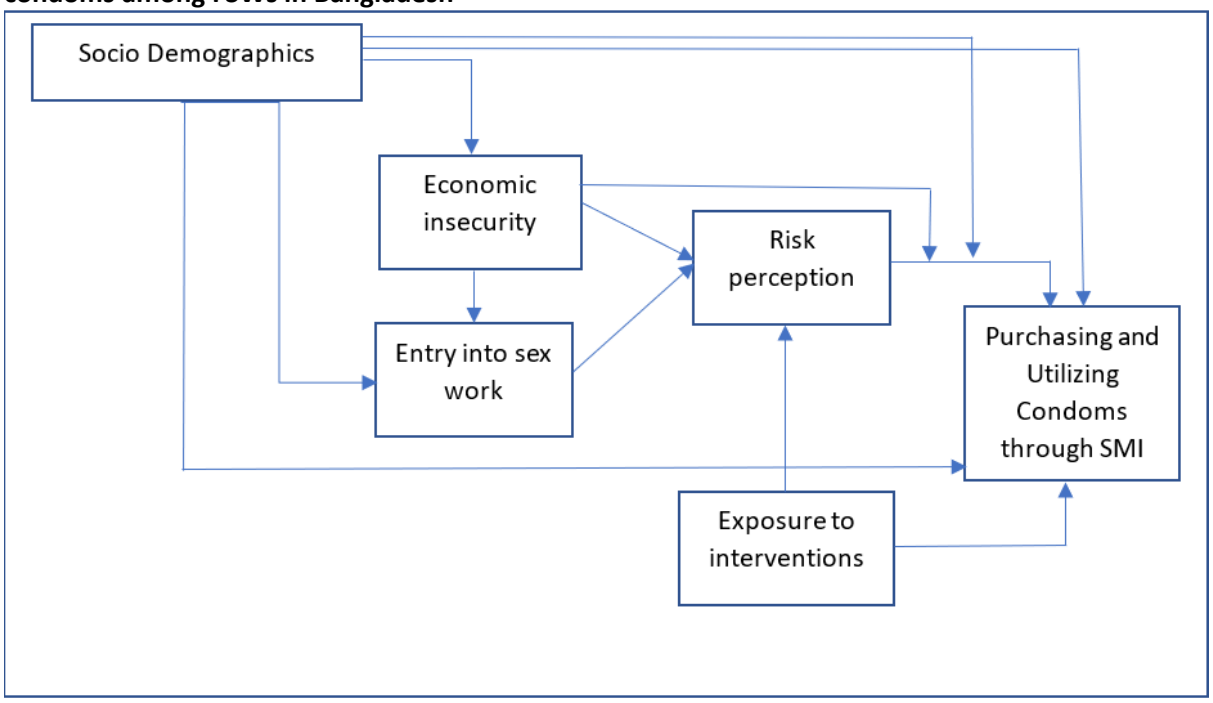
Additionally, we are considering health behavior change theories to discuss the pathway, particularly

the Health Belief Model, which holds that FSWs' perceptions of their susceptibility, severity, barriers, and benefits are crucial in helping them understand the danger associated with inconsistent condom usage. We hypothesize that SMI utilization is associated with knowledge of HIV transmission, perceived risk for HIV or STIs, and condom use knowledge (12,13). Additionally, the number of clients and days of sex work per week may indicate a higher perceived risk of HIV/STI in addition to a higher level of financial security. Sex with a non-paying regular sexual partner may also be associated with condom use due to a decrease in perceived risk based on familiarity or intimacy with regular clients (14).

Empowerment theories suggest that condom usage and, consequently, SMI utilization are significantly influenced by the autonomy and agency of Female Sex Workers, the power structure they negotiate, and their control over resources. Different dimensions of power significantly impact the decision-making processes of FSWs. Internal power dynamics, also known as power within oneself, are emphasized as critical for developing FSWs' self-esteem, confidence, and awareness of their HIV risk. Control or power over resources symbolizes an external type of power that influences FSWs' choices and possibilities, but collaborative power, or power with the community, is considered critical for the FSW community's collective empowerment (15).

Fig. 1 shows an integrated theoretical model that illustrates the relationships between the constructs in each theory discussed above. The socio-demographic characteristics in the figure, which result in various motivations for entry into sex work, represent life course vulnerabilities. The other variables in the model are also influenced by these background features, either directly or indirectly through mediated processes or as potential moderators that change the strength of the association between risk perceptions and SMI utilization. Economic insecurity is influenced by the socio-demographic factors, which then influence SMI utilization through risk perception. Economic insecurity also determines the possibility of entry into sex work of a woman. Lastly, the interventions' exposure affects FSWs' SMI utilization.

Figure 1. 1 Conceptual framework for the utilization of SMI on the purchase and utilization of condoms among FSWs in Bangladesh



Source: Modified from Fehrenbacher et al., 2016

1.3 Specific Research Questions

The specific research questions that this research will aim to answer are given below:

1. What is the prevalence of the use of condoms through SMI?
2. What is the SMI accessibility among FSWs?
3. What are the facilitating or inhibiting factors in implementing SMI among FSWs?
4. What are the best practices and lessons learned in implementing SMI?

Chapter Two: Methodology

2.1 Study Design

This study adopted a mixed-methods approach using quantitative and qualitative data. Primary quantitative data is collected using a cross-sectional survey with FSWs, whereas secondary data is extracted from the Community Information System (CIS). Qualitative data is collected using in-depth interviews (IDIs) with Female Sex Workers (FSWs) under the HIV/AIDS Program of Save the Children and key informant interviews (KIIs) with relevant stakeholders, including project staff and relevant government partners.

2.2 Sample Size and Sampling for the Study

2.2.1. Sample Size for Quantitative Data

The study is conducted in all 13 districts where the HIV/AIDS program is implemented. The sample size for the quantitative survey is calculated separately for three specific types of FSWs. For each specific FSW, the sample size is calculated using the following formula: $n_0 = Z^2 * pq \div d^2 * NR$. Here, n_0 is the estimated sample size; Z reflects a confidence level of 95%; p is the proportion of condom need of FSWs met by SMI (56%[1]); q equals one minus p; a margin of error (d) of 5%; and 5% anticipated non-respondents or incomplete questionnaires. The estimated sample size for each type of FSW is 384. However, using the finite population correction (FPC): $n = \frac{n_0}{1+(n_0-1)/N}$. The sample sizes for street, hotel, and residence-based FSWs become 373, 326, and 369, respectively. Thus, 1069 FSWs were interviewed as part of the quantitative survey. A proportional allocation (population proportion to sample) determines the sample size for each type of FSW from each district. The district-wise sample size for the quantitative survey is given in **Table 2.1**. A total of 14 female data enumerators collected data from 9 districts between January 29 and February 27 for the quantitative analysis.

Table 2. 1 Type-wise sample of female sex workers for this study

District	Street-based sex worker	Hotel-based sex worker	Residence-based sex worker	Total Sample for the Study
Dhaka	188	104	189	481
Gazipur	0	0	48	48
Narayanganj	10	0	46	56
Chattogram	37	82	26	145
Cox's Bazar	46	48	10	104
Dinajpur	25	31	11	67
Jashore	33	25	11	69
Tangail	16	0	10	26
Khulna	20	35	18	73
Total	375	325	369	1069

2.2.2. Sampling for Qualitative Data

The study conducted IDIs among the FSW, where extremely deviant sampling techniques were applied to determine who has used the SMI approach and who has not. The study also conducted IDIs among the clients of the FSWs to know the enabling factors and barriers to using condoms. In addition, KIIs were done to collect qualitative data. As part of KIIs, Drop-In-Centers (DICs)/outlet level program staffs (including the DIC/outlet manager, Supervisor, POW, site worker, Ghorwali (House owner)), and Program Coordinators from Dhaka Ahsania Mission (DAM), Save the Children (STC) and National AIDS/STD Programme (NSAP) was interviewed.

[1] Rapid assessment on condom demand and supply among Female Sex Worker (FSW) in Selected districts under the HIV program Funded by the global fund grant. It was conducted by Save the Children in 2017.

Table 2. 2 Type-wise distribution of samples for IDIs and KIIs

District	DIC/Outlet manager	Supervisor	POW	Ghorwali	Site worker	Client	Types of Sex Workers			KII (DAM, STC, NASP)	Total
							Street	Hotel	Residence		
Dhaka										3	3
Dhaka (Jatrabari)	1		2	2	1	1	1	1	1		10
Dhaka (Mirpur)		1	1	1	1	2		2	1		9
Jashore	1	1	2	1		1	1	1	1		9
Narayangonj	1		1	1		1	1		1		6
Chattogram	1	1	1	1	1	3	1	1	1		11
Cox's Bazar	1	1	2	1	1	1		1	1		9
Khulna	1		1	1	1	1	1	1	1		8
Gazipur		1	1			1	1				4
Tangail	1		1	1		1	1		1		6
Dinajpur			3	1	1	1		1	1		8
Total	7	5	15	10	6	13	7	8	9	3	83

2.3 Research Question-Wise Data Collection Methods and Types of Respondents

The following table (**Table 2.2**) shows the types of respondents and data collection methods specified based on the specific research questions provided by the study. The study combined primary and secondary data collection to approach the specific research questions.

Table 2. 3 Research question-wise data collection methods and target population

Research Questions	Target Population	Methods	Data Collection Methods
What is the prevalence of the use of condoms through SMI?	FSW	Quantitative (Both primary and secondary data)	Survey
What is the SMI accessibility among FSWs?	FSW	Quantitate, Qualitative	Survey, IDI
What are the facilitating or inhibiting factors in implementing SMI among FSWs?	FSW, site worker, ghorwali clients, DIC level program staff, Program Coordinator	Quantitative, Qualitative	Survey, IDI, KII
What are the best practices and lessons learned in implementing SMI?	DIC-level program staff, Program Coordinator	Qualitative	KII

In the selected DICs and outlets of Dhaka, Gazipur, Narayangonj, Chattogram, Coxsbazar, and Tangail, the presence of respondents (FSWs) for both quantitative and qualitative data collections were ensured by the current DIC level program staff (DIC managers, Field Supervisors, and peer outreach workers). The research team collected quantitative and qualitative data within the DIC or outlet setting with a specific number of respondents. However, in Dinajpur, Jashore, and Khulna, where the activities of DIC and outlets under PR are currently off, government healthcare facilities (such as Sadar Hospital/Medical College Hospital) were utilized for qualitative and quantitative data collection. In the districts mentioned above (Dinajpur, Jashore, and Khulna), the former peer outreach workers (who were previously involved in the PR level program activities) were recruited to establish communication with potential participants (female sex workers) and to bring them to the designated places of data collection.

2.4 Tools Development for Data Collection

The research team from the Department of Population Sciences worked on crafting a structured questionnaire for the quantitative survey. At the same time, topic guides for IDIs and KIIs were developed to collect qualitative data. The questionnaire was developed in Bengali and then translated into English. The data collection tool was finalized after conducting a pre-test (pilot interview). The data collection tools are attached in the annex.

2.5 Recruitment and Training of the Data Collection Team

Experienced and qualified survey enumerators were recruited for the data collection. The data collection team, consisting of 14 data collectors, received five days of training (including one day for the pre-test). The research team also trained the survey enumerators on collecting quality data through face-to-face interviews. The core research team conducted the IDIs and KIIs.

2.6 Supervision and Quality Assurance Mechanism

Quality data collection from the field was ensured by adequately selecting the survey enumerators and preparing them for the task through rigorous training and motivation. The following criteria was considered for recruiting the survey enumerators and supervisors: educational qualification, previous

relevant work experience, and capacity to work in a team. After completing the Five days of intensive training, interviewers participated in Mock Interview Sessions. Only successful candidates were selected as survey enumerators and there were 14 of them in total. Considering the nature of the study, all of the data enumerators were female only.

2.7 Data Entry, Processing, Analysis, Reporting

2.7.1 Data Entry, Processing

Survey data was collected through mobile or tab. The research team developed and cross-checked the data collection template. After getting feedback and approval, KoboToolBox was used to collect the quantitative data. The collected data was later cleaned and edited for analysis. Quantitative data was analyzed using SPSS 26. On the other hand, after collecting qualitative data, IDIs and KIIs were transcribed and word-processed for analysis into the NVivo software.

2.7.2 Analysis

To answer the mentioned research questions, there were two different segments of analysis in this research. First, to address the specific research questions in quantitative analysis, univariate analysis was performed to know the prevalence of the use of condoms through SMI and the SMI accessibility among FSWs. To know the significant facilitating or inhibiting factors to implementing SMI among FSWs, bivariate analysis was performed using chi-squared statistics.

Qualitative data was transcribed from the recordings of the interview sessions with participants. The transcribed files were later analyzed using NVIVO. The field notes taken during the in-depth interviews were also used to code the qualitative data and the NVIVO analysis process. The collected qualitative data were analyzed using thematic analysis.

2.7.3 Reporting

The final report is prepared by triangulating both the qualitative and quantitative data. It also contains policy implications based on the obtained results.

Chapter Three: Background Characteristics of the Respondents

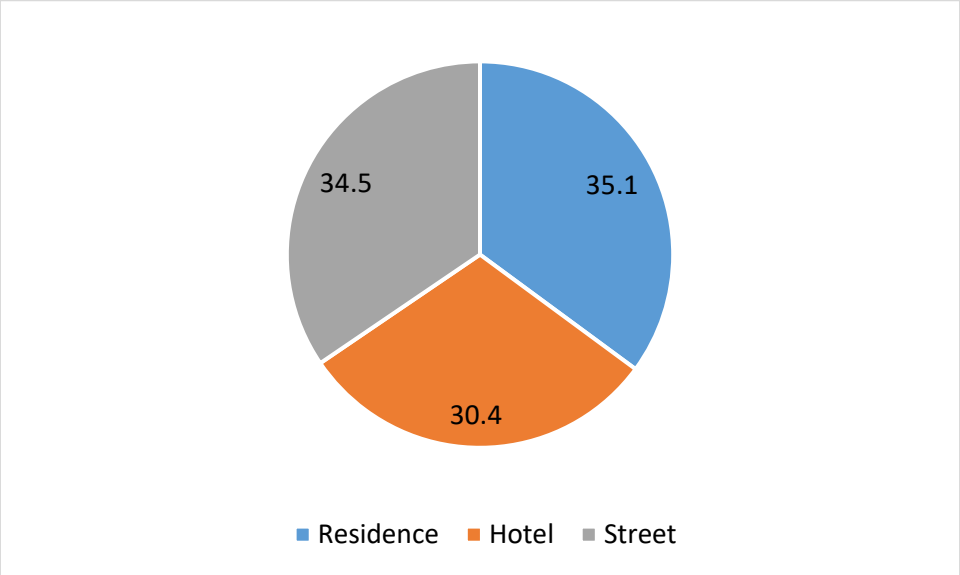
3.0 Introduction

This chapter comprises findings regarding the respondents' background characteristics. Respondents are first classified according to their location of work and meeting point with clients. Their socioeconomic status and demographic characteristics are presented along with their history and pattern of selling sex.

3.1 Background characteristics of the respondents

Figure 3.1.1 demonstrates the types of sex workers based on their meeting points with the clients. Considering the clients' meeting points, the FSWs' distribution was almost similar. The highest number of observations were residence-based (35.1%), followed by street-based FSWs (34.5%) and hotel-based FSWs (30.4%).

Figure 3.1. 1 Percentage distribution of types of sex workers



The socio-demographic characteristics of the respondents are presented in **Table 3.1.1**. All findings are based on the types of FSWs. For residence and street-based FSWs, most respondents were from Jatrabari DIC in Dhaka (31.2%), while the highest number of hotel participants were observed in Chattogram (30.5%). During the data collection period, Jashore, Khulna, and Dinajpur DICs were not operational, so interviews took place at Jashore General Hospital, Khulna General Hospital, and at the house of a peer outreach worker in Dinajpur, respectively. Among the residence category, 20.8% of FSWs were aged between 30-34 years. However, older FSWs were predominant among street-based FSWs, with 22.5% aged between 35 and 39. The majority of FSWs across all categories had primary education. Mobility was high among hotel-based FSWs; 54.7% reported residing in their current location for less than three months before the survey. Regarding marital status, 35.9% of FSWs were currently married, with 92.2% living with their husbands.

Table 3.1. 1 Percentage Distribution of the Socio-demographic Characteristics of the FSWs

Variables	Types of FSWs			Total (n= 1069)
	Residence (n=375)	Hotel (n=325)	Street (n=369)	
District				
Dhaka	188(50.1)	104(32)	189(51.2)	481(45)
Gazipur	0(0)	0(0)	48(13)	48(4.5)
Narayanganj	10(2.7)	0(0)	46(12.5)	56(5.2)

Chattogram	37(9.9)	82(25.2)	26(7)	145(13.6)
CoxsBazar	46(12.3)	48(14.8)	10(2.7)	104(9.7)
Dinajpur	25(6.7)	31(9.5)	11(3)	67(6.3)
Jashore	33(8.8)	25(7.7)	11(3)	69(6.5)
Tangail	16(4.3)	0(0)	10(2.7)	26(2.4)
Khulna	20(5.3)	35(10.8)	18(4.9)	73(6.8)
DIC/Outlet Name				
Dhaka (Jatrabari)	94(31.2)	52(19.3)	96(28.5)	242(26.7)
Dhaka (Mirpur)	94(31.2)	52(19.3)	93(27.6)	239(26.4)
Gazipur	0(0)	0(0)	47(13.9)	47(5.2)
Narayanganj	10(3.3)	0(0)	46(13.6)	56(6.2)
Chattogram	37(12.3)	82(30.5)	26(7.7)	145(16)
Cox's Bazar	46(15.3)	48(17.8)	11(3.3)	105(11.6)
Dinajpur	26(35.1)	31(55.4)	11(34.4)	68(42)
Jashore	32(43.2)	25(44.6)	11(34.4)	68(42)
Tangail	16(21.6)	0(0)	10(31.3)	26(16)
Khulna	20(6.6)	35(13)	18(5.3)	73(8)
Age (in years)				
19 or lower	29(7.7)	43(13.2)	23(6.2)	95(8.9)
20-24	63(16.8)	77(23.7)	46(12.5)	186(17.4)
25-29	72(19.2)	67(20.6)	55(14.9)	194(18.1)
30-34	78(20.8)	62(19.1)	72(19.5)	212(19.8)
35-39	66(17.6)	41(12.6)	83(22.5)	190(17.8)
40-44	26(6.9)	20(6.2)	48(13)	94(8.8)
45-49	25(6.7)	10(3.1)	20(5.4)	55(5.1)
50 or more	16(4.3)	5(1.5)	22(6)	43(4)
Religion				
Islam	366(97.6)	317(97.5)	367(99.5)	1050(98.2)
Others	9(2.4)	8(2.5)	2(0.5)	19(1.8)
Education				
No education	96(25.6)	95(29.2)	142(38.6)	333(31.2)
Primary incomplete	46(12.3)	39(12)	77(20.9)	162(15.2)
Primary	172(45.9)	129(39.7)	127(34.5)	428(40.1)
Secondary	44(11.7)	44(13.5)	16(4.3)	104(9.7)
Higher Secondary	17(4.5)	18(5.5)	6(1.6)	41(3.8)
Changed residence within 12 months				
Yes	107(28.5)	95(29.2)	111(30.2)	313(29.3)
No	268(71.5)	230(70.8)	257(69.8)	755(70.7)
Time living in current residence	(n=107)	(n=95)	(n=111)	(n=313)
3 months or less	49(45.8)	52(54.7)	53(47.7)	154(49.2)
4-6 months	35(32.7)	24(25.3)	37(33.3)	96(30.7)
7-9 months	16(15)	15(15.8)	14(12.6)	45(14.4)
10-12 months	7(6.5)	4(4.2)	7(6.3)	18(5.8)
Marital status				
Married	146(38.9)	115(35.4)	123(33.3)	384(35.9)

Unmarried	33(8.8)	39(12)	18(4.9)	90(8.4)
Widowed	38(10.1)	23(7.1)	42(11.4)	103(9.6)
Divorced	82(21.9)	75(23.1)	77(20.9)	234(21.9)
Deserted	38(10.1)	43(13.2)	59(16)	140(13.1)
Living separately	38(10.1)	30(9.2)	50(13.6)	118(11.0)
Have any children	(n=342)	(n=286)	(n=351)	(n=979)
Yes	289(84.5)	223(78)	286(81.5)	798(81.5)
No	53(15.5)	63(22)	65(18.5)	181(18.5)
No. of children	(n=289)	(n=223)	(n=286)	(n=798)
1	129(44.6)	110(49.3)	127(44.4)	366(45.9)
2	106(36.7)	83(37.2)	102(35.7)	291(36.5)
3 or more	54(18.7)	30(13.5)	57(19.9)	141(17.7)
Living with husband	(n=146)	(n=115)	(n=123)	(n=384)
Yes	131(89.7)	109(94.8)	114(92.7)	354(92.2)
No	15(10.3)	6(5.2)	9(7.3)	30(7.8)
Have any Babu*				
Yes	145(38.7)	100(30.8)	110(29.8)	355(33.2)
No	230(61.3)	225(69.2)	259(70.2)	714(66.8)

***Babu** means a person romantically involved with an FSW, not a husband, who behaves like a husband.
Note: The first figure in each cell represents the absolute number, and the parenthesis reflects the percentage.

Table 3.1.2 presents the wealth-related information of the participants. Most FSWs did not own land or homes but had savings and mobile banking accounts. Among street-based FSWs, 68.6% reported having a mobile banking account. However, savings for the future varied among different FSWs: 32% of residence-based, 34.8% of hotel-based, and 24.9% of street-based FSWs reported saving for the future. The lowest weekly earnings were reported by street-based FSWs, with 46.9% earning less than 2000 Taka per week. This pattern differed for residence-based and hotel-based FSWs. For instance, 25.8% of hotel-based FSWs reported weekly earnings exceeding 8000 Taka.

Table 3.1. 2 Distribution of Wealth information of the FSWs (n=1069)

Variables	Types of FSWs			Total (n =1069)
	Residence (n=375)	Hotel (n=325)	Street (n=369)	
Have a voter ID card				
Yes	305(81.3)	235(72.3)	293(79.4)	833(77.9)
No	70(18.7)	90(27.7)	76(20.6)	236(22.1)
Have a bank account				
Yes	143(38.1)	95(29.2)	102(27.6)	340(31.8)
No	232(61.9)	230(70.8)	267(72.4)	729(68.2)
Have a mobile banking account				
Yes	262(69.9)	200(61.5)	253(68.6)	715(66.9)
No	113(30.1)	125(38.5)	116(31.4)	354(33.1)
Have my own house				
Yes	44(11.7)	32(9.8)	27(7.3)	103(9.6)
No	331(88.3)	293(90.2)	342(92.7)	966(90.4)
Have land in my name				
Yes	57(15.2)	40(12.3)	48(13)	145(13.6)
No	318(84.8)	285(87.7)	321(87)	924(86.4)

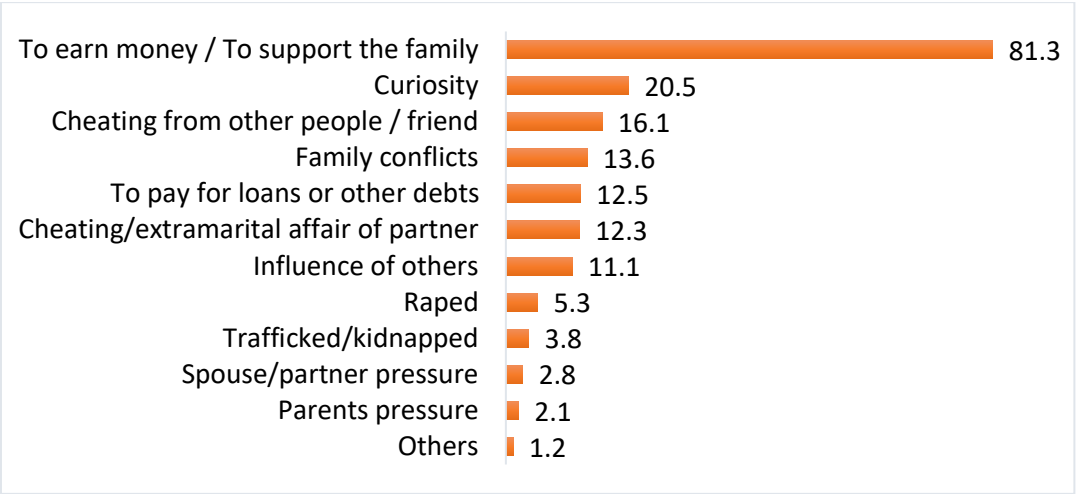
Weekly earning				
2000 TK or lower	106(28.3)	54(16.6)	173(46.9)	333(31.2)
2001-4000	119(31.7)	71(21.8)	116(31.4)	306(28.6)
4001-6000	83(22.1)	80(24.6)	44(11.9)	207(19.4)
6001-8000	28(7.5)	36(11.1)	23(6.2)	87(8.1)
More than 8000	39(10.4)	84(25.8)	13(3.5)	136(12.7)
Have savings for future				
Yes	120(32)	113(34.8)	92(24.9)	325(30.4)
No	255(68)	212(65.2)	277(75.1)	744(69.6)
Currently have any debt/loan				
Yes	170(45.3)	149(45.8)	190(51.5)	509(47.6)
No	205(54.7)	176(54.2)	179(48.5)	560(52.4)

Note: The first figure in each cell represents the absolute number, and the parenthesis reflects the percentage.

3.2 History and pattern of selling sex

Figure 3.2.1 displays the reasons for choosing sex work among the FSWs. The primary reason for choosing sex work was to earn money or support their families (81.3%), followed by curiosity (20.5%), being victims of cheating by others (16.1%), and the least common reason, parental pressure (2.1%).

Figure 3.2. 1 Percentage distribution* of reasons for choosing sex work of the FSWs (n = 1069)



*** Multiple responses**

Table 3.2.1 shows the past and present work-related characteristics of FSWs. Overall, the majority of respondents in all three categories mentioned that they had been selling sex for 6 to 10 years. On average, most FSWs were engaged in sex work for three days a week (29.9% for residence-based, 22.5% for hotel-based, and 27.9% for street-based FSWs).

Table 3.2. 1 History and pattern of selling sex for the FSWs (n=1069)

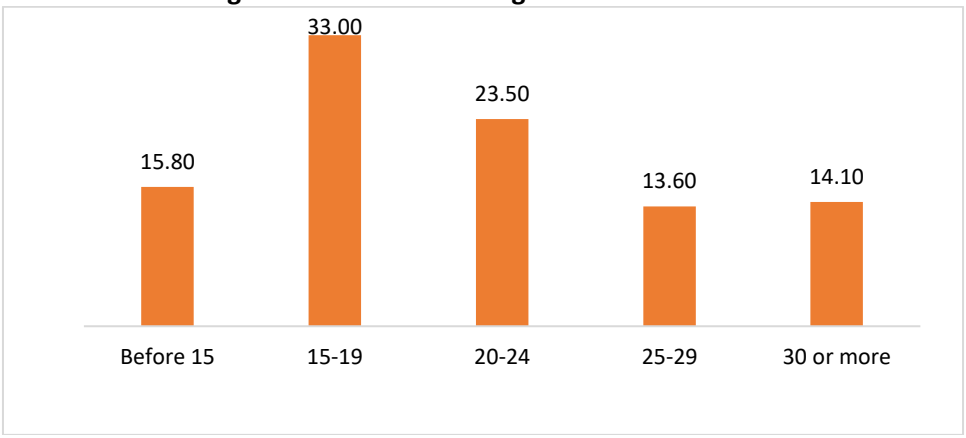
Variables	Types of FSWs			Total (n=1069)
	Residence (n=375)	Hotel (n=325)	Street (n=369)	
Duration of engagement in selling sex				
Up to 1 year	53(14.1)	75(23.1)	20(5.4)	148(13.8)
1-3 years	71(18.9)	68(20.9)	48(13)	187(17.5)
3-5 years	58(15.5)	50(15.4)	33(8.9)	141(13.2)
6-10 years	82(21.9)	75(23.1)	87(23.6)	244(22.8)
11-15 years	48(12.8)	32(9.8)	55(14.9)	135(12.6)
16-20 years	39(10.4)	16(4.9)	60(16.3)	115(10.8)
More than 20 years	24(6.4)	9(2.8)	66(17.9)	99(9.3)

Days a week involved in sex work				
1	30(8)	17(5.2)	9(2.4)	56(5.2)
2	55(14.7)	41(12.6)	29(7.9)	125(11.7)
3	112(29.9)	73(22.5)	103(27.9)	288(26.9)
4	77(20.5)	83(25.5)	81(22)	241(22.5)
5	57(15.2)	47(14.5)	82(22.2)	186(17.4)
6	18(4.8)	18(5.5)	24(6.5)	60(5.6)
7	26(6.9)	46(14.2)	41(11.1)	113(10.6)
Average number of clients meet per day				
1	57(15.2)	24(7.4)	35(9.5)	116(10.9)
2	123(32.8)	68(20.9)	105(28.5)	296(27.7)
3	94(25.1)	60(18.5)	113(30.6)	267(25)
4	38(10.1)	35(10.8)	54(14.6)	127(11.9)
5 or more	63(16.8)	138 (42.46)	62 (16.8)	263 (24.6)

Note: The first figure in each cell represents the absolute number, and the parenthesis reflects the percentage.

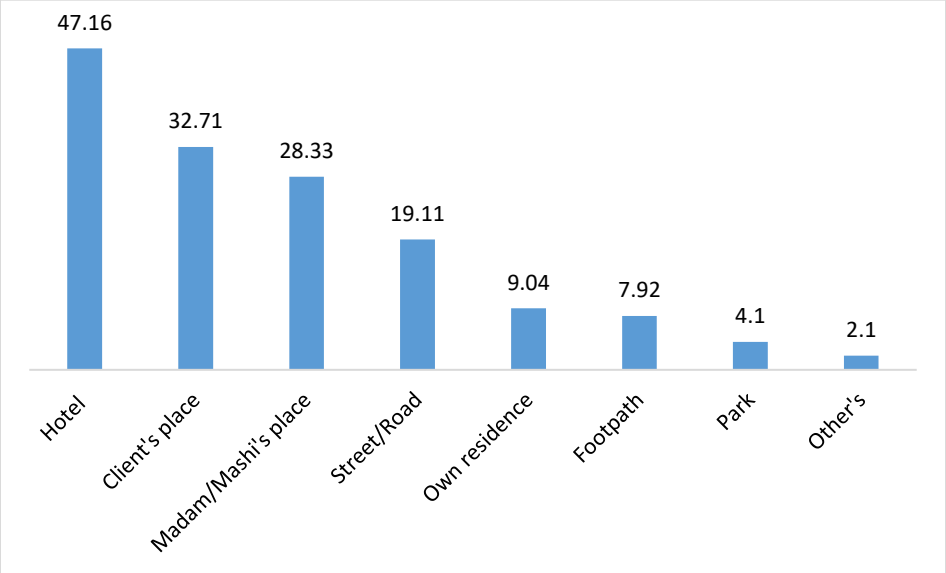
Figure 3.2.2 demonstrates the age at which FSWs engaged in their first transactional sex. A significant portion of FSWs had their first transactional sex before the age of 15 years (15.8%) and between 15-19 years (33%), totaling 48.8% during adolescence. Conversely, only 14.1% of FSWs began their first transactional sex at age 30 years and older.

Figure 3.2. 2 Percentage Distribution of the Age at First Transactional Sex of the FSWs



In **Figure 3.2.3**, we observe the usual places where FSWs engage in transactional sex. Typically, the majority of FSWs reported having sex in hotels (47.16%), followed by Client's place (32.71%) and Madam's places (28.33%).

Figure 3.2. 3 Percenatge distribution of the usual place of having transactional sex of the participants*



* Multiple response questions

Chapter Four: Prevalence of Using Condoms through SMI

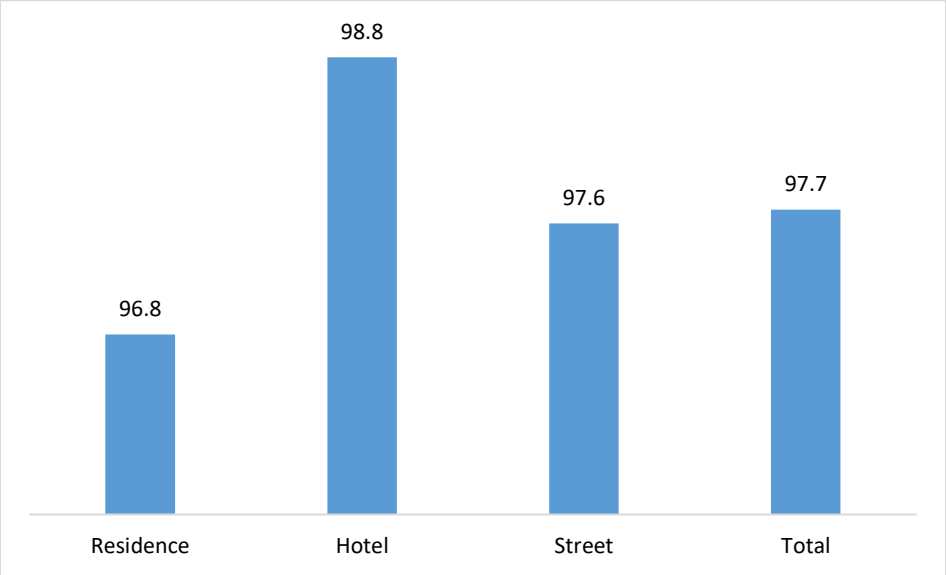
4.0 Introduction

This chapter presents the findings regarding the prevalence of using condoms through SMI among FSWs. The prevalence of using condoms through SMI is given for each type of FSW. Then, the findings are shown based on FSWs' socio-economic and demographic characteristics.

4.1 Prevalence of using condoms among the FSWs

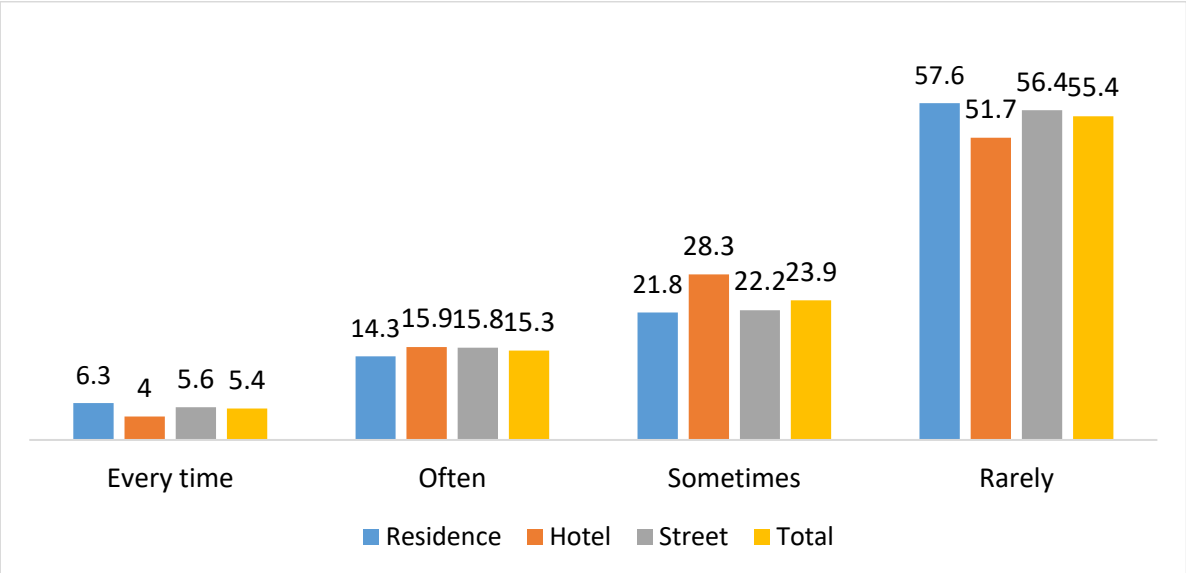
The prevalence of using condoms among the FSWs is shown in **Figure 4.1.1.** Overall, 97.7% of the FSWs reported using condoms during transactional sex in the last month. This rate was consistent across all types of FSWs. However, residence-based FSWs had the lowest, and hotel-based FSWs had the highest condom use rate during this period.

Figure 4.1. 1 Prevalence of using condoms among the FSWs



In the last month, while engaging in transactional sex, the frequency of condom use among FSWs is presented in **Figure 4.1.2**. The majority (55.40%) reported that they rarely condom use during this period, while 5.40% used condoms every time, 15% used them often, and 24% used them sometimes.

Figure 4.1. 2 Percentage distribution of frequency of using condoms for the FSWs in the last month while having transactional sex



4.2 Prevalence of using condoms through SMI among the FSWs

Table 4.2.1 shows that 63.5% of FSWs purchased condoms from POWs. Most of those purchasers (73.7%) were street-based, with hotel-based FSWs showing the lowest rate (53.2%). Among FSWs who had ever purchased condoms through SMI, 68.60% reported doing so in the last month. Similarly, among FSWs who purchased condoms through SMI in the previous month, 60.7% did so within the week preceding the survey. In every case, hotel-based FSWs had the lowest rate of buying condoms through SMI.

Table 4.2. 1 Prevalence of using condoms through SMI among the FSWs

Variables	Types of FSWs			Total (n=1069)
	Residence (n=375)	Hotel (325)	Street (369)	
Have you ever bought condoms from a peer outreach worker?				
Yes	234(62.4)	173(53.2)	272(73.7)	679(63.5)
No	141(37.6)	152(46.8)	97(26.3)	390(36.5)
Bought condoms from a peer outreach worker in the last month	n=234	n=173	n=272	n=679
Yes	169(72.2)	113(65.3)	184(67.6)	466(68.6)
No	65(27.8)	60(34.7)	88(32.4)	213(31.4)
Bought condoms from a peer outreach worker in the last week	n=169	n=113	n=184	n=466
Yes	114(67.5)	53(46.9)	116(63)	283(60.7)
No	55(32.5)	60(53.1)	68(37)	183(39.3)

Note: The first figure in each cell represents the absolute number, and the parenthesis reflects the percentage.

Table 4.2.2 shows the association between FSWs' history of purchasing condoms from POWs and selected background characteristics. Here, only the respondents who ever bought condoms are considered for analysis (n=679). The results indicate a statistically significant association between condom purchasing from POWs and district as well as types of FSWs. Dhaka exhibits the highest prevalence of condom purchases through SMI among residence-based and street-based FSWs (62.8% and 52.2%, respectively). Conversely, hotel-based FSWs from the Chattogram district show the highest prevalence of condom purchases through SMI (43.4%) compared to other districts.

On the other hand, FSWs aged 30 to 39 years show the highest prevalence of purchasing condoms from SMI among residence-based and hotel-based FSWs. Weekly earnings also correlate significantly with condom purchasing through SMI. Residence-based FSWs with a weekly income of 2001-4000 Tk purchased condoms from POWs more frequently compared to other income brackets. In contrast, the trend among street-based FSWs was highest among those earning 2000 Tk or less; among hotel-based FSWs, it was highest among those earning 4001 to 6000 Tk. The age of entry into transactional sex also influences purchasing patterns; FSWs who began working in the sex industry at ages 15-19 years show the highest prevalence of condom purchases from POWs among residence-based and street-based FSWs (35% and 37.1%, respectively).

Table 4.2. 2 Background characteristics of the FSWs who have ever bought condoms through SMI (n=679)

Variables	Types of FSWs			Total (n=679)	p-value
	Residence (n=234)	Hotel (n=173)	Street (n=272)		
District					**<0.001**
Dhaka	147(62.8)	50(28.9)	142(52.2)	339(49.9)	
Gazipur	0(0)	0(0)	36(13.2)	36(5.3)	

Narayanganj	9(3.8)	0(0)	40(14.7)	49(7.2)	
Chattogram	35(15)	75(43.4)	24(8.8)	134(19.7)	
Cox's Bazar	5(2.1)	4(2.3)	2(0.7)	11(1.6)	
Dinajpur	15(6.4)	17(9.8)	9(3.3)	41(6)	
Jashore	4(1.7)	6(3.5)	3(1.1)	13(1.9)	
Tangail	12(5.1)	0(0)	7(2.6)	19(2.8)	
Khulna	7(3)	21(12.1)	9(3.3)	37(5.4)	
Age					**<0.001**
19 or lower	9(3.8)	18(10.4)	13(4.8)	40(5.9)	
20-24	42(17.9)	31(17.9)	32(11.8)	105(15.5)	
25-29	47(20.1)	38(22)	40(14.7)	125(18.4)	
30-34	53(22.6)	39(22.5)	60(22.1)	152(22.4)	
35-39	43(18.4)	31(17.9)	62(22.8)	136(20)	
40-44	12(5.1)	11(6.4)	37(13.6)	60(8.8)	
45-49	17(7.3)	3(1.7)	15(5.5)	35(5.2)	
50 or more	11(4.7)	2(1.2)	13(4.8)	26(3.8)	
Education					**0.001**
No education	61(26.1)	50(28.9)	104(38.4)	215(31.7)	
Primary incomplete	31(13.2)	27(15.6)	55(20.3)	113(16.7)	
Primary	104(44.4)	71(41)	96(35.4)	271(40)	
Secondary	26(11.1)	16(9.2)	11(4.1)	53(7.8)	
Higher Secondary	12(5.1)	9(5.2)	5(1.8)	26(3.8)	
Changed residence within 12 months					**0.56**
Yes	69(29.5)	44(25.4)	81(29.9)	194(28.6)	
No	165(70.5)	129(74.6)	190(70.1)	484(71.4)	
Weekly earning					**<0.001**
2000 TK or lower	59(25.2)	34(19.7)	127(46.7)	220(32.4)	
2001-4000	74(31.6)	41(23.7)	88(32.4)	203(29.9)	
4001-6000	56(23.9)	47(27.2)	33(12.1)	136(20)	
6001-8000	21(9)	25(14.5)	18(6.6)	64(9.4)	
More than 8000	24(10.3)	26(15)	6(2.2)	56(8.2)	
Marital status					**0.221**
Married	93(39.7)	68(39.3)	95(34.9)	256(37.7)	
Unmarried	17(7.3)	14(8.1)	10(3.7)	41(6)	
Widowed	27(11.5)	13(7.5)	31(11.4)	71(10.5)	
Divorced	47(20.1)	41(23.7)	57(21)	145(21.4)	
Deserted	22(9.4)	21(12.1)	41(15.1)	84(12.4)	
Living separately	28(12)	16(9.2)	38(14)	82(12.1)	
Age at first transactional sex					**<0.001**
Before 15	29(12.4)	18(10.4)	62(22.8)	109(16.1)	
15-19	82(35)	42(24.3)	101(37.1)	225(33.1)	
20-24	54(23.1)	57(32.9)	50(18.4)	161(23.7)	
25-29	39(16.7)	29(16.8)	31(11.4)	99(14.6)	
30 or more	30(12.8)	27(15.6)	28(10.3)	85(12.5)	

Note: The first figure in each cell represents the absolute number, and the parenthesis reflects the percentage.

The association between purchasing condoms from POWs in the month preceding the survey and various background variables is detailed in **Table 4.2.3**. Statistically significant associations were observed for the district where FSWs operate, their current age, highest level of education, presence of any 'Babu,' and age at first transactional sex. FSWs from Dhaka exhibited the highest frequency of purchasing condoms from POWs across all three types of FSWs. Regarding educational attainment, FSWs with primary education had the highest frequency of condom purchases from POWs among residence-based and street-based FSWs. Weekly earnings also significantly influenced condom purchasing behavior. Similar to the patterns observed for ever-buying condoms from POWs (Table 4.2.2), FSWs earning 2001-4000 tk per week showed the highest prevalence of purchasing through SMI among residence-based and street-based FSWs. Additionally, FSWs who began transactional sex between the ages of 15 and 19 years showed higher rates of condom purchase across all three types of FSWs.

Table 4.2. 3 Background characteristics of the FSWs who have bought condoms through SMI in the last month (n=466)

Variables	Types of FSWs			Total (n=466)	p-value
	Residence (n=169)	Hotel (n=113)	Street (n=184)		
District					**<0.001**
Dhaka	114(67.5)	42(37.2)	104(56.5)	260(55.8)	
Gazipur	0(0)	0(0)	15(8.2)	15(3.2)	
Narayanganj	9(5.3)	0(0)	38(20.7)	47(10.1)	
Chattogram	31(18.3)	65(57.5)	20(10.9)	116(24.9)	
Cox's Bazar	4(2.4)	3(2.7)	1(0.5)	8(1.7)	
Dinajpur	1(0.6)	0(0)	0(0)	1(0.2)	
Jashore	1(0.6)	0(0)	1(0.5)	2(0.4)	
Tangail	9(5.3)	0(0)	5(2.7)	14(3)	
Khulna	0(0)	3(2.7)	0(0)	3(0.6)	
Age					**0.001**
19 or lower	9(5.3)	15(13.3)	10(5.4)	34(7.3)	
20-24	29(17.2)	22(19.5)	25(13.6)	76(16.3)	
25-29	35(20.7)	23(20.4)	27(14.7)	85(18.2)	
30-34	33(19.5)	25(22.1)	38(20.7)	96(20.6)	
35-39	32(18.9)	20(17.7)	41(22.3)	93(20)	
40-44	9(5.3)	6(5.3)	29(15.8)	44(9.4)	
45-49	12(7.1)	2(1.8)	7(3.8)	21(4.5)	
50 or more	10(5.9)	0(0)	7(3.8)	17(3.6)	
Education					**0.002**
No education	45(26.6)	36(31.9)	75(41)	156(33.5)	
Primary incomplete	23(13.6)	21(18.6)	44(24)	88(18.9)	
Primary	79(46.7)	47(41.6)	55(30.1)	181(38.9)	
Secondary	14(8.3)	7(6.2)	6(3.3)	27(5.8)	
Higher secondary	8(4.7)	2(1.8)	3(1.6)	13(2.8)	
Changed residence within 12 months					**0.793**
Yes	52(30.8)	32(28.3)	59(32.1)	143(30.7)	
No	117(69.2)	81(71.7)	125(67.9)	323(69.3)	

Weekly earning					**<0.001**
2000 TK or lower	48(28.4)	24(21.2)	90(48.9)	162(34.8)	
2001-4000	49(29)	29(25.7)	58(31.5)	136(29.2)	
4001-6000	40(23.7)	27(23.9)	20(10.9)	87(18.7)	
6001-8000	12(7.1)	17(15)	12(6.5)	41(8.8)	
More than 8000	20(11.8)	16(14.2)	4(2.2)	40(8.6)	
Marital status					**0.532**
married	69(40.8)	40(35.4)	60(32.6)	169(36.3)	
unmarried	12(7.1)	11(9.7)	9(4.9)	32(6.9)	
widowed	17(10.1)	9(8)	19(10.3)	45(9.7)	
divorced	34(20.1)	24(21.2)	46(25)	104(22.3)	
deserted	16(9.5)	18(15.9)	24(13)	58(12.4)	
living separately	21(12.4)	11(9.7)	26(14.1)	58(12.4)	
Age at first transactional sex					**0.009**
Before 15	24(14.2)	14(12.4)	42(22.8)	80(17.2)	
15-19	58(34.3)	33(29.2)	78(42.4)	169(36.3)	
20-24	38(22.5)	31(27.4)	32(17.4)	101(21.7)	
25-29	26(15.4)	18(15.9)	14(7.6)	58(12.4)	
30 or more	23(13.6)	17(15)	18(9.8)	58(12.4)	

Note: The first figure in each cell represents the absolute number, and the parenthesis reflects the percentage.

The association between purchasing condoms from POWs in the week preceding the survey and various background variables is shown in Table 4.2.4. Statistically significant associations were observed for the district where FSWs operate, including their current age and weekly earnings. FSWs from Dhaka exhibited the highest frequency of purchasing condoms from POWs among residence-based and street-based FSWs; for hotel-based FSWs, the highest frequency was observed in Chattogram. Among street-based FSWs, 52.1% of respondents with weekly earnings of less than 2000 tk bought condoms from SMI, whereas the highest frequency was observed among FSWs with weekly earnings of 2000-4000 tk for residence-based and hotel-based FSWs.

Table 4.2. 4 Background characteristics of the FSWs who have bought condoms through SMI in the last week (n=283)

Variables	Types of FSWs			Total (n=283)	P-value
	Residence (n=114)	Hotel (n=53)	Street (n=116)		
District					
Dhaka	72 (63.2)	10 (18.9)	50 (43.1)	132 (46.6)	**<0.001**
Gazipur	0 (0.0)	0 (0.0)	14 (12.1)	14 (4.9)	
Narayanganj	6 (5.3)	0 (0.0)	32 (27.6)	38 (13.4)	
Chattogram	27 (23.7)	40 (75.5)	17 (14.7)	84 (29.7)	
Cox's Bazar	1 (0.9)	0 (0.0)	0 (0.0)	1 (0.4)	
Dinajpur	1 (0.9)	0 (0.0)	0 (0.0)	1 (0.4)	
Jashore	1 (0.9)	0 (0.0)	1 (0.9)	2 (0.7)	
Tangail	6 (5.3)	0 (0.0)	2 (1.7)	8 (2.8)	
Khulna	0 (0.0)	3 (5.7)	0 (0.0)	3 (1.1)	
Age					**0.002**
19 or lower	5 (4.4)	9 (17.0)	8 (6.9)	22 (7.8)	

20-24	22 (19.3)	9 (17.0)	14 (12.1)	45 (15.9)	
25-29	25 (21.9)	10 (18.9)	13 (11.2)	48 (17.0)	
30-34	23 (20.2)	13 (24.5)	25 (21.6)	61 (21.6)	
35-39	20 (17.5)	10 (18.9)	28 (24.1)	58 (20.5)	
40-44	5 (4.4)	1 (1.9)	19 (16.4)	25 (8.8)	
45-49	7 (6.1)	1 (1.9)	6 (5.2)	14 (4.9)	
50 or more	7 (6.1)	0 (0.0)	3 (2.6)	10 (3.5)	
Education					**0.043**
No education	29 (25.4)	15 (28.3)	49 (42.6)	93 (33.0)	
Primary incomplete	16 (14.0)	9 (17.0)	25 (21.7)	50 (17.7)	
Primary	57 (50.0)	24 (45.3)	34 (29.6)	115 (40.8)	
Secondary	7 (6.1)	4 (7.5)	4 (3.5)	15 (5.3)	
Higher secondary	5 (4.4)	1 (1.9)	3 (2.6)	9 (3.2)	
Changed residence within 12 months					
Yes	37 (32.5)	15 (28.3)	38 (32.8)	90 (31.8)	**0.831**
No	77 (67.5)	38(71.7)	78 (67.2)	193 (68.2)	
Weekly earning					**<0.001**
2000 TK or lower	29 (25.4)	17 (32.1)	61 (52.6)	107 (37.8)	
2001-4000	33 (28.9)	14 (26.4)	38 (32.8)	85 (30.0)	
4001-6000	30 (26.3)	12 (22.6)	10 (8.6)	52 (18.4)	
6001-8000	9 (7.9)	6 (11.3)	5 (4.3)	20 (7.1)	
More than 8000	13 (11.4)	4 (7.5)	2 (1.7)	19 (6.7)	
Marital Status					**0.483**
Married	46 (40.4)	19 (35.8)	35 (30.2)	100 (35.3)	
Unmarried	7 (6.1)	6 (11.3)	6 (5.2)	19 (6.7)	
Widowed	11 (9.6)	3 (5.7)	15 (12.9)	29 (10.2)	
Divorced	25 (21.9)	12 (22.6)	29 (25.0)	66 (23.3)	
Deserted	10 (8.8)	9 (17.0)	17 (14.7)	36 (12.7)	
Living separately	15 (13.2)	4 (7.5)	14 (12.1)	33 (11.7)	
Age at first transactional sex					**0.132**
Before 15	19 (16.7)	10 (18.9)	24 (20.7)	53 (18.7)	
15-19	41 (36.0)	16 (30.2)	50 (43.1)	107 (37.8)	
20-24	22 (19.3)	14 (26.4)	24 (20.7)	60 (21.2)	
25-29	17 (14.9)	8 (15.1)	4 (3.4)	29 (10.2)	
30 or more	15 (13.2)	5 (9.4)	14 (12.1)	34 (12.0)	

Note: The first figure in each cell represents the absolute number, and the parenthesis reflects the percentage.

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Chapter Five: Facilitating and Inhibiting Factors to Implement SMI among FSWs

5.0 Introduction

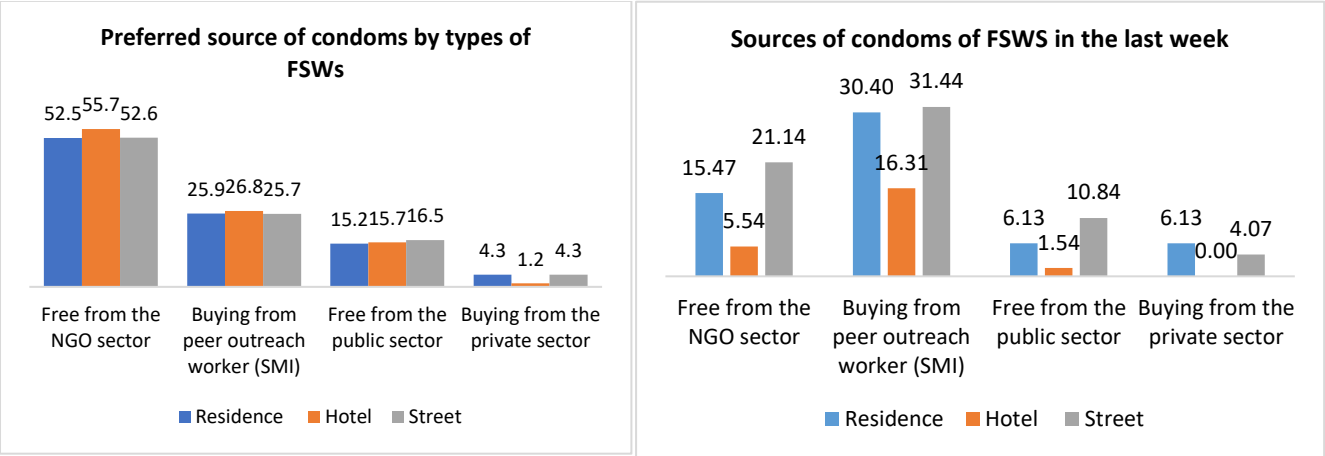
This chapter comprises findings regarding the accessibility of condoms through SMI for FSWs and the facilitating and inhibiting factors regarding implementing SMI for FSWs. Although 63.5% of FSWs in the intervention area bought condoms ever through SMI, the rate is not similar for every type of FSW. This chapter used qualitative and quantitative data to provide an in-depth understanding.

5.1. SMI Accessibility among the FSS

5.1.1 Preferred and Actual Sources of Receiving Condoms by the Types of FSWs

Preferred and different sources of receiving condoms by the FSWs are shown in Figure 5.1.1. Condom buying through SMI in the last week was higher among street-based FSWs (31.44%), and similarly, free condom collection from NGOs was also higher among street-based FSWs (21.14%). From the point of preference, free condoms from NGOs were the most preferred source for all three types of FSWs. Condoms through SMI were found to be a relatively less preferred source. Among street-based FSWs, 25.7% preferred to buy from SMI, with a slightly higher frequency observed among hotel-based FSWs (26.8%).

Figure 5.1. 1 Percentage Distribution of Preferred and Actual Sources of Receiving Condoms among the FSWs



To further analyze the accessibility of condoms, FSWs were asked ten questions, with all responses recorded on a 5-point Likert scale. Table 5.1.1 demonstrates the accessibility and availability of condoms for FSWs. The majority of FSWs (76.4%) reported that the condom source was conveniently located near them, and they did not need to travel far as POWs provided them conveniently (77%). They also indicated feeling minimal embarrassment (80.9%) or discomfort (81%) when purchasing condoms from a POW.

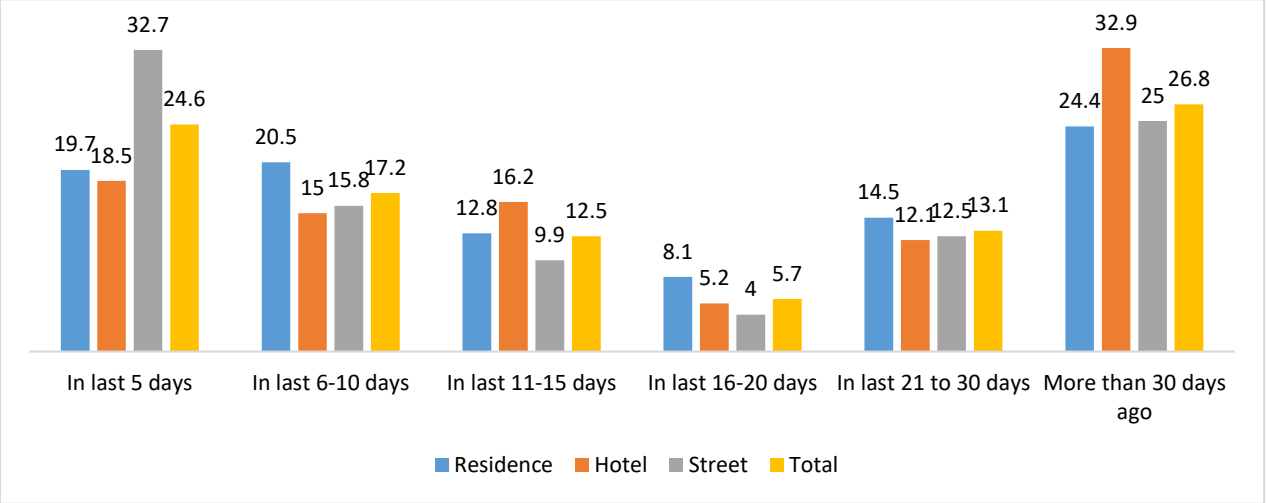
Table 5.1. 1 Opinion regarding the accessibility of condoms among the FSWs

Opinions	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
I know a nearby place where I can get condoms	80 (7.50)	147 (13.80)	26 (2.40)	300 (28.10)	516 (48.30)
I do not need to go far to get condoms, as peer outreach workers provide condoms at my convenience	23 (2.20)	56 (5.20)	167 (15.60)	280 (26.20)	543 (50.80)
I can easily get condoms	37 (3.50)	52 (4.90)	27 (2.50)	293 (27.40)	660 (61.70)
Many different brands of condoms are available through peer outreach workers	257 (24.00)	343 (32.10)	206 (19.30)	154 (14.40)	109 (10.20)
Peer outreach workers regularly visit so condoms are available	31 (2.90)	51 (4.80)	185 (17.30)	301 (28.20)	501 (46.90)
Condoms provided by the peer outreach workers are of good quality according to the price	26 (2.40)	35 (3.30)	207 (19.40)	359 (33.60)	442 (41.30)
The peer outreach activities are beneficial for us as we get many services from this	19 (1.80)	18 (1.70)	134 (12.50)	281 (26.30)	617 (57.70)
Peer outreach service saves both my money and time	23 (2.20)	26 (2.40)	146 (13.70)	286 (26.80)	588 (55.00)
It is embarrassing to buy condoms from peer outreach workers	810 (75.80)	55 (5.10)	157 (14.70)	29 (2.70)	18 (1.70)
I feel uncomfortable buying condoms from peer outreach workers	810 (75.80)	56 (5.20)	159 (14.90)	29 (2.70)	15(1.40)

Note: The first figure in each cell represents the absolute number, and the parenthesis reflects the percentage.

Figure 5.2.1 summarizes the time elapsed since the last purchase of condoms from POWs by FSWs. Most of the FSWs reported that they bought condoms from a POW more than a month before the survey (26.8%). For residence-based FSWs, 32.9% of the respondents bought condoms more than a month before the survey. Overall, 24.6% of the FSWs bought condoms from POWs in the last five days preceding the survey.

Figure 5.2. 1 Last time bought condoms from POW



5.2 Facilitating Factors to Implement SMI among FSWs

To explain the facilitating factors of SMI, we need to simultaneously compare and contrast the advantages of SMI (which encouraged condom purchasing) with the disadvantages of free condoms from NGO sectors (which discouraged their use). **Table 5.2.1** demonstrates the facilitating factors for implementing SMI among FSWs. Buying condoms from POW thorugh SMI was considered economically convenient for the FSWs; purchasing from SMI was also said to be easily accessible. The main disadvantage of free condoms from NGOs was not knowing the source. For instance, among hotel-based FSWs, 67.6% reported not knowing the source of free condoms from NGOs.

Table 5.2. 1 Facilitating Factors to Implement SMI among FSWs*

Variables	Types of FSWs, n(%)			Total
	Residence	Hotel	Street	
Advantages of buying from POW (n=506)				
Economically convenient	106(57.3)	94(75.2)	135(68.9)	335(27.9)
Easily accessible	116(62.7)	79(63.2)	107(54.6)	302(25.2)
Condom quality is good	72(38.9)	66(52.8)	60(30.6)	198(16.5)
Time convenient	38(20.5)	40(32)	36(18.4)	114(9.5)
Identity can be kept anonymous	80(43.2)	64(51.2)	84(42.9)	228(19)
Huge availability of POWs	6(3.2)	3(2.4)	14(7.1)	23(1.9)
Disadvantages of free condoms (NGO) (n=384)				
Not always available	15(9.7)	20(18)	19(16.1)	54(10.7)
Condom quality is not good	4(2.6)	1(0.9)	8(6.8)	13(2.6)
Potentiality of disclosing identity	11(7.1)	0(0)	10(8.5)	21(4.2)
Fewer variations in condom	5(3.2)	1(0.9)	5(4.2)	11(2.2)
Clients do not like these types of condoms	6(3.9)	7(6.3)	0(0)	13(2.6)
Do not know about this source	104(67.1)	75(67.6)	64(54.2)	243(48.3)
Not economically convenient	8(5.2)	7(6.3)	5(4.2)	20(4)
This source distance of POW is greater	9(5.8)	3(2.7)	8(6.8)	20(4)

Note: The first figure in each cell represents the absolute number, and the parenthesis reflects the percentage.
* Multiple response questions

The qualitative data also found the reasons why participants mentioned their preferences towards buying condoms through SMI from peer outreach workers. These reasons included dimensions such as perceived safety, identity issues, accessibility and availability issues, cost concerns etc. These issues significantly influenced the collection and utilization practices of condoms among the three categories of FSWs and their clients.

5.2.1 Easier accessibility

The accessibility issue was frequently highlighted in interviews with qualitative participants. POWs, who share the same profession and peer groups as FSWs, are considered one of the most accessible sources of condoms by both FSWs and their clients. The ease of communication and meetings with POWs is perceived as the simplest, making them the preferred source of condoms for FSWs. According to findings from the qualitative data, POWs efficiently fulfill the sudden condom needs of FSWs in specific areas.

> *"Whenever I need condoms, Apa (one of the POWs) is just one call away. She meets me every week; besides, whenever I need her, I can call her and ask her for condoms. I buy from her, and I also get some free ones along with the ones I buy with money." (A street-based FSW of Chittagong focusing on how easier accessibility motivates her to buy condoms from peer outreach workers)*

The familiarity and easier accessibility of POWs influence FSW and their clients to consider POWs as the first choice as a buying source of condoms. The area-based activities of the peer outreach workers are seen to be very effective in this regard and increase service accessibility to a great extent.

5.2.2 Availability of other medicines with condoms

The DICs where female sex workers pay visits serve as sources of condoms through SMI, alongside offering additional services such as prescriptions from doctors, diagnostic facilities for certain diseases, referral opportunities, and counseling services. These offerings make DICs appealing as service centers for the workers. The availability of medications and related products (particularly those for STDs, STIs, lubricants, and gels) and the comprehensive services provided attract female sex workers to visit DICs and purchase condoms from DIC officials, as revealed in the findings of the qualitative data.

> *"…if they buy from us, they can have some free condoms, and at the same time, they get products like gels and lubricants. They prefer getting these from here. They won't get the chance to have these similarly in pharmacies or other shops. That's why they prefer buying condoms from DICs." (One peer outreach worker explaining why female sex workers prefer buying condoms from DIC or outlets)*

Such provision of getting other products along with the condoms bought from DIC through SMI attracts female sex workers to grab these opportunities, which, according to the participants, will not be available in other sources.

5.2.3 Perceived safety

Purchasing condoms from peer outreach workers through SMI was deemed safer by participants in the qualitative data. Findings indicated that the risky exposure involved in visiting pharmacies intrudes upon the privacy of sex workers. Consequently, workers prefer obtaining condoms from peer outreach workers who distribute them through SMI. The inconvenience and potential safety risks associated with accessing condoms from pharmacies or department stores can disrupt their daily lives. According to the qualitative data, female sex workers found buying condoms from POWs to be hassle-free and more convenient.

> *"Considering what profession I am in, buying condoms from pharmacies or shops is very risky for me. I can buy condoms from Apa (POWs) in a large quantity once, and for a long time, I will be tension-free. But I have to go to shop frequently if I buy condoms from there. That's not safe to me." (A hotel-based FSW in Jatrabari opining why she considers buying condoms from POWs as safe and risk-free)*

The associated concerns, such as getting exposure to community people, prevent FSWs from buying condoms from the pharmacy and help form the habit of buying from POWs in the respective areas.

5.2.4 Identity can be kept anonymous

Continuing from the previous theme, FSWs consider POWs a safer source of condoms even when purchasing them. This safety stems from the ability to maintain anonymity. Participants in the

qualitative interviews noted that buying a large number of condoms from pharmacies or external shops could be seen as suspicious behavior, potentially exposing their identity to the community and inviting legal repercussions. These concerns deter them from obtaining condoms from pharmacies or department stores. Conversely, FSWs view POWs as fellow professionals providing a service, eliminating fears of identity exposure. Such peer interactions influence their decision to procure condoms from POWs.

> *"…when I go to a pharmacy, I cannot buy a large quantity of condoms at a single time. People will not take this easily. Everyone will question why I am doing this. My identity might be revealed because of that. But from these POWs, I don't have to fear all these things. I can buy whenever I want, in whatever quantity I desire." (A female sex worker expressing her position on why she prefers buying condoms from POWs)*

The perception of risk-free transactions and the supply of condoms in these contexts motivates FSWs to buy condoms from the POWs at their convenience and in the desired quantity.

5.2.5 Helpful and friendly attitude of POWs

The familiarity of POWs is considered a significant factor influencing female sex workers' decision to purchase condoms from them, as found in the qualitative data. The helpful and friendly nature of peer outreach workers, as well as DIC officials such as managers, medical officers, and field supervisors, motivates them to engage and procure condoms. Participants in the study emphasized this as a considerable advantage. In contrast, other sources, such as pharmacies or nearby departmental stores, do not offer the same level of support and may raise concerns. Therefore, workers feel more comfortable communicating with POWs at specific locations, DIC officials, and outlets.

5.2.6 Double benefits (benefit of getting free condoms)

One of the most common reasons cited for preferring to buy condoms from POWs was the opportunity to receive free condoms in addition to those purchased from them or DICs. Throughout the program, FSWs received free condoms alongside SMI condoms in varying ratios. Regardless of the ratio, FSWs preferred obtaining free condoms when making a purchase. This incentive increased their interest in buying condoms from POWs, as they did not receive this benefit from any other source. According to findings from the qualitative data, this dual distribution method of condoms was highly appealing to beneficiaries, leading them to frequently contact and communicate with DICs, outlets, and POWs for condom purchases through SMI.

> *"Suppose I have to pay 25 taka per 3 condoms if I buy from a medicine store. But if I pay here (DIC or peer outreach workers) 20 taka, they will give me the condoms of that money, and they will also give me some added free condoms. I can easily pass a week with those condoms just by paying 20 taka weekly. So why workers like me would go to the pharmacy and take fewer condoms after paying more money?" (A hotel-based female sex worker from Chittagong expressing her preference towards buying condoms through SMI rather than buying condoms from pharmacies or other medical shops)*

The dual benefit in this regard is helping female sex workers sustain their condom utilization practice, and they can continue using condoms without any financial hassle. According to the findings, this facilitated them to stick with the decision of purchasing SMI condoms from peer outreach workers.

5.2.7 Better quality of condoms

The condoms distributed through SMI in the program were also considered better in terms of quality by the participants, according to the findings of the study. The perceived better quality compared to the free condoms provided under this program influenced female sex workers to prefer the ones of SMI, according to the findings. The quality in terms of usability, smell, and size was assessed following the utilization of both types of condoms, and thus, the users (both FSWs and their clients) formed this preference for condoms of SMI over the free condoms and also sometimes over the condoms which are available in pharmacies and departmental stores of nearby area.

> *"The clients of hotel-based workers prefer the condoms which are bought from peer outreach workers. They don't like the free condoms. They think these condoms have some bad smell, and that is why they don't like to use the free condoms while having sex with the FSWs. Compared to the free ones, the ones bought from POWs are better." (A hotel-based sex worker from Dinajpur sharing her experience regarding her clients' preference towards the condoms which are bought from peer outreach workers through SMI)*

The preference was also similar for the clients of residence and street-based workers, where they also emphasized the better-quality issues of the condoms of SMI compared to the free condoms both from government and global funds.

5.2.8 Lower price compared to pharmacy

Qualitative data frequently highlighted the benefit of purchasing condoms at a lower price through SMI. Female sex workers (FSWs) and clients find the cost of SMI condoms considerably lower compared to purchasing them from pharmacies and other shops. Therefore, they prefer buying condoms from peer outreach workers or DICs. The financial advantage of this practice is that it helps them sustain it over a more extended period. Economic challenges faced by FSWs drive them to seek more affordable sources of condoms. The availability of SMI condoms at a lower cost through peer outreach workers is seen as a significant advantage, as these condoms are both accessible and affordable to the FSWs.

> *"Buying condoms from Apa (Peer outreach worker) is very convenient for me. If I had to buy from pharmacies or shops, that would be very costly. I have to buy ten condoms per day, and sometimes I have to buy 400-500 condoms per month. Buying all these from pharmacies is almost impossible for me. I have to pay much less when buying this from Apa." (A street-based sex worker from Narayanganj talking about her convenience while buying condoms from peer outreach workers)*

The option to defer payment also enhances convenience for female sex workers, particularly those working on the streets. The qualitative data revealed that, at times, workers find it difficult to pay for condoms immediately when purchasing them. Unlike pharmacies or other shops, where immediate payment is typically required, peer outreach workers offer the flexibility to keep the bill due and pay later at their convenience. This arrangement significantly increases the comfort of dealing with POWs for FSWs.

> *"They (peer outreach workers) know how financially insolvent we are. There are times when we take ten condoms and ask them to let us have the opportunity to pay for these later. They always agree. They don't disappoint us. If we have financial problems, we also can be sure that we will get condoms no matter what and can pay later when it is convenient for us. That's a great advantage." (A street-*

based sex worker from Chattogram opining how dealing with POWs regarding the purchase of condoms is much easier for them)

Thus, the economic advantage influences them to prefer buying condoms from the peer outreach workers around them rather than from other nearby pharmacies or departmental stores.

5.2.9 Intiatives to be taken to increase purchase through SMI

Respondents were asked to identify initiaves for increasing their purchase of condoms through SMI. Quantitative data showed that 59.02% FSWs said to lower the price of condoms provided through SMI. Among the three types of FSWs, street based FSWs (76.6%) were the highest who responded to lower the price of condoms.

Table 5.2. 2 Initiatives to be taken to increase purchase through SMI*

Variables	Types of FSWs			Total
	Residence (326)	Hotel (265)	Street (350)	
Lower the price	183(56.1)	180(67.9)	268(76.6)	631(59.02)
Active involvement or visit of outreach worker	80(24.5)	84(31.7)	100(28.6)	264(24.70)
Improving quality of condom	65(19.9)	27(10.2)	49(14)	141(13.19)
Improving behavior of the POWs	3(0.9)	2(0.8)	3(0.9)	8(0.75)
Increase no of condoms provided by the peer outreach workers	82(25.2)	38(14.3)	73(20.9)	193(18.05)
Increase the number of POW	24(7.4)	15(5.7)	20(5.7)	59(5.52)
Open DIC and provide free condoms	19(5.8)	14(5.3)	15(4.3)	48(4.49)

Note: The first figure in each cell represents the absolute number, and the parenthesis reflects the percentage.
* Multiple response questions

5.3 Inhibiting Factors to Implement SMI among FSWs

On the other hand, to explain the inhibiting factors of SMI, we need to simultaneously focus on the disadvantages of SMI (which discouraged condom purchasing) and the advantages of free condoms from NGO sectors (which encouraged their use instead of purchasing from SMI). **Table 5.3.1** demonstrates the inhibiting factors for implementing SMI among FSWs. Obtaining free condoms from NGOs was considered economically convenient for all types of FSWs, with higher rates among street-based and residence-based FSWs. For example, 93% of residence-based FSWs found condoms obtained for free from NGOs to be economically convenient. Easy accessibility and maintaining anonymity were also cited as significant reasons for preferring free condoms from NGO sectors. The main disadvantage associated with condoms from SMI was uncertainty about their source. For instance, among hotel-based FSWs, 72.7% reported not knowing the source of free condoms from NGOs. This distribution pattern can be explained by the condom distribution structure at DICs for hotels and residences, similar to what was observed in the facilitating factors for implementing SMI among FSWs (Table 5.2.1).

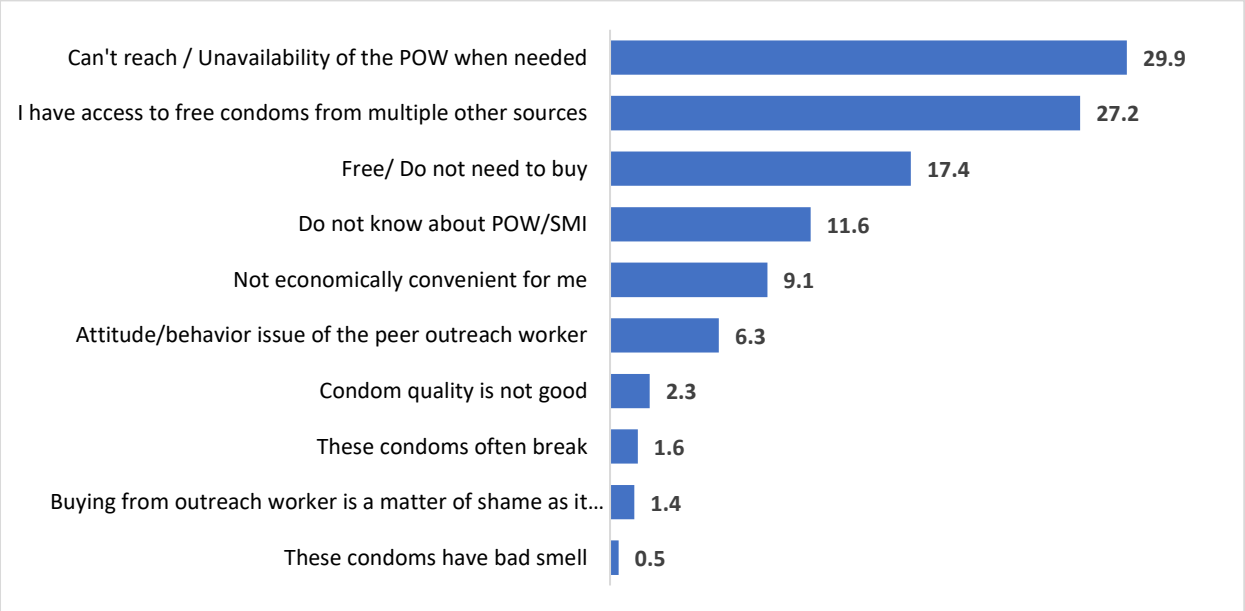
Table 5.3. 1 Inhibiting Factors to Implement SMI among FSWs*

Variables	Types of FSWs, n(%)			Total
	Residence	Hotel	Street	
Advantages of free condoms (NGO) (n=581)				
Economically convenient	173(93)	137(77.8)	210(95.9)	520(41.8)
Easily accessible	81(43.5)	92(52.3)	90(41.1)	263(21.1)
Condom quality is good	54(29)	56(31.8)	52(23.7)	162(13)
Time convenient	21(11.3)	23(13.1)	28(12.8)	72(5.8)
Identity can be kept anonymous	66(35.5)	52(29.5)	90(41.1)	208(16.7)
Huge availability	7(3.8)	4(2.3)	8(3.7)	19(1.5)
Disadvantages of buying from POW (n=420)				
Not economically convenient	18(13.6)	22(14.3)	42(31.3)	82(13.9)
Not always available	12(9.1)	12(7.8)	26(19.4)	50(8.5)
Condom quality is not good	4(3)	1(0.6)	8(6)	13(2.2)
Potentiality of disclosing identity	6(4.5)	3(1.9)	2(1.5)	11(1.9)
Fewer variations in condom	7(5.3)	5(3.2)	5(3.7)	17(2.9)
Clients do not like these types of condoms	6(4.5)	4(2.6)	0(0)	10(1.7)
Do not know about this source	78(59.1)	112(72.7)	50(37.3)	240(40.8)
This source distance is greater	9(6.8)	2(1.3)	8(6)	19(3.2)

Note: The first figure in each cell represents the absolute number, and the parenthesis reflects the percentage.
* Multiple response questions

We further analyzed the specific reasons why FSWs do not purchase condoms through SMI, focusing on the disadvantages. **Figure 5.3.1** demonstrates the reasons for not buying condoms from POW through SMI among FSWs. When the FSWs were asked about the reasons for not buying condoms from POW through SMI, the most frequent cause was the inability to reach/unavailability of the POW when needed (29.9%), followed by the availability of other free sources (27.2%), getting them for free and not needing to buy (17.4%), and the least common reason was the condoms having a bad smell (0.5%).

Figure 5.3. 1 Percentage distribution of reasons for not buying condoms from the POWs



Alongside preferences, the qualitative data also explored reasons for non-preference. Study participants cited various issues that deterred them from buying condoms through SMI, whether from peer outreach workers or DICs/outlets. These issues encompass intrapersonal factors among beneficiaries, interpersonal dynamics, and various service-related factors associated with the purchasing process.

5.3.1 Huge availability of free source of condoms

One of the primary reasons why female sex workers (FSWs) do not prefer to purchase condoms through SMI is the widespread availability of free condoms provided within the same program, as highlighted in the study. The option to receive free condoms during visits to Peer Outreach Workers (POWs), and the ability to rely solely on these free supplies discourages FSWs from establishing a habit of purchasing condoms through SMI. Throughout the program duration, the availability of free condoms remained consistent, allowing FSWs to request and receive their desired quantity free of charge from POWs, as indicated by the study findings. Additionally, some FSWs opt to travel to nearby locations to obtain free condoms, thus avoiding the need to purchase them. Consequently, participants expressed minimal inclination toward purchasing condoms from POWs.

> *"They (female sex workers) are habituated to getting free condoms. The free condoms are very easily available. Whenever I ask for these, I get them. In such a situation, why would anyone be interested in buying condoms, be it at a lower price or higher? There is no reason for this." (A supervisor from Mirpur DIC expressing how the preferences of female sex workers are building towards getting free condoms because of the easier availability of this opportunity)*

The availability of free condoms from sources outside this program also significantly influenced this situation. Participants mentioned accessing free condoms from these alternative sources, which further diminished their motivation to purchase condoms from POWs through SMI.

> *"Except us, they are also getting free condoms from other sources, too. They are getting condoms from Smiling Sun; there is an organization, RHSTEPS, that works in Sadar Hospital and provides free condoms to them. Everywhere you are getting free condoms. So why should they go to buy condoms? Isn't it unnecessary?" (A field supervisor from Jashore explaining how the free condoms are creating the preference of FSWs)*

The availability of free condoms is leaving FSWs with the option of not choosing to buy condoms from pharmacies, other departmental stores, and peer outreach workers through SMI, according to the findings of the study.

5.3.2 Perceived quality of condoms received through SMI

In contrast to the findings discussed earlier, some participants expressed that they perceive condoms received through SMI as lower in quality compared to those available in pharmacies. These perceived quality gaps lead them to opt for condoms from pharmacies or other departmental stores, regardless of higher costs. Complaints about the quality of SMI-provided condoms include issues with size, smell, durability, and sometimes even color. Personal preferences of both FSWs and clients regarding these aspects influence their decision to purchase condoms from pharmacies rather than from POWs and DICs. According to the study findings, this preference is more pronounced among residence-based and hotel-based sex workers, who generally have greater financial means compared to street-based sex workers.

"I haven't even seen the condoms distributed through SMI yet. I always buy condoms from pharmacies or other shops. I even bought condoms from India, which are very expensive and much better in terms of quality and user experience. The ones provided here are not good enough, and my clients and I do not prefer to use these for this quality issue." (A residence-based sex worker of Jatrabari about her preference for condoms available in pharmacies over condoms through SMI)

In most of the cases, 'Hero' and 'Raja' condoms were distributed through SMI, which are at the same time cheaper than other condoms and also have wider availability. Participants often perceived the other brands of condoms available in the pharmacy as better compared to the condoms sold through SMI. Such comparisons were seen to shape their purchasing preference and demotivate them to buy condoms like "Raja" and "Hero" through SMI.

5.3.3 Perception of the high cost of condoms through SMI

The perceived high cost of condoms distributed through SMI discourages female sex workers from purchasing them from POWs despite their lower prices compared to pharmacies or other stores. According to the quantitative survey, SMI condoms are priced at 3 BDT in the majority of intervention areas, whereas most FSWs are only willing to pay 1 BDT per condom (refer to Table 6.5.1). FSWs with limited financial capacity are thus disinclined to buy condoms from POWs. This economic barrier is particularly significant for street-based FSWs, influencing their preference to prioritize obtaining free condoms from POWs over purchasing them. This behavior allows them to allocate their limited funds towards daily necessities, as highlighted in the qualitative data.

"The female sex workers think that the price of the condoms through SMI is high. That's why they are not interested in buying it from the POWs. They are not interested in buying at all. Why will they spend their precious earning when they are getting free condoms side by side?" (A field supervisor from Jashore explaining how the perception of high costs among beneficiaries is creating barriers towards SMI)

This hardship is particularly pronounced among street-based workers, who often struggle to make ends meet. The need to cover housing expenses and other essential costs makes purchasing condoms challenging for them, even at a reduced rate through SMI under this program. As a result, they often choose not to purchase condoms at all, regardless of the circumstances.

"The hotel-based and residence-based workers are not affluent comparatively. They don't have to think much about the daily living. However, for street-based workers, the situation is tough. They have to support themselves and their families and manage all the expenses related to this work. They cannot do all these with the small amount of money they earn. How can they spend money on condoms?" (The DIC manager of Chattogram sharing the reality of street-based sex workers and their position towards spending money on buying condoms)

Even at a reduced rate of SMI, for some sex workers, the price of condoms was perceived as costly, which impeded them from buying condoms from peer outreach workers.

5.3.4 Remarks about the pricing of condoms among FSWs

Participants also noted that the SMI condoms they receive from POWs and DICs are perceived as more expensive compared to other available sources. According to findings from the qualitative data, this perception that SMI condoms are costlier than other options serves as a demotivating factor for

female sex workers and their clients. The availability of less expensive condoms in shops makes FSWs hesitate before purchasing condoms from POWs.

> *"FSWs are asking my POWs, why should I buy from you? I am getting other condoms in nearby stores at a lesser cost. There are condoms like Raja Super and some more ones that are widely available in the stores, and FSWs and clients have wider access to those condoms as well. In this situation, they are asking, why should they buy condoms of SMI and not go to the alternative cheaper options?" (A field supervisor from Cox's Bazar providing his opinion on how beneficiaries make a trade-off between the SMI condoms and other cheaper condoms available at the market)*

The prices not being fixed often shape the decision of the purchase and utilization of the condoms distributed through SMI under this program, according to the qualitative findings. The variation in the prices FSWs were asked for was mainly caused by the particular context of the FSWs. The peer outreach workers were found to decide the pricing of the condoms by assessing the workers' financial situation according to the findings. The workers who were financially less well-off were asked to provide a lower price for condoms through SMI, and the more economically stable workers were asked to pay a price similar to the market price.

> *".....they sometimes take 3 taka per condom, sometimes 2 taka per condom. They have customers amongst us who can take more money. But my situation is different. I am not financially stable. I am a street-based worker. I get a very negligible amount of money after every work I do. They (peer outreach workers) understand my situation, and that's why they sell the condoms at a much cheaper rate to me. And this is how I am being able to afford to buy the condoms from them along with the free ones I get." (A street-based worker in Dhaka sharing her experience of buying condoms from POWs where she gets a bit of an advantage because of not being financially stable)*

The pricing is thus determined by the POWs based on their assessment of the workers' financial condition and ability to pay the fixed prices for the condoms distributed through SMI. The participants of the qualitative interviews also indicated the rise in the cost of condoms after COVID-19. The condoms they (female sex workers of different types) used to buy in the pre-COVID-19 era were comparatively cheaper, and a hike in the price was observed after when the service was re-started. The change in pricing during this period also changed consumption patterns, according to the findings.

> *"The price is now higher compared to the pre-COVID-19 era. Earlier at that time, we used to buy condoms for two Taka per piece. But now the situation is not the same. Now, they are giving more free condoms because FSWs are not able to afford the current cost of the condoms. (A ghorwali from Narayanganj sharing her opinion regarding the change in the price of the condoms distributed through SMI and how it affected consumption pattern)*

Cheaper and widely accessible alternative sources were found to influence the decision-making process of beneficiaries regarding the purchase of SMI condoms, according to the qualitative findings. It is already evident from Figure 5.1.1 and later in Tables 6.1.1 and 6.1.2 that free condoms were the most preferred option among female sex workers (FSWs). The current program distributed free condoms to three types of FSWs alongside the distribution of condoms through social marketing initiatives (SMI). The distribution of free condoms was meticulously maintained by peer outreach

workers (POWs) at various locations in coordination with Drop-In Centers (DICs). The qualitative data identified a range of reasons provided by participants for preferring to receive free condoms from POWs and DICs in the current context, which also restricted the purchasing practice of condoms through SMI. These reasons obtained from qualitative data are briefly discussed in the following subsections.

5.3.5 Economic convenience of free condoms

The mention of economic convenience was frequently reported as the primary reason for preferring free condoms among female sex workers of all categories. Economic hardship influences workers to favor the supply of free condoms, according to qualitative findings. Specifically, street-based sex workers expressed a higher desire for free condoms from peer outreach workers, as their income was found to be lower compared to other groups of workers.

> *"Free condoms are blessings for me. Getting work now is harder than at any other time. Even if I get work, how much do I earn? That's very negligible. In such a context, how can I afford to buy condoms? For me, the only way is free condoms, nothing except that." (One street-based sex worker from Jatrabari opining about her reason for preferring condoms)*

Peer outreach workers who participated in the qualitative interviews also echoed the preference of female sex workers (FSWs) for free condoms. Their experience in the field reflects the high demand for free condoms due to the financial challenges faced by workers, as found in the study.

> *"They (FSWs) prefer free condoms. Their earning is not a guaranteed thing. You never know whether you will earn tomorrow if you are an FSW- street, hotel, or residence-based. You will most naturally prefer getting free stuff like condoms, treatments, gels, lubes etc. That is not at all abnormal from their point of view." (A peer outreach worker explaining the reason for the high demand for free condoms among FSWs)*

Although the study found that economic hardship and earning struggles are more pronounced among street-based workers compared to other groups, the preference for and tendency to seek free condoms are similar across all three groups.

5.3.6 High demand for free condoms among clients

Alongside female sex workers (FSWs), clients also prefer receiving free condoms from peer outreach workers (POWs) when communicated. The qualitative data identified instances where clients obtained free condoms from both POWs and Drop-In Centers (DICs). Clients' economic circumstances also influence their preference for free condoms provided by DIC workers.

> *"I keep free condoms with me most of the time. Everyone wants that. Not every client is rich. There are clients of FSWs who are rickshaw pullers; some are shopkeepers, and some are drivers. These categories of clients prefer not to spend money on condoms. That's why they want us to provide them free condoms all the time." (A ghorwali from Mirpur about her experience while dealing with clients regarding free condoms)*

Third parties such as pimps, *ghorwalis,* and site workers emphasized the increasing tendency of clients to obtain free condoms along with female sex workers (FSWs), facilitated by the uninterrupted supply

of free condoms under the current program. The abundant availability of free condoms facilitates clients' preferences, as found in the qualitative data.

5.3.7 Uninterrupted supply of free condoms

Throughout the program period, the distribution of free condoms remained uninterrupted, which contributed to the high reliance on free condoms among both FSWs and clients, as revealed by the study findings. The distribution of free condoms was responsive to the demand from workers in these categories.

> *We always ensure a supply of free condoms. But we cannot match the demand for free condoms. For example, if FSWs need ten free condoms, we can give them six or seven, then she may decline that we never gave her free condoms (A key informant describing the situation of demand for free condoms)*

In some cases, POWs provided solely free condoms, even in the presence of SMI condoms, because the FSWs did not agree to buy condoms from them. The continuous availability of free condoms over an extended period also led FSWs to prefer them.

Along with all of the above-mentioned demand-side barriers to implementing SMI in the FSWs, there were also factors in the supply side to implement SMI among the FSWs. The qualitative data also found some crucial supply-side barriers for which the implementation of SMI among female sex workers is facing different challenges. These supply-side barriers include condom-related issues, infrastructural and human resource-related concerns, and other difficulties arising from the particular contexts.

5.3.8 Continuous Struggle of POWs to Reach FSWs

The active peer outreach workers serve as the contact points for FSWs through whom they obtain condoms, both free and through SMI. However, in some instances, it was seen from the field that insufficient POWs pose challenges in reaching the desired or targeted number of beneficiaries and key populations. The limited presence of POWs at DICs in these cases prevents consistent communication with FSWs as planned in program documents and activity schedules. This acts as a barrier, leaving many FSWs uncontacted and beyond the coverage of SMI, as revealed in the study findings.

> *"Reaching FSWs is very tough in the present context. The number of peer outreach workers we have currently is very much insufficient against the number of the key populations we are targeted to reach. The number of key populations per peer outreach worker is becoming higher, which is why we are losing our standard. We are losing our service standard and also the standard of counseling." (The DIC manager of Tangail on how the high POW-FSW ratio is creating barriers to the standard of the service activities)*

Thus, the qualitative participants emphasize the lack of human resources as a crucial barrier to implementing the SMI activities.

5.3.9 Challenges to coordinate with the timing of the FSWs

Qualitative participants highlighted challenges regarding communication with FSWs. The continuous work schedules of female sex workers often resulted in time constraints, making it difficult for peer outreach workers to establish consistent communication, as found in the study. Additionally, the limited counseling or meeting time at specific locations posed further challenges, as workers struggled to allocate sufficient time for interactions with peer outreach workers.

"To manage some time for communication is very hard for the sex workers. Talking with them and counseling them is very hard. There are peak hours when they have to attend to many clients. At those peak hours, they are hardly available for counseling or even for providing condoms. They don't give time. Every moment is precious to them, and time means money to them. Communicating with them during their off-peak hours is often challenging for the peer outreach workers. So matching these times is a great challenge for both parties." (DIC Manager of Jashore on how challenging it is for POWs and FSWs to match the timing for communication)

The lack of coordination in this regard results in fewer POWs' visits and a shorter communication time, which causes different challenges associated with the implementation of SMI under the program.

5.3.10 POWs' financial loss to continue the supply of the condoms

One of the most frequent supply-side challenges identified in the qualitative data was the financial burden faced by peer outreach workers when distributing condoms through SMI. It was common for POWs to use their own funds to provide condoms to female sex workers, especially those who were financially disadvantaged. Participants mentioned that this personal financial loss posed a significant challenge to sustaining SMI condom distribution activities among female sex workers. POWs often incurred personal financial losses while ensuring that every FSW received the condoms distributed through SMI. This loss of personal funds emerged as a significant demotivating factor for peer outreach workers, becoming a critical supply-side barrier in this program.

"I have to buy one box of condoms from here by paying 400 taka. I have to sell these 100 condoms to the FSWs at the cost of 4 taka per condom. But in reality, I am not being able to sell these condoms 4 taka per piece as the FSWs can't buy them at this expense. But I must return at least 400 Taka to Apa (DIC Manager). For this, I must spend money from my pocket and properly complete the calculation. I have nothing else to do. I want to ensure FSWs are getting condoms properly." (A peer outreach worker of Chattogram sharing her struggle with the capital money for running SMI among FSWs)

Thus, such financial loss was found to demotivate workers in the working field. The DICs faced problems in this regard too, where the POWs were seen to fail returning money to DIC managers. In these cases, DIC managers went through struggle to continue the SMI in their respective areas.

"I couldn't get my money back in the last week. I don't know when I will get it back. I have given 5 thousand Taka but have not received even 5 taka yet!" (The DIC supervisor from Gazipur expressing her concerns regarding the capital issues)

However, POWs were found to be active despite these challenges because the service provider's identity comes in handy when dealing with other people in their daily lives. Introducing themselves as "peer outreach workers" is considered a valuable identity by the POWs for which they are willing to tackle the financial challenges associated with SMI.

Despite the financial problems, POWs continue their job. You wont see any POWs leaving jobs just because of this……I think the reason is this job gave them an identity. They also can say to people that they are having a 'job' which is prestigious for them and some money are being added as well at the end of the

month. This is a great opportunity for them considering what other work (sex selling) they are involved in." (The DIC manager from Chattogram highlighting on why POWs continue their services despite the financial challenges).

5.3.11 Storage issues

Qualitative participants also mentioned storage issues related to preserving condoms. Storing condoms alongside medicines sometimes poses challenges for DICs. This specific infrastructural barrier impedes the consistent delivery of services associated with distributing both free condoms and those under SMI.

"We have problems storing the condoms here in Sadar Hospital. We have a separate place for storing medicines, and with that, we have to keep the condoms, too, because we don't have any other place to store them. But if a new supply of medicine comes, we have to relocate the condoms to another place. There is a shortage of places to store these." (DIC Manager of Jashore providing his opinion on the shortage of space for storing condoms in the Sadar Hospital)

5.3.12 Lack of quality of condoms distributed through SMI

Some participants in the qualitative interviews highlighted significant challenges regarding the quality of condoms provided through SMI, particularly brands like Raja and Hero. These condoms often exhibit various quality issues. DICs and POWs opt for these brands due to pricing flexibility and alignment with field demand (both from FSWs and clients).

"I don't like the smell of the condoms what they (POWs) sell to us. The free condoms don't have these problems. But these Raja condoms have a weird smell. Neither I nor my clients like these." (A street based female sex worker from Dhaka providing her reasons of disliking the condoms sold through SMI)

5.3.13 Harassment from Police and other legal authorities

Another significant supply-side barrier frequently mentioned by participants in the qualitative data was harassment from police and other legal authorities during condom distribution activities. Sex work is illegal in Bangladesh, making those in this profession common targets for law enforcement. Providing health and condom-related services to this group is, therefore, a highly challenging task in Bangladesh's current context, as confirmed by the qualitative data. Service providers, particularly peer outreach workers (many of whom are themselves female sex workers), often face harassment and violence. This harassment acts as a crucial demotivating factor for POWs and disrupts the natural flow of service delivery, as highlighted by the study findings.

"We work in the field. It is a very usual scenario that we are talking with an FSW, and suddenly, at that time, a police officer comes there from nowhere. I always keep my identity card to myself. I have to receive threats from them (police officers), often they take us to jail, too! They say that we are giving them (FSWs) advantages and influencing them to keep going on in this line (sex selling profession). The local people also are against us at times. We have to keep doing

our work with all these challenges." (A peer outreach worker from Chattogram sharing her field challenges)

Negative experiences, often in the form of verbal and physical abuse, were found to create obstacles to the natural flow of service delivery to FSWs. These experiences frequently instill fear and hesitation among service providers, resulting in a decline in the quality of service, as indicated by the study findings.

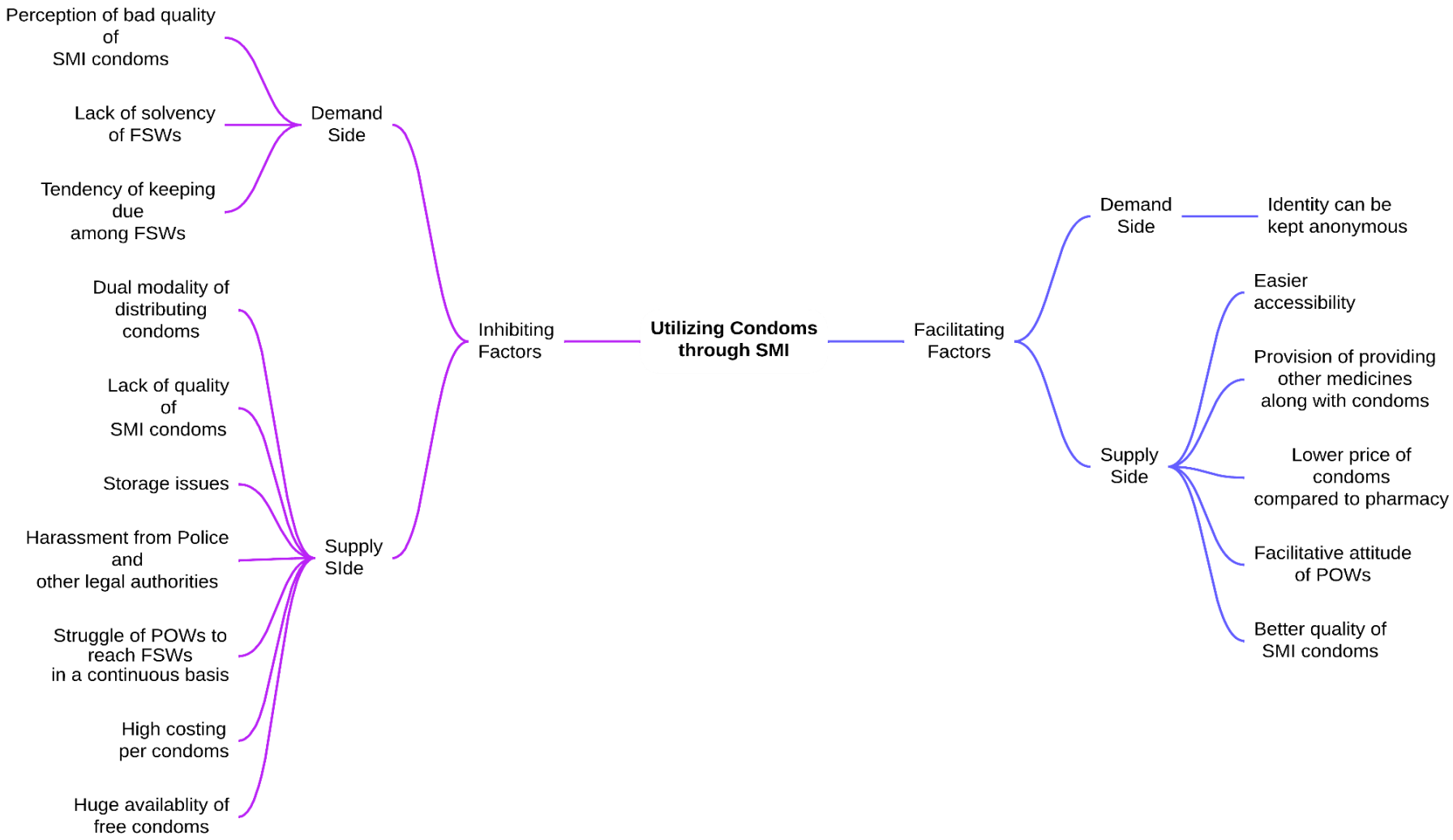
5.3.14 Relocation of workplaces of POWs

The frequent change and relocation of workplaces of POWs were identified as a critical supply-side barrier for condom distribution activities under SMI. Introducing a new POW to the respective fields and engaging them in continuous communication with FSWs proves challenging after a previous POW leaves their role. This turnover is a common occurrence, as found in the qualitative data. Establishing familiarity among FSWs and building rapport with them requires a significant amount of time, which hinders the timely achievement of targets. Therefore, such changes serve as barriers in this context.

"In our area, the peer outreach workers leave their posts frequently. A new peer outreach worker takes at least 3-4 months to get familiar with the nature of the work and the people she will serve. We have to train her, and that takes time too. After all this, she has to gain acceptance among the key populations. That also takes time. In a combined way, all these hamper the overall distribution activities through SMI. People won't buy condoms from an unfamiliar face. Will they?" (Outlet Manager from Tangail sharing his experience on how challenging it is to maintain the flow of service after the frequent changes of POWs)

Figure 5.3.2 summarizes the themes from the qualitative interviews, depicting facilitating and inhibiting factors for utilizing condoms through SMI.

Figure 5.3. 2 Facilitating and inhibiting factors of utilizing condoms through SMI



5.4 Purchasing practice of condoms among the FSWs

The price of condoms provided through SMI play a significant role in FSWs' purchasing decisions (due to financial constraints and other priorities in their challenging lives). In this subsection, we analyze the purchasing patterns of condoms among FSWs. Table 5.4.1 illustrates the condom purchasing behaviors among FSWs. Most FSWs (55.30%) purchased Raja condoms from POWs through SMI, while 39.40% did not make any purchases. Additionally, 56.4% of FSWs spent 3 Tk to buy condoms from POWs through SMI. Similarly, 76.6% of participants believed that the cost of condoms from peer outreach workers was cheaper than those from the private sector.

Table 5.4. 1 Different brands of condoms received through SMI by the FSWs (n=1069)

Variables	Frequency	Percent
Usual brand of condom purchased from POW (SMI)		
Raja	591	55.30
Hero	13	1.20
Sensation	1	0.10
U and me	2	0.20
Romantex	1	0.10
Durex	2	0.20
Nirapad	1	0.10
Don't buy	421	39.40
Others	37	3.50
Price of condom from SMI (n=642)		
Less than 3 taka	239	37.2
3 taka	362	56.4
More than 3 taka	41	6.4
SMI condoms are cheaper than private-sector		
No	13	1.2
Yes	820	76.7
Don't know	236	22.1

5.4.1 Willingness to pay for a condom

We have already observed that the price of condoms was mentioned as a barrier to implementing SMI in both the quantitative and qualitative findings. We further inquired about the FSWs to ascertain their opinions on the optimal price of a condom. Figure 5.4.1 displays the percentage distribution of willingness to pay (BDT) for a condom among FSWs. The majority of FSWs were willing to pay up to 1 taka (39%), 1-2 taka (28.1%), 2-3 taka (10.9%), and the lowest percentage preferred to pay more than 3 taka (9.7%). Additionally, 12.3% of the FSWs were unwilling to spend any money on condoms. It is noteworthy that the average amount they were willing to pay for a condom was 2.02 taka with SD of 2.94 taka (median= 1 taka).

Figure 5.4. 1 Willingness to pay for a condom among the FSWs

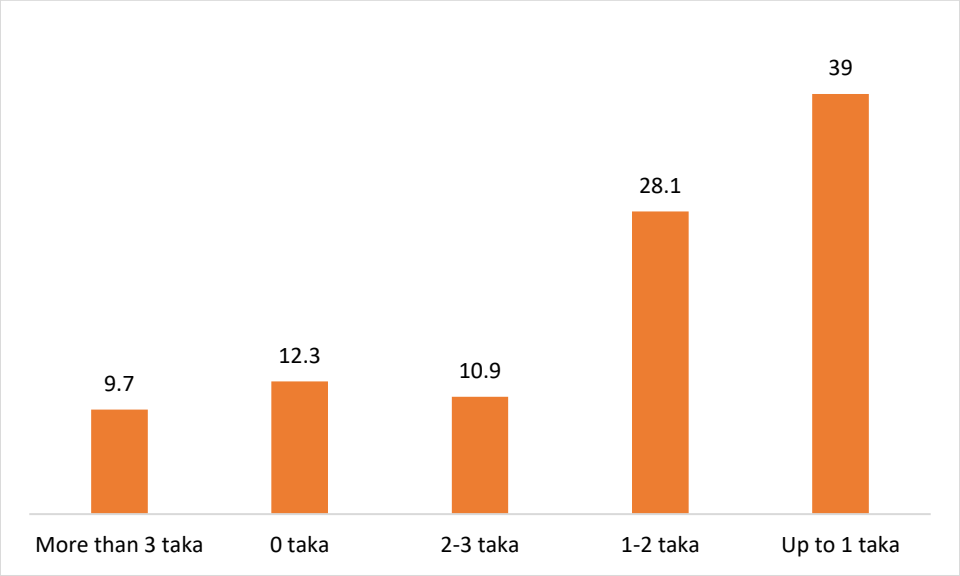
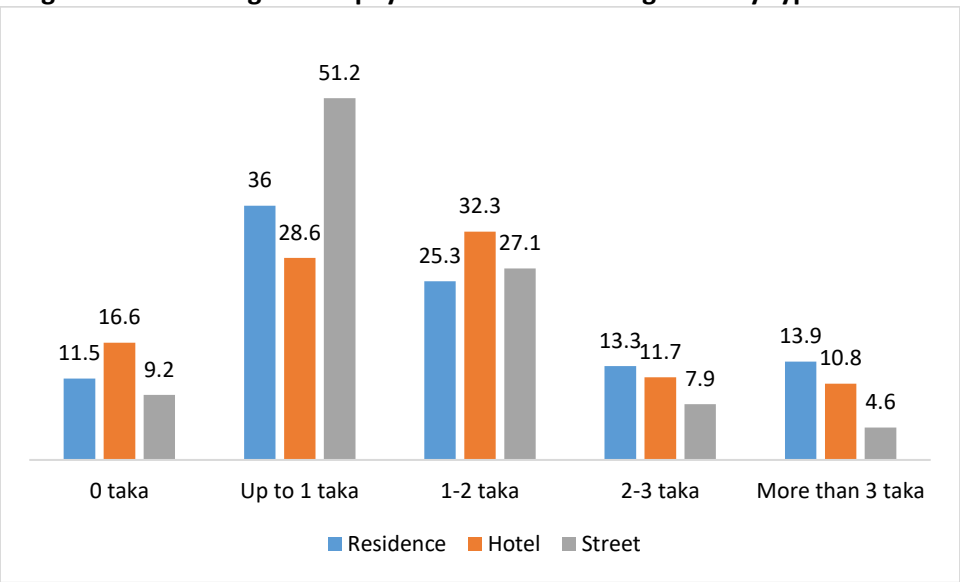


Figure 5.4.2 illustrates the willingness to pay for a condom through SMI by types of FSWs. The majority of residence and street-based FSWs want to pay up to 1 taka for a condom through SMI (36% and 51.2%, respectively), while the majority of hotel-based FSWs (32.3%) prefer to pay more than 1 taka but up to 2 taka.

Figure 5.4. 2 Willingness to pay for a condom through SMI by types of FSWs



Chapter Six: Best Practices and Lessons Learned

6.0 Introduction

In previous chapters, we explored the facilitating and inhibiting factors affecting the implementation of SMI. This chapter compiles key lessons learned from SMI to date. The findings in this section primarily stem from qualitative interviews conducted with FSWs, POWs, and various officials responsible for condom distribution and policy-making. Quantitative data findings are also included where applicable.

6.1 Best practices and lessons learned

6.1.1 The current program increased the awareness level of the beneficiaries and increased their condom utilization

The qualitative data revealed that under the current program, integrated efforts by DIC officials, including peer outreach workers, significantly increased awareness about the necessity and use of condoms, which has led to higher condom utilization among various categories of female sex workers and their clients. The qualitative data indicated that the outreach to FSWs at their locations and communication with them at DICs facilitated this change efficiently.

> *"FSWs are being able to come to the DICs. They can communicate with me; they can also communicate with the medical assistant and the supervisor. We provide them with different desired services, counseling, and awareness-building conversations. This is not surely possible for them in government hospitals. They are not comfortable going there. They can't even talk about their problems in a free mind there. But here, we are all very familiar with them and no one is judging her. She is getting condoms; she is gaining knowledge. Ultimately, she is being motivated to use condoms correctly every time with their clients. That's a significant impact. (A peer outreach worker of Chattogram sharing how she thinks that DIC officials and POWs are contributing to the increased knowledge and increased utilization of condoms among female sex workers)*

The overall supportive environment of the DIC, coupled with efficient officials under this program, facilitated increased knowledge and utilization of condoms among FSWs, according to the study findings. Continuous communication with FSWs played a crucial role in achieving positive outcomes. Weekly visits by POWs to FSWs, ensuring the distribution of condoms and counseling to a specific number, contributed to comprehensive program coverage. Outreach efforts also extended to clients, enhancing the effectiveness of awareness activities through POW counseling. Improved communication between clients and FSWs directly resulted from these initiatives, as revealed in the qualitative data.

> *"The good side of this activity was the frequent communication we established with FSWs. We have talked with them regarding condoms once, twice, thrice. Eventually, they started following what we said. They are being able to connect what happens in the absence and also in the presence of the use of condoms. They also share these with their clients. Communication is getting stronger. The program initiatives worked well by increasing their knowledge and awareness and ultimately increasing their utilization." (One DIC manager of Chattogram sharing how the communication strategies efficiently addressed the awareness and utilization issues associated with condoms in this program)*

Such activities, in this way, provided a platform for better utilization patterns, increased informed decisions, equal communication, and motivation for sustaining the behavioral change (regarding condom use) among the beneficiaries, according to the findings.

6.1.2 The reduction of price and associated awareness could increase the utilization of SMI

The condom distribution activities through SMI encountered various challenges, as identified in the study. Many of these challenges centered around financial concerns related to the pricing of condoms distributed under SMI. These findings underscored the importance of reducing condom prices to enhance utilization among female sex workers of all categories. Most participants in the qualitative data, including FSWs and clients, suggested significant adjustments to condom pricing. Lowering the cost of condoms could improve accessibility and increase their utilization, as indicated by the findings.

> *"Increasing the awareness and motivation is a must for increasing the use of condoms through SMI. But on top of that, it should be remembered that the pricing is a big factor here. They (FSWs) won't use it despite having increased awareness if the pricing does not favor them. The price has to be dropped; if this could be ensured earlier, the results would be better in terms of the acceptability of the SMI." (The field supervisor of Mirpur DIC regarding the connection of reduced price and acceptability of SMI in the current context)*

The inability to pay for the condoms, even at a discounted rate under SMI, came out as one of the crucial barriers to this activity. The lowered pricing in this context could change the scenario according to the findings of the study.

6.1.3 Ensuring the safety and confidentiality of the sex workers can motivate their SMI practices

Acknowledging the status of FSWs and ensuring their safety and confidentiality can integrate them into overall program activities. Legal harassment surrounding healthcare-related services for female sex workers was found to hinder the natural flow of services in the qualitative data. The lack of acknowledgment and awareness of their health needs complicated the service scenario, disrupting demand generation and service flow. According to the qualitative data, ensuring the safety and confidentiality of FSWs could lead to more effective outcomes.

> *"I cannot remove her (FSW) from this profession. It is her only opportunity to earn at this moment. So, re-locating her would not be a feasible option for any party. What we can do is make sure that she feels safe when she is asking for health services. I can provide her with safety and confidentiality while giving her health care services, including the distribution of condoms. We have to realize that we cannot stop the profession of sex selling. We must continue acknowledging that it is another 'profession' in this current period." (One peer outreach worker from Jashore explaining how ensuring the safety of FSWs while having health care services could integrate them more in the overall process)*

According to the findings, the generation and realization of health care needs by FSWs and acting upon the demands to avail of the services greatly depend on the safety provided in the communication strategies. Eventually, this will result in better purchasing practices through SMI and condom utilization.

6.1.4 Integration of such a program with government stakeholders can increase the demand and supply-side participation

One of the most crucial lessons learned from implementing SMI was realizing the necessity of integrating such programs with government bodies. According to participants of the qualitative data, this integration allows for more efficient coordination of both the demand and supply sides. Our experience in Jashore exemplified this through improved healthcare services provided by better-trained doctors who address beneficiaries' various health issues. The integration of government involvement was found to enhance the quality of care and increase service demand among key populations and other beneficiaries, as highlighted in the qualitative data.

> *"Previously, when the services were provided in DICs, they couldn't get care from MBBS doctors. When the government hospital got engaged with the process taking responsibilities from DIC, they had far better treatment. They also get a larger range of free medicines at the hospital. They can also get referrals, which is a great advantage for them. A large number of service seekers are coming here nowadays." (Jashore DIC manager on how the integration of FSW-focused services with government hospital increased both service quality and demand generation)*

The participants of the qualitative data also reported the necessity of coordination and collaboration among the government and NGO bodies. According to the findings, the lack of involvement of government stakeholders in this regard causes a lack of reciprocal understanding and increases communication gaps. Government stakeholders' participation and monitoring of the activities done by the program's sub-recipient bodies could benefit the efficient implementation of the program's activities.

> *"The involvement of the government bodies in our activities is not very satisfactory. I call them in different meetings. But they didn't ever pay any field visit to monitor the activities running." (The outlet manager of Tangail sharing his experience on the lack of involvement of government stakeholders in the program activities)*

Through a buy-in process, government bodies can maximize the impact of such programs and facilitate the successful implementation of the program activities. This lesson learned through the existing best practices in some of the districts can show a pathway for future similar interventions connected to the key populations of the country.

6.1.5 Associated health services (like screening and general treatment) motivate FSWs to visit DICs more

The qualitative data also found that the distribution of condoms through SMI ran smoothly in places where FSWs had the opportunity of receiving other related health care services. Including health care facilities like screening and other general and primary treatments motivated FSWs to visit DIC more frequently and to continuously communicate with the peer outreach workers in particular spots and zones. The purchasing of condoms through SMI was also facilitated by frequent visits and continuous communication, as revealed in the qualitative data. One lesson learned in this regard was that the additional services provided to FSWs while purchasing condoms through SMI increased their motivation and participatory attitude in current program activities.

> *"They are accepting the SMI gradually. But they come here not only for SMI. They are also attracted by the additional healthcare facilities we provide them and the distribution of condoms through SMI. I think the screening facilities should be*

increased further, and that will motivate them to come to the facility more often or to keep in contact with the peer outreach workers continuously." (The DIC manager of Jashore providing opinion on how the additional health services contributed to the greater cooperation of FSWs)

The program, in a very effective way, created a range of services for the FSWs, which ultimately resulted in their greater motivation towards availing of condom purchasing opportunities through SMI, according to the findings of the study.

6.1.6 DICs and outlets have provided FSWs with free, safe, and secure space for their interaction

Service hubs like drop-in centers (DIC) and outlets have provided FSWs with a free, safe, and secure platform for receiving healthcare-related services and sharing their interpersonal communication and experience. This greatly facilitated their tendency to visit DICs and outlets and receive desired healthcare services along with condoms, both free and through SMI. According to the qualitative data, a place for such interaction and service opportunities increases the potential for success of these service activities. The familiarity with the DIC officials, along with the peer outreach workers and comfortable environment, was found to influence the purchase practice of condoms among female sex worker*s.*

"There are times when FSWs can't express what they need regarding health care and counseling in front of private clinic authorities or also in government hospitals. But here in DICs, we are counseling them. A health service provider is listening to all health problems with patience. They are comfortable in this environment. They trust us. And it helps them to be more interactive and responsive." (The DIC Manager from Chattogram sharing insights regarding the feeling of FSWs when they come to DICs to seek health care and counseling)

6.1.7 Such programs demand a longer period to reflect the efficiency

Another significant lesson learned from the implementation of SMI was the requirement for a more extended period for program implementation and reflection of outcome. The study found from the participants' opinion that modifying the purchasing practice demands both the modification of service structure and micro-level behavior change of the beneficiaries and key populations. Changing behavior or practice regarding the consumption or non-consumption and purchasing or non-purchasing of health service-related products demands changes in demand and service side dynamics. A shorter program period can initiate the process in terms of bringing the desired changes in the purchasing practices, but for a sustained change to be observed, a significant amount of time should be provided to such programs, according to the qualitative data findings.

"…. obviously, it (purchasing condoms through SMI rather than receiving free condoms) will increase. But it will take a significant amount of time. The utilization of condoms was poor earlier. Slowly, it improved. Earlier, the key populations were not interested in receiving services from the medical assistants. But now they are receiving it every now and often. They (FSWs) now even call us and ask for condoms. It was unimaginable in the past. So, the purchasing practice will also be developed gradually. But we need to give time to the process. Even now, when they are out of free condoms, they are taking the SMI condoms. They know now that there is no way without purchasing when free condoms are out of market." (One

peer outreach worker of Narayanganj sharing her opinion on the time issues of such programs)

The longer implementation period can result in more sustained purchasing practices, according to the qualitative findings, and it turned out to be a crucial lesson learned from the implementation of SMI under these program activities.

6.1.8 Complication arises when both free and SMI are running together for the same FSW and provided by the same POWs

Finally, the most important lesson learned from the implementation of SMI was the challenges posed by the dual mode of condom distribution among key populations (female sex workers of three categories). However, the program aimed to distribute both free condoms and condoms through SMI to the same FSWs in a predetermined ratio. However, in practice, maintaining these ratios proved difficult. A significant proportion, particularly street-based sex workers, received a majority of free condoms due to their financial circumstances and inability to purchase condoms through SMI. Moreover, beneficiaries often showed reluctance to purchase condoms through SMI when free condoms were readily available. These complexities resulted in management challenges regarding distributing free and non-free condoms.

"A conflict is created whenever my girls are trying to 'sell' condoms through SMI. The FSWs are asking them, why are you trying to sell when you are giving free condoms along with that? We try to counsel both POWs and FSWs about this when we are taking sessions with them. I am not sure whether FSWs have yet realized the importance of SMI. Keeping these two distribution processes separate would be better for the program." (The DIC manager of Narayanganj shares the opinion on creating conflicting situations by dual mode of condom distribution activities).

The presence of free condom distribution activities was found to discourage FSWs, especially the street-based workers whose financial condition does not allow them to purchase from POWs, be it at a reduced rate. According to the qualitative data findings, these workers cannot be successfully motivated to form the purchase practice without free distribution.

"I won't buy till I get the free ones. My earnings are limited. When these (free condoms) won't be available anymore, I might think about purchasing condoms from POWs or even from pharmacies. Otherwise, why should I buy?" (One street-based sex worker from Khulna sharing her position regarding the purchasing practice in the presence of free condom distribution activities).

Such a dual mode of the program raised concerns among the beneficiaries mentioned above. In the long run, the continuation of dual distribution can lower the potential of the success of SMI implementation among female sex workers, according to the findings of the qualitative data.

Chapter Seven: Discussion, Conclusion, Limitations, and Specific Policy Recommendations

7.0 Introduction

This chapter discusses the findings presented in chapters three to seven. Based on respondents' prevalence of using condoms and exposure to SMI, their socioeconomic and demographic characteristics are presented here based on both quantitative and qualitative findings.

7.1 Discussion

This study applied a mixed-methods approach using quantitative and qualitative data to address the research questions. The quantitative data were collected from 1069 FSWs, and 83 in-depth interviews were conducted. A total of 14 female data enumerators collected data from 9 districts between January 29 and February 27 for quantitative analysis. The quantitative data were collected from 9 DICs from 9 districts among three categories of FSWs based on their meeting point with clients- residence, hotel, and street. The qualitative data were collected from officials involved in this program, such as the DIC/Outlet manager, field supervisors of the DIC/Outlet, POW, *Ghorwali*, site workers, clients, and FSWs from all three categories.

Prevalence of condom use through SMI

The overall prevalence of using condoms in the last month while having transactional sex was found to be 97.7%; among the three types of FSWs, the highest rate was observed for the hotel-based FSWs (98.8%). This high prevalence is observed due to different initiatives taken by the respective DIC/Outlets to motivate the FSWs to use condoms. However, only 63.5% of the FSWs reported ever bought condoms from the POWs, which is not satisfactory. Considering the data from the survey preceding one month, the majority of the FSWs (73.7%) who bought condoms were street-based, and the rate was lowest among hotel-based FSWs (53.2%). We saw a similar pattern for the prevalence in the last month and last week; hotel-based FSWs had the lowest prevalence of buying condoms through SMI. These findings can be explained by the distribution structure of condoms at DICs, where street-based FSWs received condoms directly from POWs, whereas residence-based and hotel-based FSWs received them through site workers and ghorwalis, who collect condoms from POWs. In terms of educational level, FSWs with primary education had the highest frequency of buying condoms from POWs among residence-based and street-based FSWs. This occurred because 40.1% of the study respondents had primary education. Weekly earnings were a significant determinant of buying condoms from POWs. FSWs with a weekly income of 2001-4000 BDT had the highest prevalence of buying through SMI among residence-based and street-based FSWs. Most of these respondents were residence-based and street-based FSWs. The purchase rate of condoms was higher among those who started transactional sex between 15-19 years for all three types of FSWs. Such findings can be explained by the characteristics of the respondents; 33% of respondents were aged between 15 and 19 years.

SMI accessibility among FSWs

The FSWs have four primary sources of getting condoms- free from public sectors (hospitals/maternity clinics), free from NGOs, buying from POWs through SMI, and from private sectors. They receive the condoms from the DIC/Outlets by different means, and sometimes it happens by another person (*Ghorwali* for residence-based FSWs and Site worker for Hotel-based FSWs). Only the street-based FSWs receive condoms directly from the POWs, which occurs outside the DIC/Outlet. Condom buying through SMI one week preceeding the survey was higher among street-based FSWs (31.4%), and similarly, free condom collection from NGOs was also higher among street-based FSWs (21.14%). Financial reasons (lower earnings compared to residence and hotel-based FSWs) and the nature of their work are the main driving factors for these findings, as street-based FSWs are the most

vulnerable among the three types. From the point of preference, free condoms from NGOs were the most preferred source for all three types of FSWs. Condoms through SMI were found to be a relatively less preferred source. Their frequent communication with the POWs can explain this higher utilization among street-based FSWs. Unlike residence and hotel-based FSWs, street-based FSWs received the most attention as they are the most vulnerable among the three FSWs. These findings clearly indicate a discrepancy between the preferred and available sources of condoms among the FSWs. Moreover, the FSWs wanted to pay less than the average price for condoms under SMI. The availability of free condoms, alongside subsidized SMI condoms from the same distributor, creates a gap between the subsidized price and their willingness to pay.

Facilitating or inhibiting factors in implementing SMI among FSWs

The current study found different facilitating and inhibiting factors in implementing SMI among FSWs. Both quantitative and qualitative data indicated the facilitating factors that encouraged FSWs to buy condoms through SMI even in the presence of the dual modality of condom distribution (both free and SMI) and also highlighted the inhibiting factors that were restraining female sex workers from buying condoms through SMI.

One of the biggest challenges to making the SMI successful is the simultaneous availability of free condoms on a large scale alongside the SMI. Free sources of condoms (from the public sector) were economically convenient for most of the FSWs. The dual modality of the program reduced the efficiency level of the interventions and the potentiality of the successful outcome. Except for dual-modality, the perception of high costs and prices not being fixed also prevented FSWs from acquiring the purchasing practice through SMI.

The current study highlighted a bunch of issues that were playing a role in FSWs' preference for free condoms. Intrapersonal or individual-level factors, such as economic inability and high level of demand for free condoms, motivated FSWs to decide to take free condoms from DIC and peer outreach workers. Such a tendency was mostly present among the street-based female sex workers as they were financially weaker than the hotel and residence-based workers. The tendency to keep due was also strongly present among the street-based workers. The due money (where street-based sex workers were unable to pay the whole payment even after receiving a particular number of condoms through SMI) was often kept unpaid. This practice usually hindered the success of SMI activities, especially among street-based sex workers.

Along with the demand-side issues, different supply-side barriers, such as the huge workload of POWs (which created barriers towards establishing continuous communication with FSWs), storage issues, coordination challenges etc., also hindered the process of a fruitful program outcome, according to this study. These supply-side issues often influenced the communication process, motivation of the POWs, and associated service-related issues. This, eventually had a great impact on shaping the condom-purchasing practice of the FSWs.

The study also highlighted the facilitating factors of purchasing condoms through SMI. Buying condoms from NGOs via POW was considered economically convenient for all types of FSWs, with higher rates among street-based and hotel-based FSWs. In contrast, hotel-based FSWs predominantly found condoms obtained through SMI to be economically convenient (75.2%). The main disadvantage mentioned for free condoms from NGOs was not knowing the source. For instance, among hotel-based FSWs, 67.6% reported not knowing the source of free condoms from NGOs. The qualitative findings of the study indicated different supply and demand side issues here to explain the factors that were facilitating condom purchases through SMI. FSWs who preferred buying condoms through SMI highlighted the interventions' strength behind forming this preference. The wider accessibility of SMI condoms through frequent visits and communication of POWs greatly facilitated the purchasing

practice of FSWs. The frequent visits of POWs also ensured the higher availability of SMI condoms whenever the FSWs expressed their needs. In these communication processes, the price of condoms through SMI was an important marker. The comparison of market price and SMI price often encouraged FSWs to choose to buy condoms through SMI. The findings showed that the bargaining process (offering a reduced price for SMI condoms to FSWs) often facilitated FSWs as they were getting the desired brand of condoms at a lower price from POWs. Communication with POWs was also considered beneficial as it was an anonymous mode of contact. The FSWs did not have to buy condoms from open shops or places where the revelation of identity could be a potential threat. The potentiality of keeping the identity safe was also facilitative, and this encouraged them to buy condoms from POWs through SMI. Besides these, the availability of other medicines with condoms, helpful and facilitative behavior from a service provider within and outside of DICs, and better quality of condoms influenced FSWs and their clients to buy condoms through SMI. The coverage and pattern of the program interventions facilitated the purchase through SMI to a great extent.

Best practices and lessons learned when implementing the SMI

The study indicated an increase in both awareness levels regarding condom use and condom utilization throughout the project period. Various beneficiary-centered interventions in this respect provided a platform for improved utilization patterns, enhanced informed decision-making, equal communication, and motivation to sustain behavioral change (concerning condom use) among beneficiaries. Reducing prices could have resulted in increased SMI utilization, removing the accessibility barriers of the key populations. The study also suggested the integration of government bodies through a buy-in process to maximize the impact of such programs in different stages of implementation. The success of DICs as a facilitative platform for the interaction of service providers and beneficiaries also turned out to be a crucial achievement of the project. The most crucial lesson learned in this project was the demand and supply side challenges associated with the dual modality of condom distribution (distributing free condoms and SMI condoms simultaneously to the same group key population), which demands systematic intervention based on the current evidence.

7.2 Limitations

This study had some limitations. The major challenge was the receipt of biased responses from the FSWs. The interviews were taken in DICs in a crowded setting where the confidentiality of the responses were hard to be ensured. These raised concerns regarding the ecological validity of the research. Moreover, the respondents, because of their professional habits and other vulnerabilities, showed the tendency to provide fabricated responses while answering the questions. It was often difficult for the data enumerators to identify these fabricated responses from the respondents. The extended interview period for the quantitative data, maintaining the required number of respondents from each category regularly proved challenging for the corresponding DIC authorities. Similarly, reaching clients posed difficulties for qualitative data. In both cases, the data enumerators and the core research team visited various locations to address these issues, ultimately achieving the required sample size.

7.3 Recommendations

Some specific recommendations based on the current study are given below to increase the program's success in the future.

1. The dual modality of distributing free condoms and selling condoms through SMI should be discontinued, and only one single approach should be implemented. From the inhibiting factors, we have seen that the widespread availability of free condoms discouraged FSWs from purchasing condoms through SMI. Such decisions can be made by implementing the program authorities, such as SCB, DAM, NASP, or DIC officials and staff.

2. The price of condoms sold through SMI should be reduced to 0.50 BDT or 1 BDT per condom to improve affordability for FSWs. Although the retail price of condoms is much higher, from the willingness to pay for condoms, we have seen that the majority of FSWs were willing to pay up to 1 taka. Removing this economic burden may facilitate the purchase of condoms through SMI.

3. The study's findings indicated that the lack of active POWs in many of the DICs often caused communication challenges. Reaching the expected number of key population and beneficiaries and expanding the coverage requires sufficient employed POWs in every DIC. This is why implementing authorities should consider ensuring 'no vacancy' in the posts of peer outreach workers and field supervisors in the active DICs in divisional headquarters.

4. The disaggregated quantitative findings and qualitative findings showed that SMI utilization was comparatively lower among residence and hotel-based sex workers. The communication point in these cases also included third parties like clients of FSWs, pimps, *ghorwali*, and site workers. The current study found a major communication gap with these third-party actors as the connectivity of FSWs with these actors was not as strong as that of FSWs. This is why, based on the study findings, it is strongly recommended that counseling meetings or workshops should also be conducted on a periodical basis with third parties like clients of FSWs, pimps, *ghorwali*, and site workers with a greater emphasis on ensuring SMI.

7.4 Conclusion

The study underscores the critical role of SMI in ensuring widespread condom use among FSWs in Bangladesh. While economic convenience and anonymity offered by SMI condoms are highly valued by FSWs, yet competition from free distribution sources in a parallel mode pose ongoing challenges to sustainability of SMI activities while distributing condoms. By enhancing awareness and reducing economic barriers, these initiatives can bolster consistent condom use and contribute to broader HIV prevention efforts. To optimize SMI effectiveness, strategic adjustments such as price reductions and single mode distribution modalities should be considered, alongside ongoing support for DICs and outlets as safe spaces offering comprehensive health services. In conclusion, while the study highlights substantial progress in promoting condom use among FSWs in Bangladesh, sustained efforts are needed to address persistent barriers and optimize the impact of SMI programs. Through targeted strategies and stakeholder collaboration, SMI can continue to play a pivotal role in enhancing sexual health outcomes and reducing HIV transmission among key populations.

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Annex (a): The Survey Questionnaire for Female Sex Workers

Face-to-face Interview Questionnaire for Collecting Data on Social Marketing Initiatives (SMI) on the Purchase and Utilization of Condoms among Female Sex Workers (FSWs) in Bangladesh

Greetings!
I hope you are well. I am from the Department of Population Sciences, University of Dhaka. We are researching "Social Marketing Initiatives (SMI) on the Purchase and Utilization of Condoms among Female Sex Workers (FSWs) in Bangladesh." I will read the detailed information and invite you to participate in this research. Please feel free to ask me anything you find hard to understand.

The AIDS/STD Programme (ASP), under the Directorate General of Health Services under the Ministry of Health and Family Welfare, has initiated different activities under the 2021-2023 grant of The Global Fund to ensure HIV-related services to female sex workers and other related populations. In this regard, Save the Children has been working on female sex workers and providing condoms through peer outreach workers. We are here to assess whether this intervention has benefited you and what the related challenges are to consider for the betterment of female sex workers.

In this interview, we will ask some basic questions about your socio-economic condition, HIV/AIDS and STIs-related knowledge, risk perception, condom use and utilization. Participation in this research is completely voluntary. You may stop participating in the interview at any time you wish. If you do not wish to answer any of the questions during the interview, you may say so, and I will move on to the next question. There is no risk of you for participating in this research. We will not ask your name or any questions through which you can be identified. Confidentiality of your answer will be strictly maintained. It will be used only for research purposes; no one outside the research team will have access to the information.

Participating in this research will help us to understand facilitating factors, challenges, barriers, and problems to use condoms through the SMI taken by the government of Bangladesh, which will ultimately help in developing a program for the FSW's benefit.

If you wish to ask questions later, you may contact the principal investigator of the research project, Professor Dr. Mohammad Bellal Hossain, Department of Population Sciences, University of Dhaka, Dhaka-1000, Email: bellal@du.ac.bd, Phone: 01766517002.

Do you understand the information provided and wish to participate in this study?
[1] Yes: Continue with the interview
[2] No: Terminate the interview

Exclusion criteria:
Were you engaged in transactional sex in the last month?

1) Yes
2) No: Terminate the interview

Date: _____
District: _____, DIC: _____
Outlet: _____

Categorization of sex workers based on their meeting point with clients:

1) Residence
2) Hotel
3) Street

Section 1: Basic Socio-demo-economic

Sl No.	Questions	Answer	Skip
101	How old are you now?	_____Years	
102	What is your religion?	1) Islam 2) Hinduism 3) Christianism 4) Buddhism 5) Others: Please specify	
103	What is the highest level of formal education you completed?	1) No education 2) Primary incomplete 3) Primary complete 4) Secondary incomplete 5) Secondary complete 6) Higher secondary incomplete 7) Higher secondary or more	
104	Have you changed your residence in the past year?	1) Yes 2) No	106
105	How long have you been living at your current residence?	_____ months	
106	How much do you earn weekly?	_____ BD Taka	
107	Do you have savings for your future?	1) Yes 2) No	
108	Do you currently have any debt/loan?	1) Yes 2) No	

Section 2: Marital Status and Partnership

Sl No.	Questions	Answer	Skip
201	What is your marital status?	1) Married 2) Unmarried 3) Divorced 4) Widowed 5) Deserted 6) Separated	205
202	Do you have any children?	1) Yes 2) No	204
203	Number of children	_____	
204	Are you currently living with a husband?	1) Yes 2) No	
205	Do you have a 'Babu'?	1) Yes 2) No	

Section 3: Current and past employment/profession history

Sl No.	Questions	Answer	Skip
301	How old were you when someone paid to have sex with you for the first time?	_____ Years	

302	How long have you been selling sex?	_____ Years	
303	Did you work elsewhere before selling sex?	1) Yes 2) No	
304	What led you to choose sex work? (Multiple choice)	1) To earn money/ To support the family 2) Family conflicts 3) Parents pressure 4) Spouse/partner pressure 5) Cheating/ extramarital affair of partner 6) Raped 7) Trafficked/Kidnapped 8) To pay for loans or other debts 9) Personal interest/curiosity 10) Cheating by other people/friend 11) Influence of others 12) Others: please specify	
305	Are you currently working elsewhere along with selling sex?	1) Yes 2) No	

Section 4: Frequency and Practice of Transactional Sexual Interaction

Sl No.	Questions	Answer	Skip
401	How many days per week are you involved in sex work?	_____days	
402	On average, how many clients do you get in one day?	_____ person	
403	Where do you usually have sex with your clients?	1) Brothel 2) At your own place 3) Hotel 4) Park 5) Footpath 6) Client's place 7) Street/road 8) Pimp's/Madam's place 9) Others: please specify	
404	In the last month, did you use condoms while having transactional sex?	1) Yes 2) No	408
405	In the last month, how often did you use condoms while having transactional sex?	1) Every time 2) Often 3) sometimes 4) Rarely	

406	In the last month, who usually took the decision to use condoms while having transactional sex?	1) Myself 2) Client 3) Pimp 4) Mashi 5) Site worker 6) Others: please specify	
407	In the last month, who usually bought condoms while having transactional sex?	1) Myself 2) Clients 3) Pimp 4) Manager 5) Mashi/Madam 6) Site worker 7) Condom was Free/did not buy 8) Others: please specify	
408	Why didn't you use condoms in transactional sex in the last month? (Multiple choice)	1) I don't like/enjoy using condoms 2) My clients don't like using condoms 3) My pimp forced not to use condoms 4) My 'Mashi/madam' forced not to use condoms 5) My peer influenced not to use condoms 6) I don't know how to use condoms 7) Condoms have 'side effects' for me, such as rashes and itching 8) Quality condoms were not available near me 9) Condom was not always available to me 10) Others: please specify	

Section 5: Frequency and Practice of Nonpaying sexual act

Sl No.	Questions	Answer	Skip
501	In the last month, have you had sex (vaginal/anal/oral) with a man (including the husband) where no payment was involved?	1) Yes 2) No	601
502	How many such nonpaying partners have you had in the last month?	_____ person	
503	Did you use condoms while having sex with a nonpaying partner in the last month?	1) Yes 2) No	505

504	How often did you use condoms with nonpaying partners?	1) Every time 2) Often 3) sometimes 4) Rarely	
505	Why didn't you use condoms with your nonpaying partners? (Multiple choice)	1) I don't like to use condoms with my non-paying partner 2) Condoms reduce sexual pleasure 3) My nonpaying partner does not like using condoms 4) Using condoms with a nonpaying partner shows a lack of intimacy & love 5) Using condoms with a nonpaying partner shows distrust 6) Condoms have 'side effects' for me, such as rashes and itching 7) Condoms have a bad smell 8) Others: please specify	

Section 10: Exposure to Intervention and Utilization of Condom through Social Marketing Initiative

Section 10.1: Exposure

Sl No.	Questions	Response option		Skip
1001	From where you have usually collected condoms in the last month?			
		Yes	No	
	Free from the public sector			
	Free from the NGO sector			
	Buying from peer outreach worker (SMI)			
	Buying from the private sector			
	Others: please specify			
1002	Which source of condoms do you prefer most? (**Only One Response**)	1) Free from the public sector 2) Free from the NGO sector 3) Buying from peer outreach worker (SMI) 4) Buying from the private sector 5) Others: please specify		
1003	What are the advantages of getting condoms from the following sectors?			
1003.1	Free from the public sector (Multiple choice)	1. Economically convenient 2. Easily accessible 3. Condom quality is good 4. Time convenient 5. Identity can be kept anonymous 6. Availability is larger		

1003.2	Free from the NGO sector (Multiple choice)	1. Economically convenient 2. Easily accessible 3. Condom quality is good 4. Time convenient 5. Identity can be kept anonymous 6. Availability is larger
1003.3	Buying condoms from peer outreach workers (Multiple choice)	1. Economically convenient 2. Easily accessible 3. Condom quality is good 4. Time convenient 5. Identity can be kept anonymous 6. Availability is larger
1003.4	Buying condoms from the private sector (Multiple choice)	1. Economically convenient 2. Easily accessible 3. Condom quality is good 4. Time convenient 5. Identity can be kept anonymous 6. Availability is larger
1004	What are the disadvantages of getting condoms from the following sectors?	
1004.1	Free from the public sector (Multiple choice)	1. Not economically convenient 2. Not always available 3. Condom quality is not good 4. Potentiality of disclosing identity 5. Fewer variations in condom 6. Clients do not like these types of condoms 7. Do not know about this source 8. Distance to this source is greater 9. Others: please specify
1004.2	Free from the NGO sector (Multiple choice)	1. Not economically convenient 2. Not always available 3. Condom quality is not good 4. Potentiality of disclosing identity 5. Fewer variations in condom 6. Clients do not like this type of condom 7. Do not know about this source 8. Distance to this source is greater 9. Others: please specify
1004.3	Buying condoms from peer outreach workers (Multiple choice)	1. Not economically convenient 2. Not always available 3. Condom quality is not good 4. Potentiality of disclosing identity 5. Fewer variations in condom 6. Clients do not like this type of condom 7. Do not know about this source 8. Distance to this source is greater 9. Others: please specify
1004.4	Buying condoms from the private sector (Multiple choice)	1. Not economically convenient 2. Not always available 3. Condom quality is not good 4. Potentiality of disclosing identity 5. Fewer variations in condom

		6. Clients do not like this type of condom 7. Do not know about this source 8. Distance to this source is greater 9. Others: please specify	
1005	Which brand of condom do you usually buy? **(Only One Response)**	**From the private sector**	**From peer outreach worker through SMI**
		1) Raja 2) Hero 3) Panther 4) Sensation 5) U and me 6) Moods 7) Gamy 8) Wonder life 9) Romantex 10) Durex 11) Love guard 12) Coral 13) Jippy 14) Nirapad 15) Green love 16) Carex 17) Deluxe nirodh 18) Xtreme 19) Super guard 20) Manforce 21) Amore 22) Ultimex 23) Sensinity 24) Dewmex 25) Donless 26) Did not buy 27) Others: please specify	1) Raja 2) Hero 3) Panther 4) Sensation 5) U and me 6) Moods 7) Gamy 8) Wonder life 9) Romantex 10) Durex 11) Love guard 12) Coral 13) Jippy 14) Nirapad 15) Green love 16) Carex 17) Deluxe nirodh 18) Xtreme 19) Super guard 20) Manforce 21) Amore 22) Ultimex 23) Sensinity 24) Dewmex 25) Donless 26) Did not buy 27) Others: please specify
1006	How much did you pay to buy the condom?	_____ taka	_____ taka
1007	Do you think that the cost of condoms from peer outreach workers is cheaper than that of the private sector?	1) Yes 2) No 3) Do not know	

Section 10.2: Utilization of Condom through Social Marketing Initiative

Sl No.	Questions	Answer	Skip
1008	Have you ever bought condoms from a peer outreach worker?	1) Yes 2) No ▼	1012
1009	Have you bought condoms from a peer outreach worker in the last month?	1) Yes 2) No ◄	1012

1010	How many condoms have you collected in the last week? (Write the no of condoms collected from each sources)	1. Collected freely from the public sector:_____ 2. Collected freely from the NGO sector:_____ 3. Bought from POW:_____ 4. Bought from the Private Sector:_____ 5. Did not collect in the previous week 6. Others:_____				
1011	When was the last time you bought condoms from a peer outreach worker?	_____ days ago				
	Please ask Question 1012 to ***ONLY*** those FSWs who have answered "No" to Question 1008 or 1008					
1012	Why do not you buy condom from peer outreach workers? (Multiple choice)	1. Not economically convenient for me 2. I have access to free condoms from multiple other sources 3. Condom quality is not good 4. These condoms have bad smell 5. These condoms often break 6. Buying from outreach worker is a matter of shame as it can expose my identity 7. Attitude/behavior issue of the peer outreach worker 8. Peer outreach worker is not available when needed 9. Others: please specify				
1013	What can we do more to increase your purchasing condoms from peer outreach worker?	1) Lower the price 2) Active involvement or visit of outreach worker 3) Improving quality of condom 4) Improving behavior of the POWs 5) Increase no of condoms provided by the peer outreach workers 6) Increase the no of peer outreach worker 7) Others: please specify				
1014	**Please read the statements and provide your opinion regarding accessibility to condoms.**	**Strongly agree**	**Agree**	**No opinion**	**Disagree**	**Strongly disagree**
1014.1	I know a nearby place where I can get condoms					
1014.2	I do not need to go far to get condoms as peer outreach workers provide condoms in my convenience					
1014.3	I can easily get condoms					
1014.4	Many different brands of condoms are available					

	through peer outreach workers					
1014.5	Peer outreach workers regularly visit so condoms are available					
1014.6	Condoms provided by the peer outreach workers are of good quality according to the price					
1014.7	The peer outreach activities are beneficial for us as we get many services from this					
1014.8	Peer outreach service saves both my money and time					
1014.9	It is embarrassing to buy condoms from peer outreach workers					
1014.10	I feel uncomfortable to buy condoms from peer outreach workers					

Annex (b): The In-depth Interview Guideline for Female Sex Workers

Background Questions

1. What are the main places you meet with your customers/clients?

Facilitators and Barriers to SMI

1. Do you use condoms while having sex (with clients)?
    a. If yes, why do you use it?
    b. If no, why dont you use it?
2. if you use condoms regularly, what are the sources you are getting condoms from?
    a. please mention the sources/places
    b. why do you prefer these sources/places?
3. Do you get free condoms from these sources?
    a. if yes, do you prefer getting free condoms?
        i. if yes, why?
    b. if you don't prefer free condoms, why?
4. Do you you use condoms which are purchased from other sources?
    a. if yes, do you buy it yourself?
        i. from where do you buy it?
        ii. reason of preference for buying it from these sources
    b. if you don't buy it yourself, who buys this?
        i. clients? Why?
        ii. Hotel managers/Site workers? Why?
        iii. Mashi? Why?
        iv. do you know from where do they buy that? If yes, where?
5. Do peer outreach workers reach you to sell condoms (through SMI)?
    a. if yes, how often do you have contacts with them?
    b. if no, why don't you have contacts?
        i. issues connected with POW? (what sorts of issues)
        ii. you don't like their access to you? (why?)
        iii. others?
6. Do you prefer buying condoms from POW?
    a. if yes, why do you prefer?
        i. personal reasons
        ii. accessibility related issues
        iii. quality related issues
        iv. other reasons
    b. if no, why do not you prefer?
        1. personal reasons
        2. financial reasons
        3. accessibility issues
        4. quality related issues
        5. other reasons
7. If you get free condoms/buy condoms from POW, would you like to sustain it in the future too?
    a. would like to sustain getting free condoms in the future too? Why?
    b. would like to sustain buying condoms from POW? Why?

8. What can be done to encourage FSWs to buy condoms from POW through SMI?
    a. What measures can be adopted?
    b. Who can be involved?
    c. What should be the process

Annex (c): The In-depth Interview Guideline for Program Officer and Staff

Background Questions

1. How long have you been involved with this project?
2. What is your current level of involvement in this project?

Facilitators and Barriers to SMI

3. Do you think that the condom distribution activities achieved the desired level of success?
    a. If you think so, why do you think so?
        i. Utilization of condom increased? How? Tell me about this
        ii. Buying of condoms through SMI increased? How? Tell me about this
    b. If you don't think so, why don't you think so?
        i. Utilization of condoms didn't increase? Why? Tell me about this
        ii. Buying of condoms through SMI didn't increase? Why? Tell me about this.
4. What are the barriers of implementing SMI among female sex workers?
    a. Demand side barriers
        i. FSW's personal issues
        ii. FSW's economic issues
        iii. FSW's clients related issues
        iv. Other issues
    b. Supply side barriers
        i. Supply related issues
        ii. Budget related issues
        iii. Human resource related issues
        iv. Infrastructure related issues
5. What are the lessons learned from these activities that should influence future interventions of the similar program?
6. In your opinion, what can be done to sustain the condom purchase and use among FSWs? Please tell me about this.

Annex (d): The In-depth Interview Guideline for Clients of FSWs

1. What is your age?
2. What is your profession
3. How long have you been keeping contacts with female sex workers?
4. What is the frequency of your meeting with female sex workers?
5. Where do you usually meet them?
6. What is about your preference of the place for sex?
7. Do you prefer using condoms while having sex with FSWs?
    a. If yes, why?
    b. If no, why?
8. Do all female sex workers agree to the use of condoms while having sex?
    a. If no, why don't they agree?
9. Do you have to pressurize FSWs to use condoms?
    a. If yes, why?
10. (contrastingly) (contrastingly) If FSWs want to use condoms, do you deny (regularly/often/sometimes)?
    a. If yes, why?
11. Do you bring the condoms?
    a. If yes, from where do you buy? Why do you prefer these sources?
    b. If no, how do you manage it?
12. Have you ever bought condoms from Peer Outreach Workers?
    a. If yes, why did you buy from them?
    b. If you bought from them, please tell us your opinion about the pricing and quality.
    c. If no, why didn't you buy from them?