Women's Organisation Network for Human Rights Advocacy (WONETHA Uganda)

Research Survey Report

A research on the frequency of abortion and its implication among Female Sex Workers in Uganda

By

Lead Researcher
Isaac Roy Kyeyune
internationalfind@gmail.com
Tel: +256 701 947494

Associate Researchers
Dr. Ronard Mukuye/Dr. Samuel Kabwigu/ Charles Genga

Glossary

AIDS	Acquired Immune Deficiency Syndrome
BTG	Bridging the Gaps
CAO	Chief Administrative Officer
DICE	Drop in Center
eMTCT	Elimination of Mother to Child Transmission
FSWs	Female Sex Workers
HIV	Human Immune Virus
IRB	Institutional Review Board
IDU	Injectable Drug Users
KP	Key Populations
MoH	Ministry of Health
MSM	Men having Sex with Men
NSP	National HIV Strategic
ODK	Open Data Kit
TBA	Traditonal Birth Attendant
UAC	Uganda AIDS Commission
UNAIDS	United Nations AIDS Program
UNCST	Uganda National Council for Science and Technology
WONETHA	Women's Organisation Network For Human Rights Advocacy

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The study was commissioned by Women's Organisation Network For Human Rights Advocacy (WONETHA). Through a bidding process, an independent consultant was identified to conduct the study. I would like to particularly recognize the efforts of the WONETHA Executive Director – Ms. Diana Natukunda, the staff, peers and volunteers of WONETHA and community members who gave in a lot of information and time to complete this study.
The Lead Researher was Isaac Roy Kyeyune, with a team of other associate researchers; Dr. Samuel Kabwigu (Gynaecologist and Obstericrs Specialist), Dr. Ronard Mukuye (Lecturer, Makerere University College of Education, Mr. Charles Genga (Senior Economist), Ms Justin Lubuga and Ms. Florence Mahoro (Research Coordinators).

The Research team worked with WONETHA Peer leaders and Staff in the six (06) Districts of Kampala, Wakiso, Mukono, Kamwenge, Kasese and Bundibugyo. These supported the research team in mobilization of the survey respondents (Female Sex Workers) and other Key Informants. The WONETHA frontline local team members were also key in providing local knowledge and guidance to the research team. I highly appreciate them for the invaluable support, time and skill sets exhibited. The research team is extremely grateful to all respondents who surprisingly appreciated all the work and were very expectant of the study findings, including local, opinion, religious and cultural leaders in the selected areas where the research was conducted.
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We are hopeful that the process, results and findings will be very significant in ensuring that services reach the most in need and the vulnerable – specifically the Female Sex Workers to who the efforts principally targeted.

Affirmation

This document is the FINAL report having addressed the goal and objectives for the research survey on the "the frequency of abortion and its implication among the Sex workers in Uganda" as conducted by WONETHA Uganda. The report is a final copy and includes and represents the true responses, discussions and recommendations from the stakeholders indicated and consulted as regards the objectives and questions and how they can be addressed to improve reproductive health care services for female sex workers in Uganda.

Except as acknowledged by the references in this report to other authors and publications, the Research Report described herein consists of own primary work, undertaken, implemented, and reported concerning the TORs given to the Lead Researcher by WONETHA Uganda.

I also affirm that primary quantitative and qualitative data collected throughout this research process has been fully compiled, analysed and the results and reccomendations generated their-in. For knowledge sharing, this report may be reffered to by other researchers and authorities although additional inquiry and persmission may need to be sought from WONETHA Uganda and the donor.

The research and the report with its content remains the property of WONETHA Uganda who is the custodian and is mandated to provide consent or any full or partial acknowldgements rights– whenever required.

Isaac Roy Kyeyune

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Lead Researcher
Survey on the frequency of abortion and its implication among the Sex workers in Uganda
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Research Abstract

This research was facilitated by Women's Organisation Network For Human Rights Advocacy (WONETHA) with support from Bridgig the Gaps (BTG). WONETHA Uganda is a women's rights organization that strives to address rampant discrimination in health care systems, social stigma, as well as advocate against punitive and restrictive legislation and policies that encourage violation of sex workers rights. The research was carried out in 06 selected WONETHA districts of operation; Kampala City Council Authority (KCCA), Wakiso, Mukono, Kamwenge, Kasese and Bundibugyo Districts in Uganda. The objectives for the research included; (i) To establish the number of female sex workers that conduct abortion in Uganda (ii) To establish the different ways and methods that female sex workers use in conducting abortion in Uganda (iii) To find out the reasons among female sex workers for conducting abortion (iv) To establish the implications abortion has on female sex workers and (v) To find out the availability and accessibility to services that female sex workers have for abortion care.

The research adopted a mixed methods evaluation approach using both quantitative and qualitative methodologies and targeted women aged 18–49, who reported having engaged in sex work in the previous five (5) years prior to the study year (2019). The primary study participants were female sex workers who directly participated in the survey. The other research respondents as key informants and focus group discussants included Sex Worker Leaders, Health Care Workers both Government and Private, Traditional Health care givers, brothel Owners, police Officers, District Health leaders, WONETHA Senior staff and relevant Ministry of Health Staff. For these participants, their method of selection was a purposive sampling technique. The data collection methods used included; Document review, Survey method (structured interviews), Key Informant Interviews (KIIs) and Focus group discussions. The sex workers that qualified to participate in the survey had to pass the following checklist; Had to be active sex workers by the time of the survey, needed to voluntarily consent to participate in the survey, was with-in the age range of 18 to 49 years, was in good physical and mental health deemed fit to give credible and reliable personal health information, and was operating the sex work business in any of the six targeted districts.

The project has two overaching outcomes; (1) to understand abortion and reproductive health challenges among Female Sex workers in Uganda and (2) to generate policy needs and gaps that require advocacy to improve Sexual Reproductive Health including abortion health care for female sex workers to improve and protect sex work as work.

The survey findings indicated that;

1. Abortion is rampant among FSWs with a rate of 43.7%
2. There are largely two methods that female sex workers use in conducting abortion; Misoprostol, used by over 44.9% of the female sex workers followed by Herbs/ Herbal medicine and solutions at 20.7%.

3. The key reasons why FSWs conduct abortion were two; limited financial capacity to support the pregnancy and also being unsure of the person/ the man responsible.
4. The implications abortion has on female sex workers are significantly two; Out of the 111 (62%) who faced health complications, the leading three issues included over-bleeding cited by 61.2% while 45% mentioned abnominal pain, then 11.7% mentioned blood/ products retentions in the uterus. The other two general concerns included; stopping to work and long periods undergoing expensive hospitalization.
5. Its was also established that abortion health and its care services are scarce in urban centers and hardly available in rural areas with government service providers not offering them while the private ones available are ill equipped, less eprienced and ill trained, hence the majority chosing to utilize traditional medicines and usually with a high cost. We conclude that FSWs family planning needs in both rural and urban areas are unmet and we recommend regularatory reviews of the abortion policy in Uganda, sensitization of the beneficiaries and stakeholders of the needs and gaps as well as improving and intergrating access to reproductive health needs in exisiting services for FWS specifically in innovations like DICES among others.

Figure 1: A Summary of key quantitative survey indicators

No	Indicator	Percent
1.	% of FSWs that have conducted an HIV Test	97.3%
2.	% of FSWs that have tested positive for HIV	35.7%
3.	% of female sex workers that have conducted abortion	43.7%
4.	% of female sex workers that have ever conducted an abortion in the three urban Districts of Kampala, Mukono and Wakiso	50.5%
5.	Highest % of FSWs in a district conducting abortion (Bundibugyo District)	57.1%
6.	% of FSWs that report pregnancy as a result of a condom burst	34%
7.	% of FSWs that conduct abortion on their own	20.2
8.	% of FSWs that use misoprostol to conduct abortion	44.9%
9.	% of FSWs that use herbs for abortion	20.7
10.	% of FSWs that conduct abortion by Traditional Health Practioners (TBAs)	7.8%
11.	% of FSWs that conducted abortion and countered complications	62.3%
12.	% of FSWs that seek professional health services while conducting abortion	66.8

CHAPTER ONE: INTRODUCTION

1.1 The implementing Agency

Women's Organisation Network For Human Rights Advocacy (WONETHA) is a women's rights organization which strives to address rampant discrimination in health care systems, social stigma, as well as advocate against punitive and restrictive legislation and policies that encourage violation of sex workers rights. The organisation promotes the rights and livelihoods of sex workers in Uganda, through improving their economic opportunities, empowering them to organize and advocate for equitable access to health, legal and social protection.

1.2 The Research Context

Despite large reductions in pregnancy-related deaths in Uganda over the past two decades (the maternal mortality ratio dropped from 684 per 100,000 live births in 1995 to 343 per 100,000 in 2015), the high number of maternal deaths there remains a public health challenge. Unsafe abortion continues to contribute significantly to this public health problem: A 2010 report by the Uganda's Ministry of Health estimated that 8% of maternal deaths were due to unsafe abortion.

Abortion in Uganda is illegal unless performed by a doctor who is convinced that pregnancy places the woman's life at risk[1]. However, the 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights go even further—permitting abortion under additional circumstances, including in cases of fetal anomaly, rape and incest, or if the woman is HIV-positive. Yet, existing laws and policies on abortion are interpreted inconsistently by law enforcement and the judicial system, which makes it difficult for women and the medical community to understand when abortion is permitted[2.] Because of this ambiguity, medical providers are often reluctant to perform an abortion for any reason, out of fear of legal consequences. Yet for females who engage in sex work, accidental or un-intended conception or pregnancy is simply not just a health issue but becomes a "work related accident or job risk" that must be addressed. This implies that abortion related services to FSWs is a routine service that is required and if not available or scarcely accessible (like in many places in Uganda) implicates the FSWs and puts their lives in danger. Its this broad need to appreciate the frequency of abortion and hence the level of need for abortion related services among FSWs that jusfies this survey.

1.3 Research Scope

Female Sex Workers (FSWs) are regulary predisposed to a broad range of social, sexual and reproductive health problems such as sexually transmitted infections (STIs)/ HIV, unintended pregnancy, violence, sexual exploitation, stigma and discrimination. Female sex workers have unmet need for contraceptives and require comprehensive Sexual and Reproductive Health (SRH) prevention interventions. Existing programs pay little attention to the broad sexual

[1] Moore, Ann M.; Kibombo, Richard; Cats-Baril, Deva (2014). "Ugandan opinion-leaders' knowledge and perceptions of unsafe abortion". Health Policy and Planning. **29** (7): 893–901.
2 Constitution of the Republic of Uganda, 1995.

and reproductive health and rights of these women and often focus on HIV and other STIs prevention, care and treatment while neglecting their reproductive health needs, including access to family planning methods.

The aim of this study is, therefore to establish, "the frequency of abortion and its implication among the Sex workers in Uganda". In the context of the research and legal scenario with abortion in Uganda, the study limited itself and concentrated on "Abortion among sex workers" since in Uganda, all abortions are illegal. We used the World Health Organization (WHO) definition, which defines "Abortion" as a procedure of pregnancy termination either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both"

1.4 Research Area

The research was carried out in six (06) selected WONETHA districts of operation including Kampala City Council Athority (KCCA), Wakiso, Mukono, Kamwenge, Kasese and Bundibugyo Districts in Uganda.

1.5 Survey Objectives

1. To establish the number of female sex workers that conduct abortion in Uganda
2. To establish the different ways and methods that female sex workers use in conducting abortion in Uganda
3. To establish the reasons among female sex workers for conducting abortion
4. To establish the implications abortion has on female sex workers
5. To establish the availability and accessibility to services for female sex workers for abortion care

1.6 Survey Questions

1. To what extent is abortion prevalent among female sex workers in Uganda?
2. What ways and methods do female sex workers use in conducting abortion?
3. What are the reasons given by female SWs for conducting abortion?
4. What implications does abortion have on Female Sex Workers in Uganda?
5. What services are available for female Sex Workers related to abortion care?

1.7 Organisation of the Report

The report is organised into Six Chapters:

1. Introduction
2. Survey Methodology
3. Characteristics of the survey particicpants
4. Situation analysis of frequency of abortion and its implication among the Sex workers
5. Frequency of abortion and its implication among the Sex workers in Uganda
6. Study Findings and discussions
7. Conclusions and recommnedations
8. Annexes

CHAPTER TWO: METHODOLOGY

2.1 Research Design

The research adopted a mixed methods evaluation approach. It employed both quantitative and qualitative methodologies. The quantitative method was useful in determining magnitudes of issues under investigation for each objective such as: percentage of sex workers who undertake abortions, distributions of percentage use of different abortion methods and variations in terms of reasons for aborting, among others. On the other hand, qualitative data provided insights, descriptions and interpretations of issues under investigation in terms of experiences, processes and challenges, among others. This was from other categories of respondents using Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs). These included; select Health Care Workers from both govemnent and private facilities, Sex Work leaders, Traditional Health care givers, Brothel Owners, Police Officers, District Health Officers, WONETHA Senior staff and Ministry of Health Staff – for Policy angagement and dissemination.

2.2 Area and Population of the Survey

The survey was conducted among active sex workers in the six (06) districts namely; Kampala City Council Authority, Wakiso, Bundibugyo, Kasese, Kamwenge and Mukono. Sex work in this case is defined as 'providing sexual services in exchange for money as part of an individual's livelihood. As provided in the Terms of Reference (ToRs) and further clarified in the inception report, the study participants included the following:

a) 407 FSWs aged 18–49, who reported to having engaged in sex work in the last 12 months prior to the study.
b) 06 FGDs of FSW leaders (1 discussion of not less than 6 persons in each District)
c) 06 FGDs of Government Health Care workers (1 discussion of not less than 6 persons in each District).
d) 06 FGDs of Health Care workers in Private facilities (1 discussion of not less than 6 persons in each District)
e) 06 KIIs with Traditional Health Care givers/ TBAs (1 from each of the 6 District)
f) 06 FGDs with Brothel Owners (1 discussion of 6 persons in each District)
g) 06 KIIs with Police Family Units (1 from each of the 6 District)
h) 06 KIIs with District Health Assistants (1 from each of the 6 District)
i) 03 KIIs with WONETHA Key staff in management, programs and outreach
j) 02 KIIs with Senior Ministry of Health Staff responsbile for HIV and AIDS, Reproductive Health and also Planning

In total, the study targeted 614 people in their different categories as respondents or Key imformants on the survey

2.3. Size and Sampling Framework

This sample size per a district was calculated based on the 2017 Ministry of Health Key Population (FSWs district sample estimates). The study indicates the following size estimates for the target Districts; Kampala (1,015), Wakiso (260), Bundibugyo (150), Kasese (150), Kamwenge (150) and Mukono (159). So the total is 1,884. If 100% = 1,884, then the % size estimates is calculated as; Kampala (53.9%), Wakiso (13.8), Bundibugyo (8%), Kasese (8%), Kamwenge (8%) and Mukono (8.4%). Thefore using Krejcie and Morgan (1970), at the 95% confidence level with a margin error calculated at 3.6%. The sample size per each District is therefore calculated and distributed as follows; Kampala (53.9 x 515 = 278), Wakiso (13.8 x 515 = 71), Bundibugyo (8 x 515 = 41), Kasese (8 x 515 = 41), Kamwenge (8 x 515 = 41) and Mukono (8.4 x 515 = 43). This meant that the sample size for FSWs is calculated at 515 although this was not achieved in the field for different reasons, however on review, several similar studies used a similar or even a smaller total; Tanzania used 448 (Sarah C. Keogh, 2015), Ethiopia used 346 (Rishan Weldegebreal, 2014), Benin used 450 (Gentiane Perrault Sullivan, 2016), Uganda used 400 (Margaret Erickson, 2015). This interrelation is adequate to qualify the sample and results as admissible for the WONETHA Uganda study.

Figure 2: *A detailed table showing the tools, categories and number of respondents*

No	Respondent category	Data collection method	Respondents						Total
			Kla	W'kiso	B'gyo	M'kono	K'sese	K'nge	
1.	Female Sex Workers	Structured interviews	194	56	42	49	46	20	407
2.	SW leaders	Focus Group Discussions	6	6	6	6	6	6	36
3.	Health Care Workers (Government)	Key informant interviews	6	6	6	6	6	6	36
4.	Health Care Workers (Private)	Key informant interviews	6	6	6	6	6	6	36
5.	Traditional Health care givers/TBAs	Key informant interviews	6	6	6	6	6	6	36
6.	Brothel Owners	Key informant interviews	6	6	6	6	6	6	36
7.	Police Officers	Key informant interviews	6	6	6	6	6	6	36
8.	District Health Assistants Officers	Key informant interviews	6	6	6	6	6	6	36
9.	WONETHA Staff	Key informant interviews	03	0	0	0	0	0	03
10.	Ministry of Health Staff	Key informant interviews	02	0	0	0	0	0	02

2.4 Data collection methods and Tools

The research team conducted a qualitative and quantitative study with 407 women who self-reffered as sex workers operating the sex work business in the six Districts of Kampala, Wakiso, Bundibugyo, Kasese, Kamwenge and Mukono. The invitation to participate in the study was transmitted through WONETHA Peers and community workers, although sex workers did not have to be and were not all WONETHA registered or subscribed members[3]. Much as the community Peer Educators were the lead contacts to reach the sex workers for interviews, the researchers also adopted the snowball technique, asking FSWs in some locations to direct the team to other locations where other sex workers operated. This was aimed at minimizing any bias associated to only relying on WONETHA pre-determined peers. We interviewed women between 18 and 49 years to avoid issues related to legal consent (below 18 years) and memory errors in relation to previous reproductive events (for participants above 49 years). Participants considered for the study needed to self report as sex workers but also self report to receiving money or goods in exchange for sex in the prior six months as a source of livelihood.

Consistent with the Uganda National Council of Science and Techonology guidelines on conducting research, Research Ethics Board (REC) approval and national approval was sought as well as engagement with Ministry of Health Uganda and the Uganda AIDS Commission. This enabled the team to conduct the research. Participants were not reimbursed with money, however a cost for a soft drink worth 2,000 Uganda Shillings (approximately US$0.53) was reimbursed and majority preffered to have this in cash to buy any eatable of own preference during the interview. This was acceptable by the research team considering the mobile work shchedules of the sex workers that were being targeted. Informed consent was obtained prior to enlisting any respondent for the research. Interviews were conducted at the respondents places of work, such as brothels, residence compounds or streets at times as defined by the participants. The research team and assistants had received adequate training to manage gender biases and other stereotypes that were deemed to potentially affect the data collection process. The interviews were guided by a semi-structured questionnaire divided into six sections; (i) Social demographics (ii)Number of FSWs conduting abortion (iii) the different ways FSWs conduct abortion (iv) reasons FSWs give for conducting abortion (v) the implications of abortion on FSWs (vi) availability and accessibility to abortion care services. Interviews were conducted in three languages, English, Luganda and Lukonzo (in Kasese) and part of Bundibugyo Districts. The interviews were transcribed and independently analysed by the lead research team. All data was anonymized to avoid any identification of the participants.

(a) Document Review

There is considerable global, regional and local literature on sex workers and specifically on issues concerning rights, abortion, health care and others. We reviewed this information, pointing out the implications. The key documents reviewed included; similar Study reports

[3] *WONETHA Uganda is a membership sex work organisation and female sex workers pay an annual subscription fee to become members and enjoy the associated benefits*

nationally and globally, District health reports as well as project activity works and reports from sex work agencies both in Uganda and around the globe. The literature review process also helped to guide the research team in developing tools for data collection including questionnaires and focus group discussion guides. The team however takes note that much of the relevant imformation/ literature was old, some 10 years and beyond. Indeed, the researchers realised that to a great extent, there was limited relevant research specifically concerning female sex workers that has been done in the area of abortion.

(b) Survey method (structured interviews)

The researchers used paper questionnaires instead of the highly expensive and technical ODK system for data collection and storage. The paperwork and tools required training of research assistants on how it works as well as conducting interviews. All risks related to loss or destruction of questionnaires were addressed by training data collectors in paper data collection and management. The team also purchased bags to ensure the data is kept safely. The researchers were also teamed up to support and secure each others while in the field.

(c) Key Informant Interviews (KIIs)

KIIs were conducted with sex work leaders and those partners that the team deemed to have had vital imformation and regular interaction with SWs. These include Police, Local Council leaders and the District Health office. Permission was sought and where it was granted, the audio recordings of the KII proceedings was done. The key informant interviews were conducted using a KII guide.

(d) Focus Group Discussions

Focus group discussions were conducted with health workers. These interactive discussions enabled the team to generate data on practices and records as regards reproductive health and abortion care services sought, available, offered, the costs, challenges and suggestions. The team also conducted FGDs with brothel owners. Each FGD comprised of six participants to ensure closer interaction.

2.5 Data capture, processing, and analysis

This study yielded two sets of data- qualitative and quantitative data. These were analyzed differently.

2.6 Quantitative data

Working with the study statistician, the quantitative data was analysed using SPSS and MS excel. Frequencies disaggregated the key desired variables. Data was presented in a tabulated form to allow easy interpretation and analysis. Cross tabulations was carried out for some key variables to understand the relationship between the variables and how they relate to the purpose of the study. This aided findings and reccomendations.

2.7 Qualitative data

Bogdan and Biklen (1982:145) define qualitative data analysis as "*working with data, organizing it, breaking it into manageable units, synthesizing it, searching for patterns, discovering what is important and what is to be learned, and deciding what one tells others*".

Audio recorded data from FGDs and KIIs was transcribed and typed in English and analyzed using content and thematic techniques. The themes were designed based on the survey objectives. Processing of qualitative data was handled as follows:

- Review of all transcripts to delineate aspects directly relevant to the research objectives of the study.
- Prepare an analysis grid showing the major key issues of investigation against key thematic areas.
- Review of data for each specific issue of investigation to extract key quotations, insights, explanations and interpretations.

A post-fieldwork data analysis matrix was developed, organized according to the various tools. Key themes from each tool formed the sub-themes in the matrix. The matrix was populated with data from transcripts/field notes drawn from each of the tools that rhymed with the sub-themes in the matrix. While writing on a theme, data was extracted from the matrix to facilitate the process of analysis and writing on that thematic issue in the findings. This was followed by content analysis that was carried out to provide in-depth interpretation of the data and draw conclusions and lessons.

2.8 Inclusion and exclusion criteria

Those included were;

- Only active female sex workers
- The sex workers that consented to participate
- Only active female sex workers with-in the age of 18 – 49
- Someone who has willingly consented to participate
- Someone in good health to participate

2.9 Ethical consideration

The research team observed a set of measures to comply with ethical standards during the whole process of the study. These included:

- ✓ The core research team and research assistants individually signed the participant confidentiality policy to commit themselves to abide by it.
- ✓ All Research Assistants were trained in basic counseling skills especially on how to handle vulnerable populations or persons with special attention to sex workers.
- ✓ In as much as possible, questions that may cause psychological harm to women during interviews were avoided. This was carefully considered while designing the data collection tools and training research assistants on probing.
- ✓ Informed consent was sought from all study participants by clearly explaining the study purpose. Consent forms were developed and used in securing written consent.

- ✓ All interviews were conducted in a private space (but visible space) to guarantee confidentiality.
- ✓ All study participants were assured of the confidentiality and non-disclosure about their identities and data provided for the study. Their names did not appear on the questionnaires as well as in the stored data. Only codes were used. Properly locked up places for storage of data was done. This was to ensure safety and confidentiality.
- ✓ The right to participate or not to participate. Participants were given the option to opt-out of questions or the whole interview, if at any time, they believed a response would contain sensitive information. This was made clear at the start of the process for each of the respondent/ group.
- ✓ All information provided was kept confidential and used for the study purpose only. To protect the identity of participants, field notes, and transcripts simply contained personal identifiers. Only members of the research team had access to the transcripts and raw data. All raw and processed data was kept under password protected on computers.
- ✓ For their easy identification, the researchers and enumerators always bore the research visa (IDs) given to them for the purpose.
- ✓ Recommendation letters introducing and justifying the relevance of the assignment were sought and given to the members.
- ✓ Seeking and obtaining formal consent from each informant before interviewing or engaging in discussions.

2.10 Translation of the data tools

Data tools were translated in the other 2 common local languages other than English. The languages included Luganda (for greater Kampala, Mukono and Wakiso) and Lukonjo (for Kasese and Bundibugyo)

2.11 Time frame and the study management

The overall survey was a 10 step process that was planned and conducted between September 2019 to January, 2020. The following steps were followed; (i) Contract negotiations and signing (ii) Inception workshop and report (iii) Development, uploading and pretesting tools (iv) THETA Resaerch Ethics Committee (REC) and Uganda National Council of Science and Technology Approvals Process (v) Develop Training manuals (vi) Recruit and Train Data collectors (vii) Field/ Data Collection (viii) Data cleaning and Analysis (ix) Reporting development and sharing and (x) Dissemination of the study report and findings.

2.12 Quality assurance

Quality assurance is critical for effective and credible base-line results. The study team ensured quality assurance through six (06) key strategies and procedures; The development of the inception report and the tools together with WONETHA to ensure approval before the field survey started. The team sought the Institutional Review Board (IRB) at THETA Uganda sanctioned by Uganda National Council of Sciece and Technology for ethical

clearance and validation. WONETHA Uganda also set up an internal committee led by the WONETHA Programs Manager to evaluate the research tools, processes and reports. The data collection (research) assistants were selected based on an independent criteria and assessment by the researchers. These needed among others to have knowledge of the local language and culture, familiarity with Key Population and SWs in Uganda, familiarity with the local areas where the research was conducted – among others. These were also trained and oriented for 3 days in the research protocol, basics of data collection as well as the specific requirements for this Survey and the planned methodology and the tools. Pretesting of data collection tools was done and emerging issues incorporated in the final tools for data collection. During the field work, research assistants/enumerators were supervised closely by selected supervisors for process and outcome quality assurance. Each district had a supervisor responsible for overseeing data collection activities and quality assurance for the process. Daily review of data collected was done to ascertain progress, challenges encountered and planning for the following day. The Research Assistants were trained on how to conduct informed consent and research ethics dealing with human subjects and these consent forms submitted to WONETHA Uganda.

2.13 Ethical Considerations

All possible measures were taken to protect confidentiality, observe informed consent, and to reduce any potential adverse consequence to the participants. The team sought the Institutional Review Board (IRB) at THETA Uganda sanctioned by Uganda National Council of Sciece and Technology for ethical clearance and validation. Research assistants were oriented in how to conduct interviews with vulnerable women. Points of referral incase of advese effects or crisis were established. The survey recruited a gynaecologist (Dr. Samuel Kabwigu) who beyond leading the research also gave advisory support in different settings where women and clinicians needed further advise on the safety and care of women with abortion related aspects. Notably also was that all interviews were conducted in a private space to guarantee confidentiality. Other aspects included; (a) For their easy identification, the researchers and enumerators wore the research visa IDs (b) recommendation letters justifying the relevance of the assignment were sought from WONETHA (c) anonymity was guaranteed and no names were revelead. The data capturing and analysis process instead of names used codes for both qualitative and quantitative data. This was vital in ensuring confidentiality as well as proper use of data collected at all levels.

2.14 Study Limitations

The survey team admits to key study limitations. Several, based on similar study reports reviewed, seem common for studies targeting vulnerable populations. However the findings should be kindy judged in respect to the legal, policy and political environment that sex work is being conducted and tolerated in Uganda. In fact owing to the different categories and modes that sex work generally appears or is conducted, this study only limited itself to street and brothel based sex work – to which itself is a weakness as the study did not cascade into SWs that work from their homes, the escort agengies, massage parlours or cosmopolitan hotels and others.

The research relied on self-reported data and did not have a robust strategy to cross-check or test evidence - say if a respondent concurred or denied any previous abortion experience. Although we are still confident of these findings because previous studies suggest that sex workers and drug users usually provide truthful accounts of their sex and drug use activities when questioned in a non-threatening environment (Needle R, 1995). Nevertheless, its possible that some facts were under-represented.

Almost all the FSWs targeted belong to a financially low and needy class who live a "hand-to-mouth" life. Many requested for money to participate and actually several opted out, urguing that a compensation with a soft drink was not worth the information and the time required. Its also possible that even those that consented to participate were motivated by the small "soft drink incentive" and fitted themselves into the study criteria rather than being eligible to participate. The study team for example cannot rule out that participants underdeclared or over declared their age below 49 or above 17, just to qualify to participate, although a trained team of research assistants had been oriented to detect and eliminate such biases by say observing and probing further should there be any suspicion. We recommend that should a similar study be conducted in future, a more comprehensive participartory approach and indirect discussion techiniques be used to eliminate such possibilities, however unlikely.

Suffice to note that majority of these weakneses are structural in nature and in fact several had been anticipated hence were widely discussed with WONETHA, the Ministry of Health, Key Population specialists as well as during the training of the research assistants to ensure the impact and effects on the survey findings is limited. However we recommend future studies to learn from these limitation in the design, methodology and practice. Despite these limitations, to our knowledge, this is the first study reporting rate of abortion among Female Sex Workers and conducted by a Sex work led agency (WONETHA) in Uganda. We believe our findings are significantly accurate and serve important implications for the advancement of policy, planning and practice as regards to reproductive health services, access and utilization to them among female sex workers.

CHAPTER THREE:
CHARACTERISTICS OF RESPONDENTS

3.1 Social Demographics

The researcher considered key socio-demographic characteristics relevant to the goal and objectives of the study. These included; partipants location information (district), age, level of education, relationship/ marital status, HIV status, alternative sources of income and length of period while doing sex work. Please note that gender/sex and main occupation were not considered since all survey participants (SWs) were female. However, information on alternative sources of income was sought. *Below is the detailed information (3.2 – 3.9)*

3.2 Survey Population characteristics

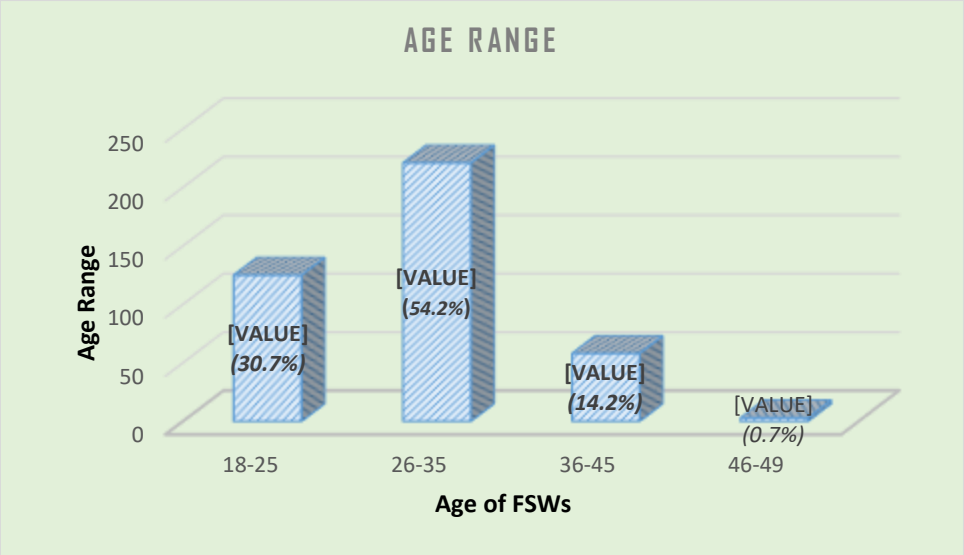
Overall, 614 respondents participated in the survey, out of which, 407 were Female Sex Workers (FSWs). This means FSW made 66% of the total population. According to the number of FSWs targeted, Kampala District had 194 (47.6%), Wakiso District; 56 (13.7), Bundibugyo District 42 (10.3%), Kasese District 46 (11.3%), Kamwenge District 20 (5%) and Mukono District 49 (12%). Only female Sex workers were targeted so the gender was the same.

On the general population, the other respondents included leaders of Sex Workers, Government Health Care Workers, Private Health Care Workers, Traditional Health care givers/TBAs, Brothel Owners, Police Officers, District Health Assistants and WONETHA Staff. For these categories; FGDs and Key informant interviews were used.

3.3 Age of the Survey Participants

The age range of the survey participants was determined. Out of the 407 FSW, the range for the participants as indicated was as follows;

Figure 3: *Age range of the female sex workers in the survey*

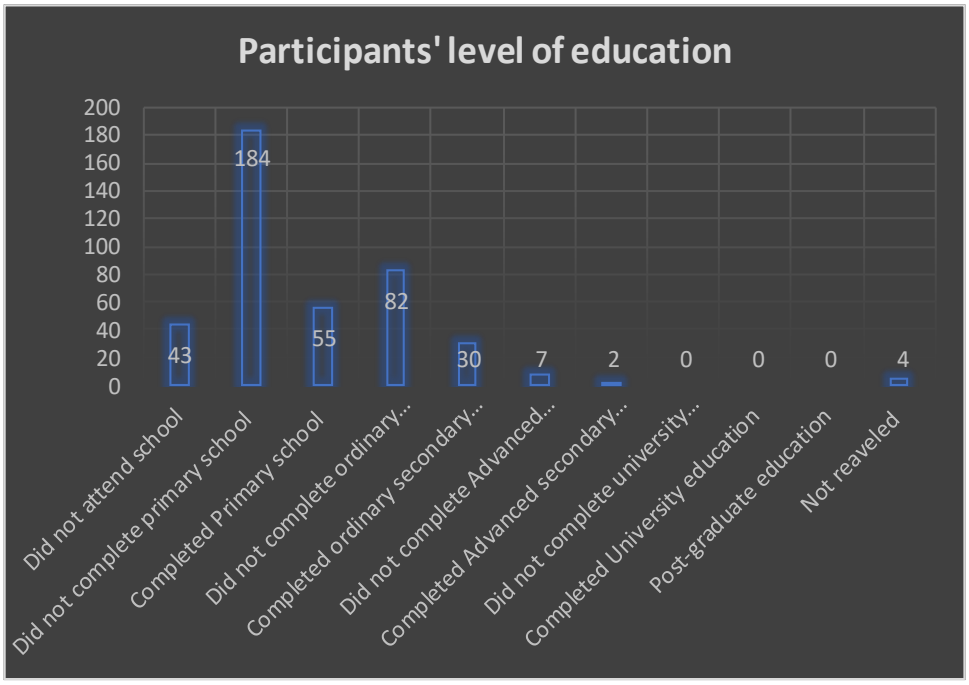


As for the table above *(Fig. 3)*, for the 407 FSWs that were interviewed, a number of 221 were in the age range of 26 – 35 (54.2%). Then 58 were 18 – 25 yrs (30.7%) and only 3 were above 46 years (14.2%). It appears majority of active SWs are in the age range of 26-35 years.

3.4 Level of Education of the Survey participants

The level of education of the survey participants was assessed (Fig 4). Overall, 43 (10%) of participants indicated had never attended school, 184 (45.6%) stopped before completing primary school, 30 (7.4%) had completed Ordinary Secondary School level, and almost a negiligible number (less than 2%) had gone beyond Ordinary Secondary School level. No participant indicated to have done/ completed post-graduate education.

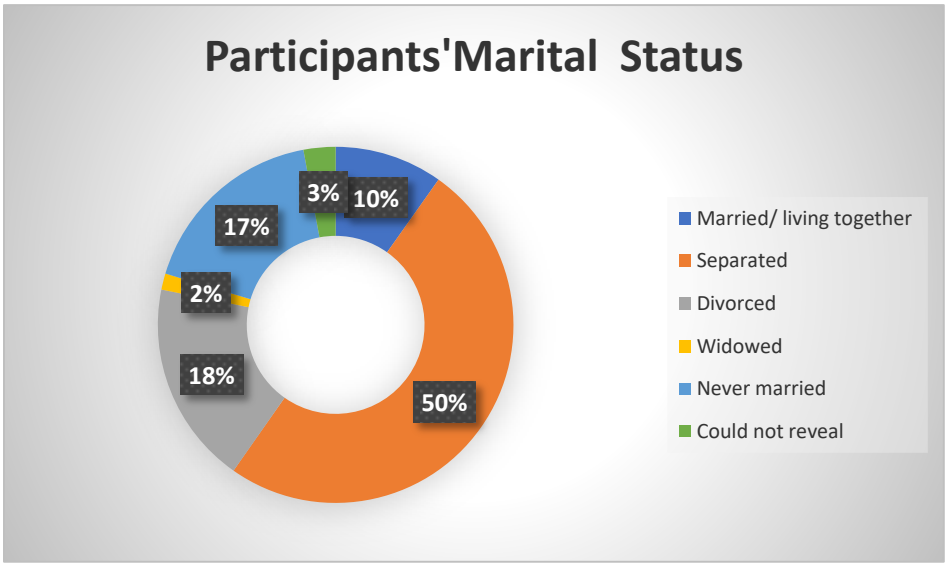
Figure 4: *Survey respondents level of education*



3.5 Relationship/ Marital Status

Overall, only 40 participants out of 407 indicated they were married or lived together with their partners. This is only 10% while 203 respondents (over 50%) had been married before but had separated, divorced or widowed, implying that this number had previously been in formal relationships. The significance of this is that there are several sex workers presently in formal sexual relationships. These are more likely to conduct abortion if the resultant relationship is not for their present formal partners. These also face regular domestic violence and sexual assault in cases of abortion. In the same vain, there is need to note that majority of FSWs are not presently in any formal sexual relationships even when they were initially engaged.

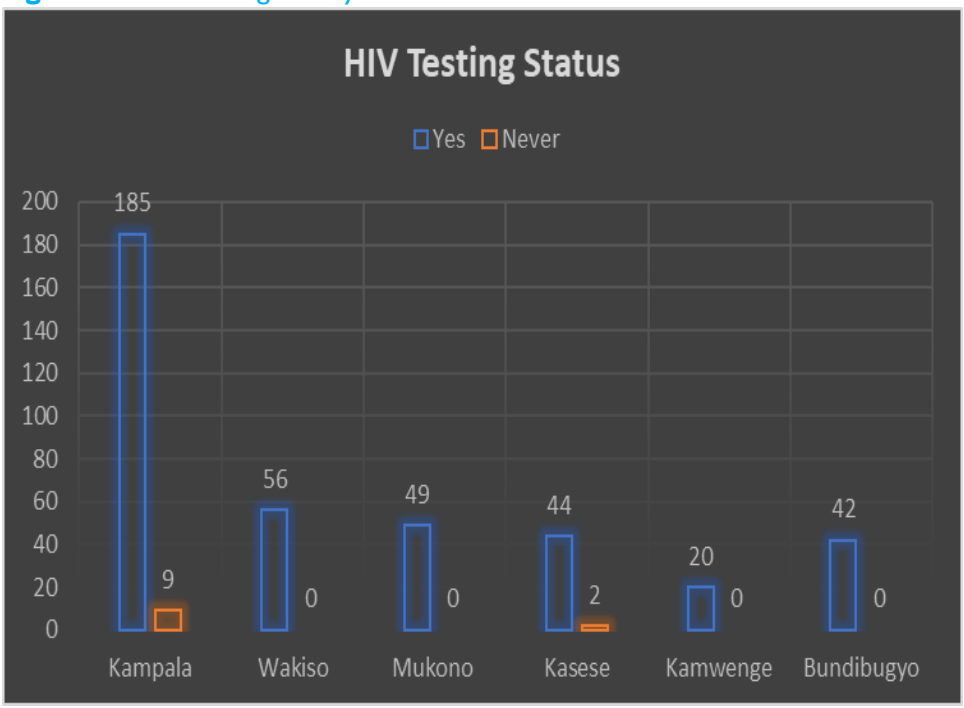
Figure 5: *Relationship status of the survey participants/ FSWs*



3.6 HIV testing among Participants

Overall, on HIV testing, only 11 participants (2.7%) of the total number of 405 participants in the survey had never done an HIV test, implying almost a 97.3% HIV testing coverage among FSWs. Only Kampala and Kasese had a sex work who had not done an HIV test. All FSWs in Wakiso, Mukono, Kamwenge and Bundibugyo had conducted an HIV Test before by the time of the survey.

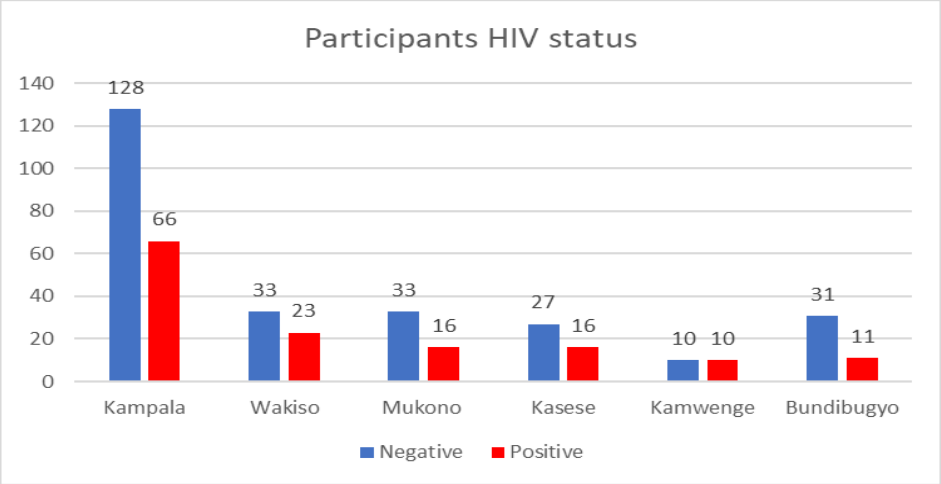
Figure 6: *HIV Testing history*



3.7 The HIV Status of Participants

The survey established that out of the 407 women that were interviewed, 262 (64.3.%) indicated their last HIV test as being negative while 145 (35.7%) were positive. With possibilities of inadequate confidentiality during the survey in mind, its also key to note that levels of stigma (including disclosure and discrimination) are still rampant among members of the Key Population. Taken on average, the HIV prevalence rate in the six Districts according to the WONETHA study figures is 35.7%.

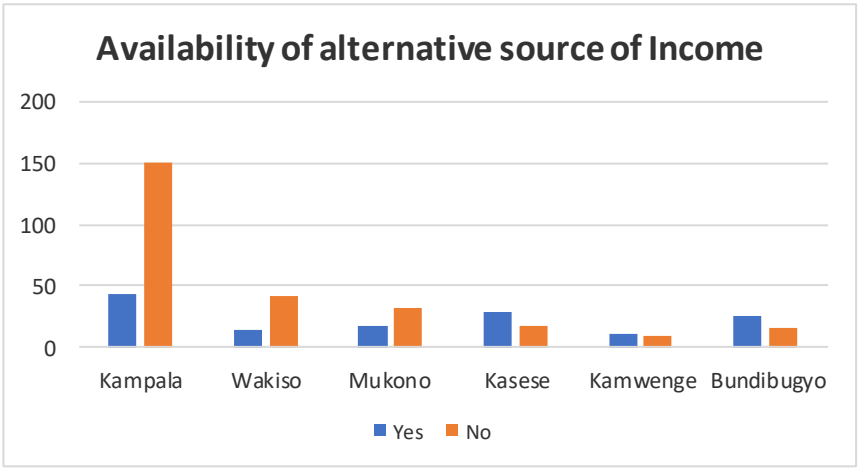
Figure 7: *HIV Test Results/ HIV Status among female sex workers by number*



3.8 Alternative sources of income

The survey also inquired about other alternative work that FSWs are engaged in. On this, 266 (65%) indicated that their only source of income was Sex work (Fig.8). The 141 (35%) that had alternative income sources were engaged in semi permanent jobs/ service provision. Many indicated were waitresses, attendants, petty traders or casual labourers. It was not clear if the alterntive job disclosed was the first job before sex work or sex work came first before they decided to opt for an alternative source of income. This question is vital for further inquest to eatblish if Sex work is a primary or secondary driver of women to alternative livelihood sources. Notably, SWs in urban districts appear to have Sex work as the only source of income and the trend apparently changes for SWs based in rural districts *(see figure 9 below)*. This trend may suspicuously have an interrelationship with abortion since its also more rampant in urban centers. Its most likely that having an alternative source of business may reduce the pressures to angage in abortion.

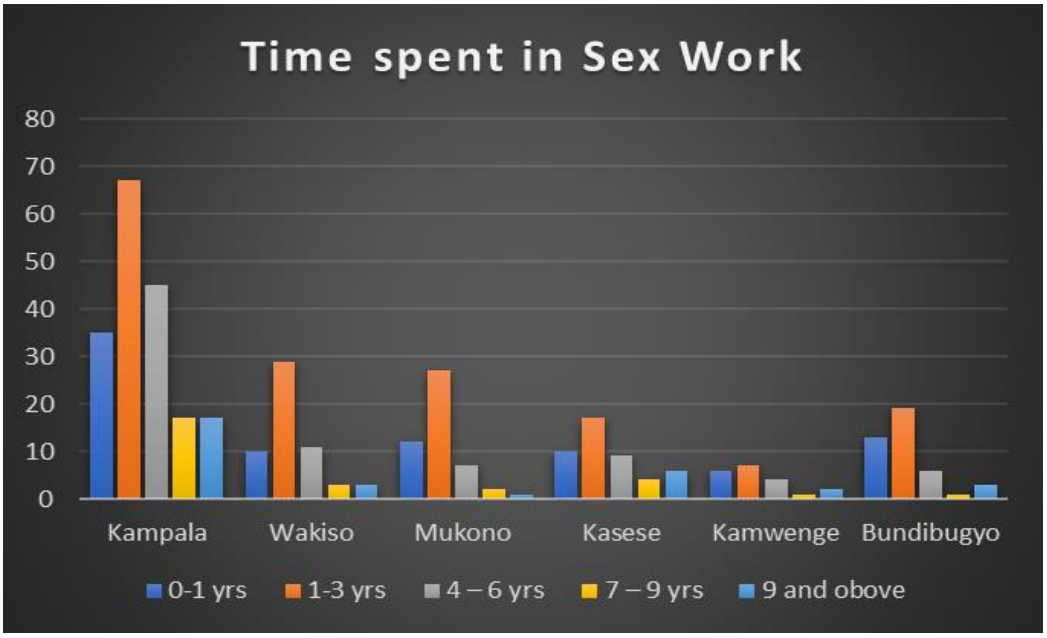
Figure 8: *Alternative Sources of Income for FSWs*



3.9 Length of period in sex work

This data indicates that the biggest number of FSWs had been in the practice for more than 3 years (166 participants) while new entrants (less than 1 year) were 86. The general trend indicates that the number falls beyond 4 years, which may imply that SWs, usually after 4 years, join other trades for reasons that may need to be established. The team was unable to conclude if the length of time had any relationship to conducting abortion or even increased HIV infection risk. Although a summation of the age of the participants indicated that much older clients (above 30 years) reported less cases of abortion among them compared to new entrants in the business.

Figure 9: Period/ Time spent in Sex work



The WONETHA study findings then could be used to conclude that the longer FSW take in the practice, the less likely that they will engage in abortion. It may also be that they gain much more practice and caution to avoid risky sex or engage in more safer abortion practices.

CHAPTER FOUR: SITUATION ANALYSIS

The review of previous and current works gives a context and relationship that the study has on national, regional and international works in relationship to abortion and its implication among the sex workers.

4.0 Demographic Characteristics of Sex Workers in Uganda

The constitution of Uganda refers to Sex work as prostitution and is illegal, according to Uganda's 1950 Penal Code. This illegalization subsequently makes it difficult to collect statistics for the sex industry, including other factors like low response rates, the small scale of research compared to the size of the sex industry, and the diversity of the industry. This also means that published statistics in Uganda (and several developing countries) concerning Sex Work is often conflicting and contested[4]. However sex workers and sex work are big in number almost in every country.

There are 40 to 42 million SWs in the world, according to a 2015 Report from Fondation Scelles. Though there is a challenge in estimating the actual number of Female Sex Workers (FSWs) globally especially dissagregated by country, available data indicates that in sub Saharan Africa, about 0.7– 4.3% of women exchange sex for money or goods although they do not formery associate or are not recognised as sex workers. In Uganda, 3.3% of women aged 15 and above were estimated to be practising Sex work in the capital city of Kampala. The official 2019 estimates of sizes of Key and Priority Populations in Uganda indicate over 130,000 FSW country wide[5].

Either voluntarily or recruited, the commonest age that girls and women enter and sustain Sex work is between 13–24 years[6]. There have been several incidences of much young girls. According to the African Network for the Prevention and Protection Against Child Abuse and Neglect (ANPPCAN), research findings on boarder and conflict areas like Gulu in Northern Uganda usher in much young girls (aged 11 – 13) engaged "sex work" but for legal reasons preffered as transactional sex. This therefore indicate that there are so many factors that determine the age for Sex Work in developing countries like Uganda. In the same vain, several studies have also indicated much older women (35 years and above) engaged in sex work. The WONETHA study in its context indicate that 221 respondents were aged 26 – 35 and above. This study is relieved of the fact that its target was between the age of 18 – 49 otherwise, there is need to establish the age sequence based on all females engaged in Sex work.

According to the Joint United Nations Programme on HIV and AIDS (UNAIDS), 36.7 million people were living with HIV globally by end of the year 2016, yet 30% did not know their

[4] Home Affairs Committee (15 June 2016). Prostitution: Third Report of Session 2016–17 (PDF) (Report). House of Commons. pp. 8–9.
[5] Synthesis, Consolidation and Building Consensus on Key and Priority Population Size Estimation Numbers in Uganda (Key Population Size Estimates Report, 2019)
[6] "Uganda 2017 Trafficking in Persons Report". U.S. Department of State. Archived from the original on 3 July 2017. Retrieved 18 January 2018.

status and in Uganda, it was estimated that FSWs and their clients accounted for 18% of the new HIV infections in 2015/2016 in the same year and persons who are yet to take an HIV test.

However and notably, Gerald Pande (2017) in his recent study "Preference and uptake of different community-based HIV testing service delivery models among female sex workers along Malaba-Kampala highway, Uganda, 2017" notes that there is high HIV testing practices among FSW. In this study, (390/456) of the FSWs that participated in the study had taken an HIV test in the last 12 months. This translates 86% of the total number of SWs that had tested. Of these 390 FSWs, 72% (279/390) had used static facilities, 25% (98/390) had used outreaches, and 3.3% (13/390) used peer to peer mechanisms to have an HIV test. Overall, 35% (159/390) of the FSWs who had taken an HIV test were HIV positive[7]. The findings do not fall far behind the findings for the WONETHA abortion study which also indicate a similar percentage of female sex workers having already taken an HIV test by the time of the study and were aware of their HIV status. With a rate of 35.7% HIV prevalence rate, it collaborates Pande's reseach in Uganda that indicated 35%[8]. Both figures appear to be in the national range of 33% - 37% national HIV prevalence rate among FSWs.

The recent findings of the study by Ministry of Health in Uganda and Gerald Pande (2017) also offer findings indicating that the 61% (279/456) of the FSWs belonged to age category 25–34. Female sex work was the primary occupation (source of livelihood) for almost all 99% (453/456) of the FSWs. Half, 51% (234/456) of the FSWs reported to have been divorced or separated or widowed from their partners. Forty eight percent (219/456) of the FSWs had attained primary education while only, 34.2% (156/456) had secondary education. The majority, 72% (327/456) of the FSWs were permanent residents of the place of interview (Stayed in the study area for at least 1 year). These facts collaborates the findings of the WONETHA research that indicate the same age group as the average for the FSWs interviewed, the same applies to their education stardard.

Another crucial factor related to the WONETHA study and sex work is that sex work has a diret connotation with education levels. Wolfgang Hladik (2017), established that HIV infection is associated with low levels of schooling and in Uganda, several females engaged in Sex worker did not attend school beyond Primary school level[9]. This collaborates both the study's notion that sex work was directly related to levels of education.

[7] Preference and uptake of different community-based HIV testing service delivery models among female sex workers along Malaba-Kampala highway, Uganda, 2017

8 Preference and uptake of different community-based HIV testing service delivery models among female sex workers along Malaba-Kampala highway, Uganda, 2017

9 Burden and characteristics of HIV infection among female sex workers in Kampala, Uganda – a respondent-driven sampling survey

An Article in the New Vision on 18th December, 2011 tittle "Abortion pills sold over the counter in Kampala partly reads.

In Uganda buying abortion pills has become as easy as buying sweets. Our undercover reporter went to a number of pharmacies in Kampala and procured the pills, to find out how easy it is. In total disregard of the law and professional ethics, pharmacies dish out the pills to any girl who wants them. Sadly, these pills can kill. Up to 1,200 girls die in Uganda every year while trying to abort. After getting information that abortion pills are sold in town openly, I decided to go to the city centre to find out how easy or hard it is to get the killer pills.

First was a pharmacy on Luwum Street. At the counter were three ladies. I approached the one who looked more friendly and told her I desperately wanted abortion pills. She looked at me and whispered in my ears: "Go to Wilson Street and ask for Flavia. Tell her that you have been sent by Masitula," she said. I asked her how much I was supposed to pay and she told me a dose is at sh5,000. I quickly went to the specific pharmacy and confidently asked for Flavia. I told her I was two months pregnant and I wanted to abort. "Why did you keep it for this long?" she asked. I looked at her miserably and told her that I was still at school. She demanded to know how much I was willing to pay, I told her sh5,000. "Sh5000, bbera serious nawe," she said. She asked me to pay sh20,000 or else stay with the baby. Sensing that she was getting irritated, I gave her sh20,000. She pulled out five tablets in a grey packet and I explained how I should use them. "Swallow two tablets and insert two in your private parts, make sure they do not fall, if you see blood coming out, take the remaining tablet. You are going to experience serious abdominal pain and please do not take alcohol," she said and continued chatting to her colleague. I crossed the road and went to a pharmacy on Majestic Plaza, where I found four people. I decided to approach the lady who was playing with her baby in the dispensing room. I whispered to her that I was three months pregnant and I had no plans of carrying the child. She placed her baby down and asked me why I wanted to abort. I told her that my boyfriend was not serious. "Young girls!" she said.

The information shows the significance and critical need of the study given the unfriendly environment and unhealthy context abortion appear to occur in Uganda specifically among vulnerable and poor women – including the female sex workers.

4.1 Frequency of abortion among female sex workers

The legal status of abortion in Uganda is ambiguous; the penal code permits abortion only if a woman's life is in danger, but the 2006 policy guidelines expanded legal abortion to HIV-positive women and in cases of fetal anomaly, rape or incest. Despite this legal lacuna, abortion is very rampant in Uganda. In the year 2003, 294,000 induced abortions were estimated to occur each year in Uganda but this was among all women. In fact as of 2010–2014, an estimated 36 abortions occured each year per 1,000 women aged 15–44 in developing regions, compared with 27 in developed regions. This seems to concur with national facts in Uganda where in the year 2013, an estimated 128,682 women were treated for abortion complications and an estimated 314,304 induced abortions occurred, both slightly up from 110,000 and 294,000 in 2003, respectively. The national abortion rate was 39 abortions per 1,000 women aged 15–49, down from 51 in 2003. These facts appear to concur with the WONETHA survey that has also indicated 43.7%, as the rate of abortion among the FSWs. Of course the rate among FSWs is much higher than the national rate and studies in other African countries specifically Kenya, Tanzania, Nigeria and others collaborate this rate. This may throw less light on abortion among FSWs vurses abortion among the general community.

In respect to the regions, other reseaches shows variations in FSW abortion rates but more rampant in urban and cities than rural areas. Some of the surveys indicated as high as 77 per 1,000 women 15–49 in Kampala region, to as low as 18 per 1,000 women in Western region of Uganda. These research trends concur with the WONETHA research that indicates that rates in Kampala were much higher at 50.5% while the rural average for the three districts is 40.7%.

For SWs, abortion seem to take a different trajectory from the other community members. SWs face elevated risks of unintended pregnancy due to a high frequency of intercourse and a high number of sexual partners[10.] Risks are exacerbated by concurrent paying and non-paying partnerships and by-sexual and gender-based violence, gender inequalities and stigma towards sex work, which reduce women's power to negotiate within sexual relationships[11]. Unintended pregnancy is a high priority issue for many female sex workers (FSWs) who usually have dependents to support and for whom pregnancy may increase financial dependence on sex work and add to already high levels of stigmatisation[12]

Luchters S (2016) in a study in Kenya among FSWs notes that half (50%) of those interviewed reported a previous induced abortion, although only a third of those had sought care from public sector services. Studies in different parts of the world − Russia, Colombia, Nigeria, Hong Kong, Kenya and Thailand − reported that more than 50% of the female sex workers reported having experienced at least one abortion in their life time (between 16 – 40 years). In the same perspective, Abortion Worldwide Report (2017) indicates that abortion among FSWs is very rampant and 20–24-year-old women tend to have the highest abortion rate of any age-group, and the bulk of abortions are accounted for by women in their twenties. Another study examining contraceptive need and use among FSW in Kenya reported high unmet SRH needs; 52% of women reported ever having an unintended pregnancy and 37% reported ever having an induced abortion[13]. A Canadian study found that 36% of local sex workers have had at least one abortion in their reproductive life[6], while 86% of Kenyan sex workers have had at least one abortion and 50% of them have had more than one[7]. There seem to be consistent data on abortions among FSWs specifically in resource rich countries, several of the mentioned studies in low and middle-income countries generally report high rates of abortion among FSWs. For example, a study in Colombia found that 53% of FSWs interviewed reported having ever had an abortion, Kenya reported both 37% and 50% for those reporting more than one. Studies in different parts of the world − Russia, Colombia, Nigeria, Hong Kong, Uganda and Thailand – all reported more than 50% of the female sex workers having reported experience at least one abortion in their life. This collaborates with the WONETHA study which also established a general rate of abortion being 48% and in some cased stretching to 57.1% for isolated districts like Bundibugyo.

[10] Falling through the cracks: contraceptive needs of female sex workers in Cambodia and Laos,. Contraception 2011
[11] Socio-demographic characteristics and behavioral risk factors of female sex workers in sub-saharan Africa: a systematic review. AIDS Behav
[12] Luchters S , Bosire W , Feng A , et al. "A Baby was an added burden": predictors and consequences of unintended pregnancies for female sex workers in mombasa, kenya: a mixed-methods study.
[13] Corneli A, Lemons A, Otieno-Masaba R, Ndiritu J, Packer C, Lamarre-Vincent J, et al. Contraceptive service delivery in Kenya: A qualitative study to identify barriers and preferences among female sex workers and health care providers. Contraception. 2016

4.2 Methods of conducting abortion

In many parts of Africa, health care and access to services even for the most obvious of cases, is still limited and where it is, is very poor. The poorer and less educated women and those living in rural areas are far less likely to give birth in the presence of a skilled health worker than better educated women who live in wealthier households or urban areas. Reasons for this include distance and expenses to reach health-care centres, but also inappropriate sociocultural practices.

Several studies indicate that the women resort to all possible methods regardless of the risks. Several women reported to using steel, wood, metallic pieces to cut or pierce the foetus. Several studies also indicate that or so many studies, oral contraceptives, use of condoms, female sterilization and intrauterine device insertion were the most common methods of contraception. Women who were poorer, who initiated sex work at a younger age and who reported use of illegal drugs were associated with inconsistent contraception.

Conversely, socio-economic conditions have led many women to seek for unsafe abortion using different tools and machinery. Where abortion is still prohibited and illegal like in Uganda, women further resort to many other mathods. Many use plant preparations to induce abortion. At the same time, in areas where abortion is legalized, some women still prefer to use traditional preparations to protect their privacy by not going to public gynaecological centres. In Tanzania's rural areas, 45% of women seeking abortion have used plants to induce abortion (Nikolajsen et al., 2011). Twenty one plant species are known by Traditional Birth Attendants both in Uganda and Tanzania to induce abortion (Nikolajsen et al., 2011). Most of the above studies acquired their data from Midwives, Traditional Birth Attendants, Traditional Healers and Key Informants; very few studies recorded the knowledge of lay people on gynaecological and obstetric treatments.

The commonest plant parts used are leaves (85.3%) including combinations with other plant parts. With regard to the conservation status, 68.4% (52) medicinal plant species are harvested from the wild populations, 17.7% (15) are under cultivation and 11.8% (9) are partly cultivated and or collected in the wild or the expecting mother herself (self-medication) mainly prescribe these herbal remedies to induce labour. Some of these medicinal plants are also fed to cows and goats in labour. Some healers use these herbs to make a local medicinal capsule called "Emumbwa", made from clay mixed with the herbs, then dried for use at any time when a woman is in labour. Special containers made of clay are used to crush this capsule and mixing it with water for oral administration.

For instance, Cleome gynandra is widely used in hastening childbirth (Oryem- Origa et al., 2003). A herbal drug made up of leome gynandra is used to fasten childbirth (Tabuti, 2003) widely throughout the entire country, which may imply that the plant may be potent (Kamatenesi-Mugisha, 2004). Chagnon (1984) reported that the methanolic extract of Bidens pilosa showed weak uterine stimulant effects on the guinea pig uterus in Rwanda. In addition, the water-methanolic plant of Iboza riparia extract showed weak activity on guinea

pig uterus stimulation and weak activity on guinea pig ileum smooth muscle (Goto et al., 1957). Chagnon (1984) further reported that the methanolic extract of Iboza riparia relaxed toad skeletal muscle (Rectus abdominus), caused weak guinea pig ileum smooth muscle relaxation and weak guinea pig uterine stimulation effect. Luffa cylindrica seeds were reported to be abortifacient (Saha et al., 1961; Ng et al., 1992).

4.3 Reasons to conduct abortion by Female Sex Workers

Although abortion occurs in every society, and a substantial proportion of pregnancies are resolved by abortion worldwide, there is little empirical research on why women obtain abortions largely because this cannot be generalized. Each woman has her reason and often her peculiar circumstance that drives her into abortion. This lack of information about this specific area is part of an overall scarcity of data on abortion. Legal, moral and ethical issues surrounding abortion make research on all aspects of abortion difficult to undertake, and also affect the quality of the information obtained. Collecting good information on reasons for abortion may be especially difficult, because it requires asking women to articulate the often complex and sensitive process that led to the decision.

Economic coercion often forces members of key populations, particularly sex workers, to practice unprotected sex in exchange for goods or money. For example, a qualitative study from Tanzania found that FSWs were willing to forego condom use with clients or engage in other risky sexual behaviors for perceived financial gains *(Phrasisombath, 2012)*. A research in Colombia showed that poorer FSWs were more likely to use condoms inconsistently, which contributed to a high prevalence of lifetime abortions *(Bautista et al. 2008)*. Younger members of key populations are particularly vulnerable to economic pressures. In a qualitative study from Ghana, adolescent FSWs were perceived as naively engaging in unprotected sex for what they thought were large amounts of money *(Onyango 2015)*. The unstable economic conditions faced by key populations often force individuals to engage in risky sexual behavior that places their reproductive health and intentions in jeopardy and later seek abortion.

However for the surveys that have been conducted successfully, most of the results and findings in this specific area tend to agree. Worldwide, the most commonly reported reason women cite for having an abortion is to postpone or stop childbearing, although it also has varying reasons why they feel they are not ready to have children then. The second most common reason—socioeconomic concerns—includes disruption of education or employment; lack of support from the partner; desire to provide schooling for existing children; and poverty, unemployment or inability to afford additional children. In addition, relationship problems with a husband or partner and a woman's perception that she is too young constitute other important categories of reasons. Women's characteristics are associated with their reasons for having an abortion: With few exceptions, older women and married women are the most likely to identify limiting childbearing as their main reason for abortion.

Although some of these reasons that the rest of women give to abort may slightly be unique or rank differently from those by FSWs, it appears that for all women, the biggest ranked

factor is economic (inability to support the pregnancy and a child), or perternity reasons (father unknown or does not intend to support the pregnancy)[14]. This has significantly been achoed by the WONETHA research to which inability to cater for the pregnancy has dominated the reasons for SWs to abort.

The reasons why women (and do not have to be Sex workers) choose to have an abortion are often closely related to union status and age; however, the decision to have an abortion is also influenced by other social, economic, partnership and health factors[15]. Sedgh G et al (2016) indicates that socioeconomic concerns is the most frequently cited type of reason, followed by wanting to stop childbearing and wanting to postpone or space a birth. Other main reasons include partner- and health-related issues, which vary widely in prevalence by country.

In Ghana and Uganda, partners' knowledge of and support for the decision to have an abortion have been associated with women's obtaining a safe abortion, partly because partner support often means help with the costs[1617]

Suffice to mention that unintended pregnancy is a high priority topic as well as an issue for worry for many female sex workers (FSWs)[18] because they usually have dependents to support and for whom pregnancy may increase financial dependence on sex work and add to already high levels of stigmatisation. This has been confirmed by consultation with FSWs in Kenya and workshops with FSWs to inform development of a pregnancy prevention intervention[19]. Participants expressed considerable fear and anxiety about pregnancy, related personal and peer experiences of pregnancy scares and emphasised the importance of improving knowledge of family planning in their community (unpublished qualitative data, Mombasa, Kenya). The participants associated the pregnancy with loss of regular clients, abuse from regular lovers and often associated with lack of knowledge of the persons responsible. Several SWs also determined their competence at work with "capacity to dorge preganancy" and hence when someone finally gets a pregnancy, this was detected as weakness and in-exprince[20].

A study in India showed that fear of violence from both noncommercial partners and clients can deter sex workers from negotiating condom use and accessing STI services for testing and treatment *(Deering 2015).* In Gambia, one study found strong linkages between coerced sex/sexual violence and decreased condom use and unintended pregnancy *(Sherwood 2015).* Similarly, a study in Uganda revealed that the forced sex, rape, and other forms of physical and sexual violence experienced by FSWs has resulted in an urgent need for safe abortion services in a country where the practice of unsafe abortion is common *(Marlow et al. 2014).*

[14] International Family Planning Perspectives, 1998, 24(3)
[15] Chae S et al., Reasons why women have induced abortions: a synthesis of findings from 14 countries, Contraception, 2017, 96(4)
[16] Moore AM, Jagwe-Wadda G and Bankole A, Mens' attitudes about abortion in Uganda, Journal of Biosocial Science, 2011, 43(1):31–45
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[18] Khan MR, Turner AN, Pettifor A, et al. Unmet need for contraception among sex workers in Madagascar. Contraception 2009
[19] Ampt FH, Mudogo C, Gichangi P, et al. WHISPER or SHOUT study: protocol of a cluster-randomised controlled trial assessing mHealth sexual reproductive health and nutrition interventions among female sex workers in Mombasa, Kenya. BMJ Open 2017;7:e017388 10.1136/bmjopen-2017-017388
[20] Scorgie F, Chersich MF, Ntaganira I, et al. Socio-demographic characteristics and behavioral risk factors of female sex workers in sub-saharan Africa: a systematic review. AIDS Behav 2012;16:920–33. 10.1007/s10461-011-9985-z

Many FSWs like any other female wish to have children. A few studies in recent years have noted an association between inconsistent condom use among key populations who have intimate or regular partners and their desire to conceive *(Aho, Koushik, and Rashed 2013; Beckham 2015; Deering 2015)*. Among FSWs in Burkina Faso, for example, a large majority reported a history of pregnancy and motherhood, although the study did not report on the women's pregnancy intentions *(Papworth 2015)*. Similar findings are reported elsewhere *(Todd et al. 2010)*. However, the desire for children and support for safer conception and a healthy pregnancy are often overlooked aspects of key populations' reproductive health.

To prevent both vertical and horizontal HIV transmission, safer conception services must be expanded beyond HIV-discordant couples to include members of key populations who wish to become pregnant (Schwartz 2014), including those who are HIV-positive and those whose partners are known to be HIV-positive or whose partners are at high risk of acquiring HIV. Safer conception approaches ensure the viral suppression of HIV-infected partners through antiretroviral therapy (ART) and use behavioral measures to reduce unprotected vaginal sex (Schwartz 2014). A study that surveyed FSWs in Burkina Faso and Togo found that nearly 20 percent of respondents had a desire to have children. Twenty-five percent of HIV-positive respondents trying to conceive were on ART, indicating a critical need for safer conception counseling to be more firmly integrated into HIV prevention and treatment services (Schwartz 2014). These findings further support the need for safer conception services to minimize HIV acquisition or transmission among members of key populations who are trying to conceive.

The completed researches generally agree with the WONETHA research to which women have cited inability to support the pregenancy as the leading reason to abort, followed by the denial of the person responsible. In so many aspects, these surveys agree on this front.

4.4 Implications of abortion on female sex workers

Because most abortions are the result of unwanted pregnancies, FSW are at risk for death and/or severe complications (such as sepsis, hemorrhage, perforated uterus). These complications are common sequelae in settings where unsafe abortion practices take place, especially in developing countries.

Unsafe abortion is a known contributor to maternal mortality in Uganda, although its impact seems to have decreased over time. In 2006, Uganda's Ministry of Health (MOH) estimated that abortion-related causes accounted for 26% of maternal deaths[21]. A 2007 study, conducted in 553 health facilities to monitor provision of obstetric care services in Uganda, found that complications from abortion were directly responsible for 11% of maternal deaths[22]. A more recent estimate, reported by the MOH in the 2010–2015 Strategic Plan

[21] Uganda Ministry of Health. Roadmap for accelerating the reduction of maternal and neonatal mortality and morbidity in Uganda Kampala, Uganda: Ministry of Health; 2007.
[22] Mbonye A, Asimwe J, Kabarangira J, Nanda G, Orinda V. Emergency obstetric care as the priority intervention to reduce maternal mortality in Uganda. International Journal of Gynecology and Obstetrics. 2007

for the Health Sector, suggests that 8% of maternal deaths were due to unsafe abortion[23]. This implies and implicates that majority of abortions in Uganda are conducted using uncouth methods and are largely unsafe.

Unsafe abortion also largely impacts abortion morbidity. Unsafe procedures, including oral or intravaginal introduction of herbs, caustic substances, drugs, and/or sharp objects, result in complications that can be quite severe and even result in permanent damage to the body. In 2003, it was estimated that over 85,000 women were treated for complications arising from abortions; the aforementioned 2007 health facility study also found that about 40% of admissions for emergency obstetric care were the result of unsafe abortions[24].

Condoms (69%) and oral contraceptives (38%) were most commonly reported, and less than 3% had ever relied on an intrauterine device. We found low rates of dual protection (34%). About half of the respondents reported one or more lifetime abortions. Inconsistent condom use, frequent alcohol use and longer-term cohabitation were associated with prior abortion.

The WONETHA research established that FSWs engage in unsafe abortion which then exposes them to further risks and complications. The same issues and challenges that were raised by other studies concur.

4.5 Availability and accessibility to abortion care services by female sex workers

Sex workers' need for safe abortion services in Uganda is greater than that of the population of women of reproductive age because of their number of sexual contacts, the inconsistent use of contraception and their increased risk of forced sex, rape or other forms of physical and sexual violence.

Treatment of complications from unsafe abortion consumes a significant portion of the total expenditure for reproductive health in Uganda. In 2010, an estimated $13.9 million (in US dollars) was spent towards the provision of post abortion care (PAC) services. This corresponds to 4.1% of the total government expenditure on health, which is estimated at $350 million (in US dollars).

Barriers at the structural level—particularly social injustices and human rights violations—further impede the ability of key populations to access and meet their reproductive health goals (Schwartz 2014). Antidiscrimination and protective laws are needed to eliminate stigma, discrimination, and violence against key populations, including violence in the context of sex work (Elmore-Meegan 2004). Human rights lawyers can work with key populations to facilitate the reporting of violence, and those who do report violence should be provided

[23] Uganda Ministry of Health. Health sector strategic plan III: 2010/11-2014/15. Kampala, Uganda: Ministry of Health; 2010.
[24] Mbonye A, Asimwe J, Kabarangira J, Nanda G, Orinda V. Emergency obstetric care as the priority intervention to reduce maternal mortality in Uganda. International Journal of Gynecology and Obstetrics. 2007

with proper legal and police protection (Beattie et al. 2010). Sensitization workshops with police (Bekker 2015) and journalists can help foster empathy toward key populations and improve understanding of their unique needs. Finally, addressing legal barriers and advocating for the removal of restrictive laws, policies, and guidelines would help ensure that key populations have access to comprehensive SRH services (Petruney et al. 2012).

In this regard therefore, female sex workers, given their heightened risk of acquiring HIV and sexually transmitted diseases - have the right to sexual and reproductive health (SRH), including the right to determine the number and timing of their pregnancies. Although research and public health interventions tailored to key populations have been on the rise in recent years—most notably for female sex workers—the majority of interventions have focused on preventing and treating HIV and other sexually transmitted infections (STIs), without taking into account broader reproductive health needs (Sutherland 2011). Yet, enabling women, including sex workers, to achieve their reproductive intentions offers far-reaching health benefits. Reducing unintended and high-risk pregnancies contributes to optimal birth spacing and reduces maternal and newborn mortality. For women living with HIV who do not wish to become pregnant, family planning offers the added benefit of preventing mother-to-child transmission, thereby reducing the number of infants born with HIV and the number of children who need HIV-related care (Wilcher et al. 2013).

The findings from the WONETHA study is an indication that access to abortion care services by female sex workers is limited and still very challenged by structural, policy and financial issues;

At a structural level, the research findings indicate that female sex workers access the services more from private facilities as opposed to government health centers and reasons given mainly include the services and supplies being unavailable and government health centers being inaccessible. As a consequence, sex workers need to walk and travel for long distance to access the services which in most cases they do not get.

The other dominant challenges sited by female sex workers in the process of access to abortion related services include;

1. Lack of knowledge about the services available
2. Self ignorance to appreciate the need for professional health services
3. Inability to afford the professional health services

The study is a clear manifestation of the need to address key policy and strategic issues (supplies, personnel, distance and cost) as a method of improving availability and access to abortion related services targeting female sex workers in Uganda.

CHAPTER FIVE:
PRESENTATION AND DISCUSSION OF FINDINGS

5.1 Participants Charactristics

5.1.1 The number and category of participants

Overall, 614 participated in the survey; 407 FSWs which was 66% of the total population. Kampala had 194 (47.6%), Wakiso; 56 (13.7), Bundibugyo 42 (10.3%), Kasese 46 (11.3%), Kamwenge 20 (5%) and Mukono 49 (12%).

Table 1: *Table showing number of Survey participants (FSWs) per each District*

Sr.	District covered	Number of FSWs	Percentage
1.	Kampala	194	47.6
2.	Wakiso	56	13.7
3.	Bundibugyo	42	10.3
4.	Kasese	46	11.3
5.	Kamwenge	20	5
6.	Mukono	49	12
	Total	407	100

The remaining 207 (33.7%) were other respondents other than the FSWs. These included leaders of Sex Workers, Government Health Care Workers, Private Health Care Workers, Traditional Health care givers/TBAs, Brothel Owners, Police Officers, District Health Assistants and WONETHA Staff.

5.1.2 Age of the Survey Participants

The age range of the survey participants was analysed and the results were as follows; 18 – 25 years was 30.7%, 26 – 35 (54%), 36 – 45 (15%) and those above 46 were 0.73%.
In general, this shows that the categories of females that engage in SW – in terms of age, are mostly in the age range of 26 – 35 years. Some possible reasons could be increased family and personal responsibilies. It's also the most fertile age hence likely to engage in abortion related activities if not supported with reproductive health services.

5.1.3 Level of Education of the Survey participants

Overall, 43 (10%) of the participants had never attended school, 184 (45.6%) stopped before completing primary school, impying they were primary school drop-outs. This implies that more than 50% of the participants had the education level below Primary seven, which is the lowest education level in Uganda. This further indicates that many of the sex workers had low levels of education, which may have further impact on the design of services meant for Sex workers like imformation om reproductive health and others. They may need to be tailored and localized to their levels. Further studies may need to be done if level of education had a contribution to women joining SW or even abortion.

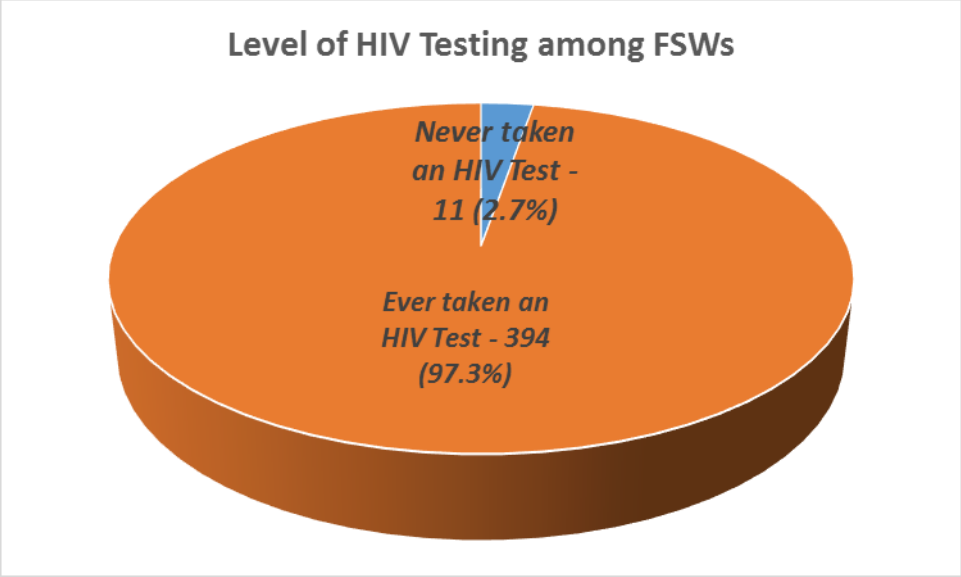
5.1.4 Relationship Status

Overall, only 40 participants out of 407 indicated they were married or lived together with their partners. This is only 9.8% of the total participants. The biggest number which is 203 participants (49.8%) had been married before but had separated. The implication is that a bigger number of FSW had been previously in relationships and had left, hence divorce or separation from a previous relationship appears to be a pull/push factor to sex work. This scenario also is likely to have a relationship with increasing domestic violence or neglect by make partners.

5.1.5 HIV testing among Survey Participants

Overall, only 11 participants (2.7%) of the total number of 405 participants had not yet done an HIV test. The number that had done an HIV test is 97.3%, infact its only Kampala and Kasese that had registered participants without tests so far. All FSWs in Wakiso, Mukono, Kamwenge and Bundibugyo had conducted an HIV Test by the time of the survey. This demonstrates the success of HTC services in the areas by WONETHA and other stakeholders, although that reason alone may not be adequate to demonstrate that this same testing rate was apparent in the other general community. It was apparent that efforts had only yielded among FSWs and need to be enhanced with-in the general public.

Figure 10: *Level of HIV testing among female sex workers*

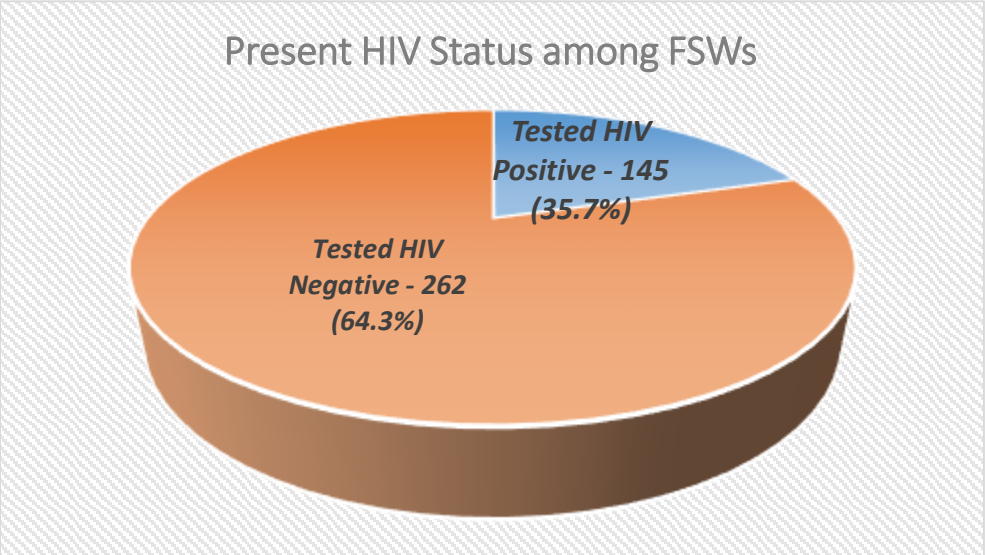


5.1.6 The HIV Status of the Survey Participants

The survey established that out of the 407 women that were interviewed, 262 (64.3%) were HIV negative while 145 (35.7%) were positive. With possibilities of inadequate confidentiality during the survey in mind, its also key to notice that levels of stigma (including disclosure and discrimination) are still rampant among members of the Key Population. In Uganda now, for instance, while HIV prevalence in the general population stands at 7.3%, HIV prevalence ranges between 33 and 37% among FSWs. It shows this range is static, if not increasing since the average in the WONETHA study for all the 6 districts as calculated is 35.7%. There is a

possibility that the HIV prevalence among FSWs may be on the rise. But also for individual Districts, it appears Kamwenge and Wakiso are the highest with 50% and 43% HIV prevalence among FSWs respectively, while Kasese and Mukono are also statistically high at 39% and 33%. Kamwenge and Wakiso are much higher than the national rate. In multiple analyses, factors significantly associated with availability of landing sites, high ways seem to be key factors to these factors. More tailored services may be required to address this apparent rise. Unfortunately, it was never established if these HIV positive participants had access to ART services or even comprehensive and layered HIV and AIDS prevention services to avoid further infection.

***Figure 11**: HIV prevalence among female sex workers*



5.1.7 Alternative sources of income

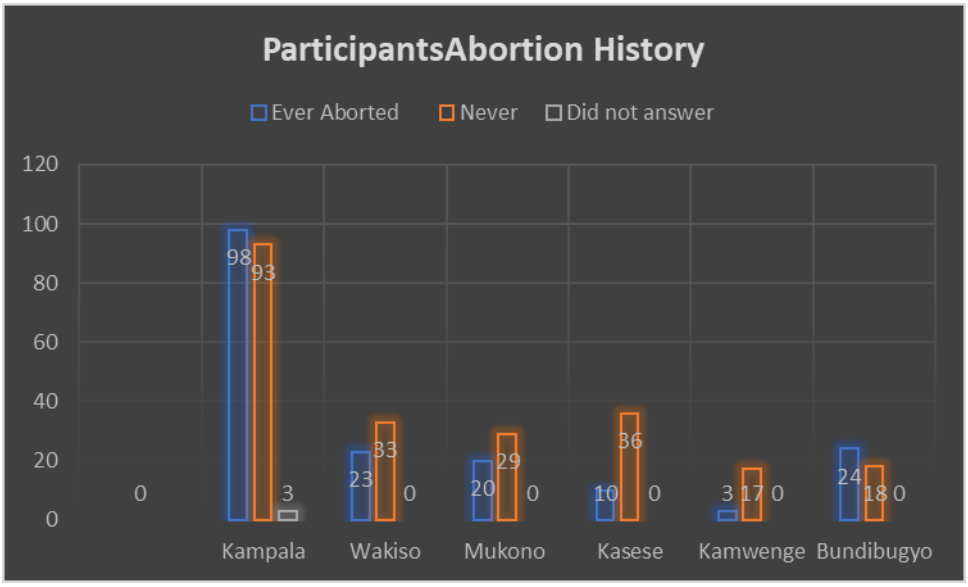
Results indicate that 266 (65%) had Sex work as their only source of income while the 141 (35%) that had alternative income sources were engaged in semi permanent jobs/ service provision, working as waitresses, attendants, petty traders or casual labourers. This on its face value shows how significant abortion may be in respect to women's survival and is likely to be a factor that increases its occurrence as women may not survive for their time of healing or child care.

5.1.8 Length of period in sex work

The biggest number of FSWs had been in the practice for more than 3 years (166 participants) while new entrants (less than 1 year) were 86. Further research may need to be done to establish if length had a relationship with abortion although several surveys have indicated that young FSWs are more likely to commit abortion more than those that had been in the practice longer.

5.2 Female sex workers that conduct abortion

Figure 12: *Female Sex Workers that had committed abortion*



Overall, 178 women of the 407 that participated in the survey had conducted an abortion in the last five years prior to the study. This means an average of 43.7% of the FSWs in the six districts had aborted. This trend once devided into rural and urban districts presents very interesting divergent findings.

The study collaborates with several others. Infact in several other places in Africa, FSWs reported similar experiences of induced abortion. In a study in Côte d'Ivoire showed that overall, 72 percent of FSWs who had ever been pregnant reported having one or more abortions, with half of FSWs reporting at least one abortion performed without the care of a trained service provider *(Schwartz, Papworth, Thiam-Niangoin, et al. 2015)*.

5.2.1 Abortion among Rural vurses Urban Districts

The abortion rate with-in the three (03) urban districts; Kampala, Wakiso and Mukono is far much higher than that of the three rural districts of Bundibugyo, Kasese and Kamwenge. At a combined population of 299 participants, 144 participants had conducted an abortion. This translates into 48% FSWs among urban districts that had conducted an abortion while for rural districts; Kasese, Kamwenge and Bundibugyo, its 40.7%. Its apparent that there is a significant difference in abortion rates among rural and urban areas. Infact the trend indicates that the more urban, the higher the number of abortions with Kampala (50.5%), Wakiso (41%) and Mukono (40.5). In a unique case, Budibugyo District appears to be a different. Although its common and is supported by several other studies that rural districts have lower abortion rates, strangely, the rate in Bundibugyo appears to defy the trend as its higher than even the three (03) urban districts of Kampala, Wakiso and Mukono. At 57.1%, Bundibugyo is the highest among all the six Districts where the survey was conducted.

Conducting abortion does not seem to mean that the more urban, the more the FSWs conceive, but rather that FSWs in rural areas are more likely to retain a pregnancy to full term than those in urban areas. This seems to be a true reflection as many FSWs that the study interacted with in rural districts had biological children from multiple partners. Also, that FSWs in urban areas are more likely to access abortion services than rural ones. There could also be a likelihood that abortion methods used by rural FSWs are less effective than those in urban settings.

Although another angle to this is the fact that research data in Uganda indicates that Eastern, Western and Karamoja regions have low abortion rate estimates (18–25 abortions per 1000 women aged 18–49). This is likely due to a combined effect of high fertility and an inability to prevent unintended pregnancy – even for FSWs. Around 50%-55% of the pregnancies in Western Uganda region are unintended. Furthermore, only around a quarter of women from this regions use a modern method for contraception and 37–41% of them have an unmet need for modern methods. These factors, in addition to the high excess fertility (around two children per woman) and the high proportion of unplanned births (34–39%), suggest that FSWs in Kasese, Kamwenge and Bundibigyo areas are more likely to carry an unintended pregnancy to term than to resolve it with an abortion.

This comfirms that FSWs in the three rural districts are less likely to access, afford or utilize reproductive Health Services, even when they are available unless they free or very cheap. But also they need a lot of information and sensitization. However the urban trend indicates that abortion in urban settings is very high/ rampant (at 50.5%). It may also mean increased risk taking among FSWs in urban regions through having unprotected sex or multiple sexual partners.

The voices below confirm the different challenges with abortion in developing countries like Uganda.

5.2.3 Number of abortions conducted

Table 2: *Abortions by number as conducted by the FSWs*

Code	District	One	Two	Three	Four	Five	More than five	Total
1.	Kampala	63	20	08	01	03	03	98
2.	Wakiso	19	01	02	01	0	0	23
3.	Mukono	13	03	03	01	0	0	20
4.	Kasese	07	02	0	0	0	0	10
5.	Kamwenge	03	0	0	0	0	0	03
6.	Bundibugyo	14	06	04	0	0	0	24
	Total	**119**	**32**	**17**	**3**	**03**	**03**	**178**

On average, 66.8% of the FSWs (119 of the 178 respondents) had aborted atleast once by the time of the survey, 18% (32) had aborted atleast twice, 9.5% had aborted three times while 1.6% had aborted more than three times. With exception of Bundibugyo, urban

districts led by Kampala Wakiso and Mukono top in abortion rates. Kampala has the highest number and infact has the only 6 respondents reporting to have aborted more than five times. Its critical to note that the study did not consider attempted but unsuccessful abortions although during the interviews, this was mentioned in some instances. These are also emphasized by other community voices as below;

"Within one month at a certain spot at Bundimasali - Bundibugyo they get over four cases of abortion among the sex workers and at the moment its becoming rampant and in a day 3 victims terminate their Pregnancies." - **FGD Sex worker leaders Bundimasali - Bundibugyo.**

"It is mostly married women that conduct abortion due to fearvof their husbands finding out." - **Sex Worker Leaders, FGD in Kalitunsi zone - Kamwenge District.**

5.2.4 Circumstances for getting pregnant

Out of the population of 119 that aborted, the study established that there were five (5) significant categories how the pregnancy was concieved;

Table 3: *Circumstances of conception of the pregnancy that was aborted*

Code	Curcumstance	Total	%
1.	Voluntarily wanted to conceive even if they later aborted	45	25.2
2.	Consented to unprotected sex but did not want to conceive	52	29.2
3.	Did not consent to unprotected sex and was unconscious at the time of sex	06	3.3
4.	Were raped and concieved	05	2.8
5.	The condom burst	62	34.8
6.	Other general reasons	08	4.4
	Total	**178**	**100**

"I am certain of about 50 Sex Workers operationg within my area. I even know the different spots and places where they operate. Of late, I have heard that many of them are getting because, as I am told, they have started ignoring condoms" - **KII L.CI Chairman Lower Customs Kabwiri Road.**

Findings indicate that the three leading situations to which those pregnancies aborted get concived is through;

a) Condoms bursting (62 cases reported out of 178 cases) at 34.%
b) Consented unprotected sex but never wanted to conceive (52 cases reported out of 178 cases) at 29.2%
c) Consented to unprotected sex and wanted to conceive but decided to abort - 25.2%

Other reasons like rape resulting in an abortion were not very common, although rape in itself as a challenge in sex work was commonly mentioned.

Condoms bursting was the most cited reason with Kampala getting the highest number of 43 out of the 98 respondents. This implies that there is a direct relationship between the

increased rate of abortions among FSWs and the quality of the services specifically condoms in this case.

"We have lately seen an increase in the cases where Sex Workers report condoms breaking. You know what happened early 2019, condoms from the unauthorized batches released by Marie Stopes Uganda were additionally found to be defective by the National Drug Authority (NDA). In other words, the condoms had holes. Following complaints from contraceptive users, the NDA on November 20th, 2019 ordered Marie Stopes Uganda to issue a recall on more than 1 million Life Guard brand condoms. But as of November 28th, nearly 20% of the condoms from the defective stocks had still yet to be recovered "– ***Ministry of Health***

Its unclear wether this is one of the effects of the above quoted incident however chances are that these two are related. There is need for concerted efforts to reverse the effects of this or further study the immediate causes and how they can be addressed.

However, studies from both Asia and Africa also reported high rates of condom failure among surveyed FSWs as a result of condom breakage or slippage. For example, the prevalence of condom slippage and breakage in the past three months reported by FSWs in a study in southwestern China was 36 percent and 34 percent, respectively. Findings from this study also revealed that condom failure was significantly associated with client-perpetuated violence (Choi et al. 2008). In studies in Cambodia and Laos, about one-third of FSWs reported condom breakage in the past three months, and condom failure was associated with increased abortions (Morineau et al. 2011). In comparison, a somewhat higher prevalence of condom failure was reported among FSWs in Swaziland: 48 percent of respondents experienced condom breakage or slippage with partners in the past 30 days (Yam 2013).

Its also worth exploring the second and third commonest cucumstaces given. These include; consented to unprotected sex but never wanted to conceive (52 cases reported out of 178) at 29.2% and consented to unprotected sex and wanted to conceive but decided later to abort at 25.2%. The first one would imply lack of knowledge of the implications of unprotected sex and this can be addressed with additional information. The third one appears to imply "changes in expectations, conditions or terms that had initially prevailed on conception" so that someone has to decide to abort. During FGDs, some of these factors that forced women to reverse their decisions not to continue with the pregnancy included;

- Partners leaving or ceasing to offer support
- Partner violence
- Changes in HIV or health status
- Being unsure of the person responsible after continuously having unprotectd sex with other regular sexual partners
- Fear of long period of work suspension as one carers for pregnancy
- Impressing another new partner

5.2.5 Knowledge of the partner responsible for the pregnancy

The study also established if the respondent was aware of the partner responsible for the pregnancy aborted

Table 4: *Awareness of the partner responsible for the pregnancy*

Code	District	Yes	%	No	%	Total
1.	Kampala	65	66.3	32	34.7	98
2.	Wakiso	18	78.2	05	11.8	23
3.	Mukono	11	55	09	45	20
4.	Kasese	08	80	02	20	10
5.	Kamwenge	03	100	0	0	03
6.	Bundibugyo	17	70.8	07	29.2	24
	Total	**122**	**68.5**	**55**	**32.5**	**178**

A large number of respondents (122 out of 178) which is 68.5% were sure of the partner responsible for the pregnancy before deciding to abort. This would comfim that FSWs had other consicious reasons for decising to terminate the pregnancies also owing to the fact that several often consent to unprotected sex with their formal or regular partners. It then appears that if they know, then it could be urged that these were their formal or regular partners and hence programs like Assisted Partners Notification (APN) should be cascaded and strengthened. There is however a percentage of 32.5% who indicated they were not sure (not that they did not know) of the partner responsible for the pregnancy they aborted. Infact Kampala has a high number of respondents in this category. This could be because FSWs usually have multiple sexual partners but it also shows increased risk through unprotected sex by FSWs with more than one partner. More education and sensitization on HIV prevention strategies should be emphasized.

In fact when further asked the category of partners responsible for the pregnancy, over 80% comfirmed these are their present spouses or regular sexual partner/ client.

5.3 Ways and methods of conducting abortion

The study also established the source of support for the FSWs in conducting the abortion. Its key to note that the word "help" in this does not refer to who exactly conducted the abortion. In this context, it refers to support limited to aiding the process; like referral to where someone can do it from, a written guide on what to do, a subscription of a drug or help in administering the dosage.

Table 5: *Sources that helped the FSWs to conduct the abortion*

Code	The source of help in conducting abortion	Total	%
1.	Professional Health workers	119	66.8
2.	Fellow sex workers	06	3.3
3.	Traditional health care givers	14	7.8
4.	Spouse	0	0
5.	Regular sexual partner	0	0
6.	Friends	03	1.6
7.	SW leaders	0	0
8.	No one (myself)	36	20.2
	Total	**178**	**100**

Overwhelemingly, three (03) sources of help in abortion were cited; helped by health workers (119 respondents out of 178) or done by self (36 out of 178 respondents) and helped by the Traditional Health Care givers/ Traditional Birth Attendants (14 of 178 respondents)

"Sex workers use, "mesoprostol" to conduct abortion" **- KII Kamwenge Health Centre III.**

5.3.1 Health Workers;

At 119 (66.8%), its clear the highest number of FSWs seek the services of health workers to conduct abortion. It was indicated that each of the FSWs community has their own designated clinic or health establishment, well known among them for abortion purporses. Further discussions indicated that such clinics are largely privately owned and do not neccesarily have the professional persons to offer quality abortion or post-abortion care services but are usually friendly, accessible, cheap and confidential, although specifically in urban districts, some professional centers and CSOs were listed to offer professional abortion care services. But suffice to also note that to this study, the variable **"health workers"** may not mean a SW working in a health center to seek an abortion but largely means a regulated clinic and center where SWs purchase pills with basic or minimal consultations.

Although we also noticed a trend when it comes to health workers themselves.

Participants mentioned names of clinics in districts that were reputed for facilitating abortions. Others reported that only consultations and appointments are made with particular doctors and midwives in the hospital space, and arrangements made to meet at another private venue where the abortion is conducted. A few others said that it is totally impossible to procure abortion within the formal hospital environment especially upcountry – although it appeared possible in Kampala and Wakiso (most likely because they are urban and very cosmopolitan. Some of the FSWs severally mentioned names, and addresses of personnel who facilitate abortions. Some names were repeatedly mentioned in all the different study locations in a single district. In Kampala, popular places in Bwaise, Wandegeya, Mulago area, Kabalagala almost kept on coming up and it appeared each knew them. This reavelaed that specific centers who offer the service are uniform and may be widely known. Upcontry, several health workers, pharmacists and drug shop staff were also mentioned to prescribe and/or sell medications to facilitate abortion in the home of an aborting mother.

"Sex workers that conduct abortion largely seek assistance from private/ personal medical personnels at especially from clinics in private centers due to fear of stigmatization and discrimination"- **FGD interview with sex workers in lower custom-Kabwiri Road, Kasese District"**

5.3.2 Abortion by Self

The 36 of the 178 respondents (20.2%) indicated that they did administer the process of abortion themselves. This obviously indicates that these too were unsafe, however its key to exermine how this happens and the decision making process. Ofcourse confidentiality is associated with this as many FSWs, however open to each, preffered to still keep issues of abortion to themselves.

5.3.3 Abortion by Traditional Health Care Givers/TBAs;

Only 14 of the 178 respondents had sought the help of TBAs/ traditional health care providers to conduct the abortion.

During the Research and Focus Group Discussions, Traditional medical practitioners were also frequently mentioned to be experts in providing abortion and post-abotion services. What is unique here is that in each area where research took place, Entebbe Abayita Ababiri, Kajjansi, Bwaise, Mukono- Kayunga, Kasese Town, Bweera and others, particular herbalists seemed to be popular and were highly rated because of their success rate and kind heart. They also often seemed to provide counselling and parental advise – specifically to young girls and those who aborted more than once. Unlike in other areas, in Central Uganda Districts of Kampala, Mukono and Wakiso, there was also a mention of "medicine carried from the village, havin been mixed by the elderly relatives, ssengas and jjajas who are not necessarily socially recognised healers. Its belived that knowledge about herbs, medicines and spiritual cures is revealed by the ancestors to lay people who pass it on to their descendants.

5.3.4 Sources that help in abortion

- ✓ Infact if the responses are analysed by urban and rural devide, the three rural districts of Kamwenge, Kasese and Bundibugyo between them only have (10 respondenrs out of the total of 119 who stated that they were helped by professional helth workers to conduct abortion. 91.5% of respondents that visited professional health care workers were in urban districts of Kampala, Wakiso and Mukono vurses the 8.5% from the rural districts.
- ✓ In terms of Self and TBAs, with exception of Kampala, the rural districts indicate a total of 19 respondents combined, while Wakiso and Mukono have 07 respondents only. So out of a combined percentage of all respondents reporting use of TBA and self, the rural districts have 86.3%.
- ✓ The implication is that without established professional services and designated formal centers providing abortion related care services, all these abortions were unsafe and lead to undesired health consquences. None of the respondents indicated that they got support from a public health facility even when some were near by, however its common that after abortion, almost all respondents indicated that they visit government health centers to; (i) comfirm if the abortion was successful (ii) treat the possible complications and do not admit the abortion was induced.

According to this study, we collaborate the findings and conclude that;

- ✓ Majority of abortions among FSWs are induced for economic and health reasons
- ✓ Majority of abortions among FSWs in rural areas are "self administered" or conducted by TBAs and a few who visit health centers still access private health service providers – majority of who are not qualified or equipped to provide the service.
- ✓ Majority of FSWs first attempt to do abortion by themselves and usually seek additional health care services after failing or if and when complications are noticed.
- ✓ Majority of FSWs in urban centers have access to specialized service providers or even those that do "self administration of abortion" are better informed and use more appropriate methods

5.4 Methods and instruments FSW use for abortion?

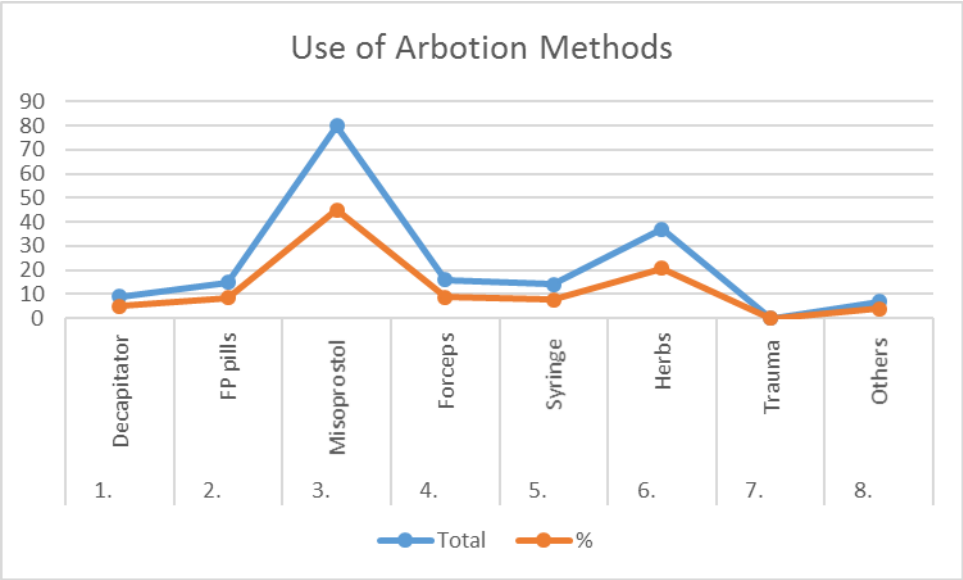
Table 6: *Methods/ Instruments FSWs use to conduct abortion*

Code	Method	K'la	Wakiso	Mukono	Kasese	Kam'nge	Bun'gyo	Total	%
1.	Decapitator	4	2	2	0	0	1	9	5
2.	FP pills	0	8	0	0	0	7	15	8.4
3.	Misoprostol	44	5	10	8	3	10	80	44.9
4.	Forceps	9	2	5	0	0	0	16	8.9
5.	Syringe	10	3	0	0	0	1	14	7.8
6.	Herbs	24	3	3	2	0	5	37	20.7
7.	Trauma	0	0	0	0	0	0	0	0
8.	Others	7	0	0	0	0	0	7	3.9
	Total	**98**	**23**	**20**	**10**	**03**	**24**	**178**	**100**

According Table 6 above, the overall, common methods that FSWs use to conduct abortion are significantly two; the first being Misoprostol (reported by 80 out of 178) which is 44.9%, followed by Herbs/ Herbal medicine and solutions with 37 out of the 178 respondents (20.7%) as the method they used. The rest of the methods are almost equaly used in the same range; forceps, family planning pills, syringe and decapitator come in 3rd to 6th in that rank. The forcep is a tool used to crush, grasp, and pull the inside body apart. There are look-alike local tools that have been designed for a similar purporse. Some of these tools are used by more than one person or the same person using the same tool more than once. Its apparent that these are a possible source of infections. The decapitators are mere sharp instruments that women use to pirce or stab any part of the foetus and once its disintergrated, the pieces are pulled out. Some of these sharp instruments, as the respondents testified, appear in different sizes, types and makes but majority are metallic or steel in nature. The other category are Family Planning Pills used in different sutiations by different persons. They mentioned the use of emergency pills among others.

"Most of the sex workers that conduct abortion make use of a range of different methods and instruments including local medicines such as Luwoko, tea leaves, pills, syringes. Some use nails tied with a rope." **- FGD with Sex work Leaders in Kamwenge District-Kalitunsi This is misplaced, take it to 5.3**

Figure 13: *The descriptive presentation showing the rate of use of select abortion methods*



"My boss, these SWs have to make a choice. You use what you can afford. To my regular clients, an injection, which begins to work within 35 minutes of being administered, costs Shs194,500 ($48). A pill, which takes 45 minutes to induce the abortion, costs 167,000 ($41). The vacuum clean, which removes the fetus in 17 minutes, costs Shs236,000 ($59). Cleaning the womb after the abortion may range from 50,000 ($12) – 100,000 ($25)"
– A private Health Operator in Mukono District stated

Its key to note that these tools and instruments specifically decapitator and forceps are used by and with limited support from trained health workers as in most cases, its fellow sex workers – if not self that administer it. They are usually forged using local metallic or steel materials. A decapitator comes in form of a hand made hook while forceps are just bent steel or metallic materials that are used to damage and pull the dilapidated foetus.

"For me a herbal stick was introduced into cervix and left there to open the cervix. They told me this was to interfere with foetal life. The stick was removed when bleeding started bu the beeding became too much and I was rushed to the hospital for treatment" - **a FSW in Mukono**

This implies that unsafe abortion methods was higher among poorer rural women in Uganda. However, it is possible that reproductive health campaigns and messages have not reached such women in low-income areas. Its also possible to associate risky abortion methods with rampant drug use. It is possible that women using a method may not be utilizing them correctly, particularly if they are under the influence of drugs (especially marijuana and kuba among others)

5.4.1 Use of herbs for abortion among FSWs

Traditional medicine plays a crucial role for 70–90% of the African population as a primary health care option (Antwi-Baffour SS, 2014). The practice of traditional medicine in Africa is a method of healing founded on its own concept of indigenous knowledge systems that

developed over a long period of time within various societies. Being practiced for countless generations well before the introduction of Western medical care, traditional medicine is culturally valued and accepted by most African communities (Mahomoodally MF, 2013) and studies have shown that women in Africa extensively depend on cultural health practices for their maternal health and wellbeing.

According to the WONETHA research, herbs and the traditional plant concoctions are the the second most used by female sex workers in the abortion process (reported by 37 out of the 178 respondents) which is 20.7%. In normal birth, most of these plants are claimed to be oxytocics and are used to induce and maintain labour, help remove the retained placenta, regulate post-partum bleeding and as abortifacient. These plant species also increase the spontaneous activity of the uterus causing increase in contractions. For Kasese District being near the game park, some of the SWs also indicated that some animal products are also used in inducing labour and in the removal of retained placenta such as Hippopotamus amphibious (skin and meat) and Panthera leo (fats and faeces), which are boiled and the cooled decoction taken orally. These medicinal plants are usually taken towards the end of gestation period or at the on-set of labour pains. Some of these medicinal plants are also fed to cows and goats in labour. The commons herbs or plans used for concoctions include;

a) Endod/Phytolaca dodecandra (Oluwoko)
b) Commelina benahalensis (Ennanda)
c) Bidens pilosa/ black jack (Ssere)
d) Tea leaves (Amajaani)
e) Carica papaya L. (Ekippapaali)
f) Sweet potato leaves (Amalagala galumonde)
g) Entegotengo-sodom apple (solunum incarnum)
h) Vernonia auriculifera Hiern (Kikokooma)
i) Hoslundia opposita Vahl (Kamunye)
j) Musa paradisiaca L. var sapientum (Gonja)

These seemed to cut across all the other regions, even when the names often seemed to be different and in some places, the uses too. They are used in different ways as mixtures, concoctions and for different purporses from inducing the abortion process to cleansing.

More detailed information about the types of plant species used and how they were used were provided through in depths interviews with the traditional providers and nurses. Twenty one plant species were identified as commonly being used as abortion-inducing remedies According to the interviewees, most of the plants were taken orally, often in large amounts as a concentrated brew or alternatively chewed. A few of the plant species were used intra-vaginally. Ennanda was one of the most commonly used plants and mentioned by many of the traditional providers and nurses

To understand factors that motivate the use of traditional and complementary medicine among African migrants, the Andersen's sociobehavioural model of health service utilization was used *(Lee YS, 2015).* It posits that health service utilisation depends on three core components which include: predisposing characteristics, enabling resources, and need

factors. This theoretical framework also effectively integrates different factors which may influence the use of traditional and complementary medicine. For instance, predisposing factors such as socio-demographic characteristics (e.g. age, gender, and education), knowledge, perceptions and attitudes, and race/ethnicity have been indicated to influence traditional and complementary medicine use. Likewise, enabling factors such as income, insurance, access to and cost of conventional care have been shown to determine the use of traditional and complementary medicine *(Yussman SM, 2004)*. The need factors have also been consistently found to influence traditional and complementary medicine use based on previous studies. While human behaviors are complex, this model provides a comprehensive framework to describe health behaviors leading to utilization of traditional and complementary therapies.

"For me, they inserted a cassava stem and it tore me. So painful" – **a FSW from Bweera in Kasese.**

Over 60 % of conventional medicines on the global market have been derived either directly or indirectly from natural products, including herbs. This means that alternative/herbal medicines, hereafter herbal medicines, have a variety of biological properties, among them the ability to contract the uterus and thereby induce abortion and/or reduce post-partum bleeding25. Such medication if well researched and produced can be a very good alternative for it will be cheap are accessible. Examples of plants used traditionally to procure abortion, whose uterotonic properties have been formally tested and confirmed, include: Bidens pilosa L., Commelina africana L., Desmodium barbatum (L.) Benth, Manihot esculenta Crantz, Ocimum suave Klilld., Oldenlandia corymbosa L., and Vernonia amygdalina Delile. The use of different plant parts and solvents to obtain a plant's extracts might account for differences in the extracts' biological properties. The highest test concentration of an ethanolic root extract of Bidens pilosa (1.40 mg/ml) decreased rat uterine contractility below the level of spontaneous contractions (i.e. was toxic to the uterine muscle) while a similar concentration (1.43 mg/ml) of an aqueous leaf extract of Bidens pilosa increased uterine contractions[26]. Other uses of herbs in folk medicine have been reported, some being confirmed by formal testing of the herbs' pharmacological activity. Hoslundia opposita is used post-partum to cleanse the uterus of any blood clots and heal vaginal lacerations after abortion or childbirth.

In abortion, some of these solutions are also used by some of the healers to make a local medicinal capsule called "Emumbwa", made from clay mixed with the herbs, then dried for use at any time when a woman is in labour. Special containers made of clay are used to crush this capsule and mixing it with water for oral administration. Emumbwa is widely used in commercial centres, towns and big cities where plants that can be used to quicken birth are not easily obtained and hence a business for the traditional birth attendants and other herbal medicine vendors, who live in towns and cities reported that if such oxytocic plants

[25] Gruber CW, O'Brien M. Uterotonic plants and their bioactive constituents. Planta Med. 2011;77(3):207–20
[26] Nikolajsen T, Nielsen F, Rasch V, Sorensen PH, Ismail F, Kristiansen U, et al. Uterine contraction induced by Tanzanian plants used to induce abortion. J Ethnopharmacol. 2011;137(1):921–5.

are used during the first months of pregnancy, they could induce an abortion. The commonest herbs are grasses called Endod/Phytolaca dodecandra L'Hér (Oluwoko) and Commelina benahalensis (Ennanda)These, especially can and is always administered directly to induce the pregnancy.

When asked if they encountered any effects and complications during abortion, a total number of 111 out of the 178 SWs (62.3%) indicated that they indeed encountered some health complications associated with abortion. In fact in each of the Districts, the number of those that reported complications during abortion almost doubles.

Table 7: *Whether the SWs encountered any complications during abortion*

Code	District	Yes	No	Total
1.	Kampala	58	40	98
2.	Wakiso	15	8	23
3.	Mukono	14	6	20
4.	Kasese	7	3	10
5.	Kamwenge	2	1	03
6.	Bundibugyo	15	9	24
	Total	**111**	**67**	**178**

This comfirms that a significant number of 62% that conduct abortion suffer several complications. These range from situations of incomplete abortion or miscarriage, while many tear or get life threanening injuries. In fact, on further probing, the health workers noted that these are the key reasons for admission to gynaecological wards specifically for FSWs. This report almost gives the same range like a study in 2015 in rural Tanzania, where 125 (67 %) of 187 women admitted with incomplete abortion, when interviewed empathetically, revealed that they had experienced unsafe abortion prior to the current admission[27]

5.5 Reasons to conduct abortion among female sex workers

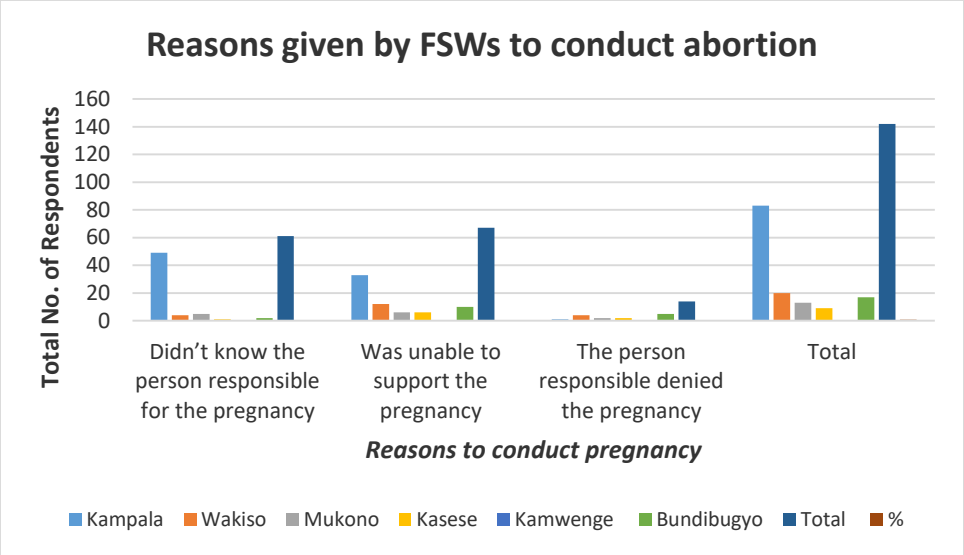
In the WONETHA study, three reasons are significantly cited by FSWs. Out of 178 respondents that conducted abortion;

- ✓ 67 (37.6%) indicated the reason as inability to support the pregnancy
- ✓ 61 (34.2%) did not know the person responsible for the pregnancy
- ✓ 14 (7.8%) the person responsible denied the pregnancy

In total, these three issues in total account for 79.7% of all reasons that FSWs give to conduct abortion.

[27] Unsafe abortion in rural Tanzania - The use of traditional medicine from a patient and a provider perspective (2015)

Figure 14: *Reasons for conducting abortion among FSWs*



"Most sex workers are normally not into conception or getting pregnant since it affects the work they do for aliving." **- The L.C l Chairman Lower custom- Kabwivi Road Kasese.**

"Others conduct abortion since they are never certain of responsible person as a result of engagments with many different men" **- Kll with health worker at Mukono General Hospital, with more emphasis from FGD- Brothel owners,upper cuctoms Kabwiri Road.**

"Most of the sex workers have children but not married, who told you sex workers get married?" **- FGD sex workers, Kalitunsi zone Kamwenge town council.**

"The existence of sex workers is known by several law enforncement persons since they are the body in charge of security. Most of the different entertainment spots especially bars, lodges, city streets and hotels are always occupied with sex workers who embrace such places to target customers either during the day or in the evening hours" **- KII Police in Mukono taxi park police station**

5.6 Implications of abortion on female sex workers

Out of the 111 (62%) who faced health complications, the leading three issues raised included over-bleeding cited by 68 respondents (61.2%), followed by abnominal pain cited by 50 (45%) and blood/ products retentions in the uterus cited by 13 (11.7%). Several of these effects were mixed with others so it as not a case of a single implication per each FSW.

"Most of the sex workers are not educated, and yet they could benefit from adult learning opportunities and capacity building. Some of these things require some bit of education to understand and comprehend" **Kll L.C.l Kamwenge ward - Kalitunsi Zone.**

"Some sex workers fear to take responsibility of the pregenancy since it requires alot of money and time" **- FGD Sex worker Leaders, Kasese.**

"Abortion can real be very painful for SWs. Some use sharp sticks and conduct abortion by themselves." **- FGD Bundibugyo-Tranzane Sex worker leaders.**

Its even possible that these being highly medical terms, the concerned FSWs were unfamiliar with them but the fact that majority of these once probed disclosed they ended up seeking for medical attention specifically in severe cases indicates that the effects could have been greater or more than what they got to know.

"Abortion reduces blood in the body which causes Anaemia, Pelvic inflamatory diseases PID." **KII-Health worker ,Kamwenge Health Centre lll.**

"Abortion is costly and expensive ranging from 100,000/= for proffessional services by a trained medical personnel along with other costs for post abortion services." **- Kll health worker Bundibugyo Hospital.**

"Please help but we are dying. You abort and the whole of you tear. Even a man cannot enjoy sex with you" – **A sex work at Hima Center in Kasese.**

In reference to the above article and several other observations and discussions, Sex workers face the same problem and situation on a more regular basis given their nature of jobs. When asked of the other general/ negative effects and implications of abortion. The FSWs listed several that included social and economic implications. Many of the FSWs were affected by;

- Stopping work
- The effecr that prolonged hospitalization would have on their business/ sex work, which would cause financial problems
- The stigma, trauma and psychosocial effects associated with pain that they went through and also "losing a child"
- Some were worried about the possible arrest and imprisonment by their husbands or partners

"The most common health implications that sex workers face is mainly heavy and continous bleeding which affects their work operations. Eeeeeh. Especially these new young SWs. They can bleed, stink and you feel sorry for them" – **Kll with a heatlhy worker - Kamwenge Health Centre lll.**

"Sex workers that conduct abortion face a range of health complications mostly permanent Damages of the reproductive system since some of them use so many elementary methods such as using sharp sticks, nails."KII **- Health Centre lll Bundibugyo Hospital.**

5.7 Availability and accessibility to services

The significant range of barriers within health-care settings suggests the need for approaches that would enable FSWs to access and use appropriate health services. Strategies to address stigma and discrimination in the health sector include sensitization of providers and all staff on the reproductive rights and options of women in general and training in the delivery of confidential counseling free of stigma and judgment. Younger FSWs may need more tailored,

innovative efforts, such as DICES, targeted outreach and peer support, or application of mobile phone technologies to help deliver services (Onyango 2015). Training to improve providers' counseling and communication skills should address the full range of affordable contraceptive options, including dual-method contraception, LARCs (Lim 2015), and emergency contraception as a backup method to prevent unwanted pregnancy, including in situations of force (Erickson et al. 2015; Schwartz, Papworth, Thiam-Niangoin, et al. 2015).

Members of key populations face wide-ranging social, economic, and political barriers to health care. Compared to the general population, members of key populations are misproportionately affected by violence, particularly sexual violence from sex-seeking clients, nonpaying partners, and police. They often experience stigma and discrimination in health care settings, and punitive laws restrict their ability to advocate for their own health and human rights—including their reproductive rights and fertility intentions. Given these challenges, concerted efforts are needed to ensure that key populations have access to high-quality family planning and reproductive health services, including voluntary, informed-choice counseling and a wide range of effective contraceptive options.

"There is no treatment at all. Fo abortion, you have to go to Mbarara clinics, which is another District and so many kilometers away from here. Just abortion and you cannot access services even when you have your money?. Terrible!!! **KII- SW Leader ,Kasese District.**

"A Sex work cant dare face a government work in their hospital that they have come to do abortion. Even if it were me. They will abuse you, call you all sorts of names, eat your money for such poor services. I think they can even call police for you. No, no no no!!!!." – **FGD with Brothel owners Kasese District.**

Unmet need for modern contraception has also remained nearly unchanged and at a high level during the past decade. According to the 2011 UDHS, the proportion of married women having an unmet need for modern contraception—that is, those women who either do not want a child in the next two years or do not want any (more) children, and are using a traditional method of contraception (periodic abstinence, withdrawal) or none at all—was 38%, a proportion that is lower than ten years ago (51%), yet still high. Moreover, the level of unmet need among sexually active unmarried women has not changed at all and is currently greater than that of married women—45%. Despite improvement among married women, levels of unmet need for modern contraception in Uganda are still some of the highest in Sub-Saharan Africa[28].

"We know the services for FSWs especially in rural areas are scarce and not accessible. It will be our dream from this report to see how this gap can be addressed." **Kll- WONETHA Staff Kampala District- Makindye division.**

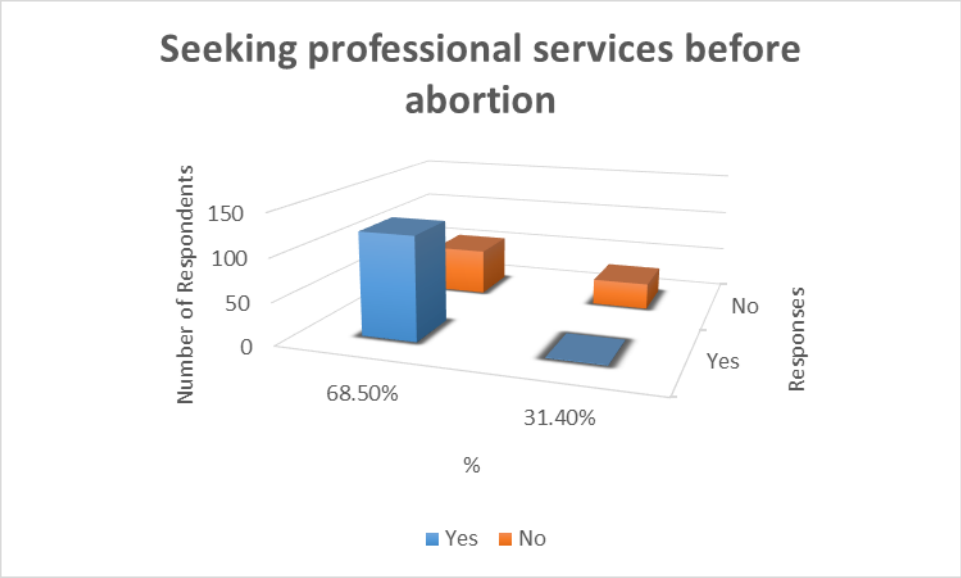
[28] Westoff C. Unmet need for modern contraceptive methods. Calverton, MD: ICF International; 2012. Report No.: 28.

" There are services offered at the Padre Pio and Kamwenge Health Centre lll where the sex workers have a focal health personel who responds to all their health related concerns" - **Kll Health worker at kamwenge Health center lll.**

"Sex workers need to visit Health facilities to seek for proffessional services on all relevant health issues so that they can get informed as well as be responsive towards out reach programs in communities to benefit from arange of health services." **Kll L.C 1 chaiman Butebe Zone-Mukono district.**

5.6.1 Those who sought any professional health services during abortion

Figure 15: *Whether the Sex Workers seek for professional services in the abortion process*



The research sought to establish if the participants seek for professional services (services from trained health workers and at centers). Over 68.5% seek for services against the 31.4% although on further assessment, the following information was generated. It shows that a very good number of participants are keen to sek for professional health services. The challenge may be other factors that limit access like distance, lack of trained service providers at the health centers and or lack of knowledge about where services can be accessed.

Table 8: *A table showing providers based on where abortion services were sought*

Sr.	Nature of Facility	Rate	Percentage
1.	Government Health Centres	18	18%
2.	Private Health Centres	75	76%
3.	Traditional Health Providers	05	5%
4.	Others	0	0%
	Total	**98**	**100%**

As for figure 20 above, among those who chose to seek for professional health services, the majority (76%) sought for services from private health centers and only 18% from

government centers. This further tells an important story that there are hinderances to service seeking and access by FSWs in government and private facilities hence the choices. These hinderances need to be addressed.

Table 9: *A table showing reasons given by those who did not seek for profeesional health services during abortion*

Sr.	Nature of Facility	Percentage
1.	Did not know of the availability of the service	25%
2.	Could not afford the cost of professional services	25%
3.	Fear to be criminalised	9%
4.	Did not think needed professional health services	12%
5.	Others	29%
	Total	**100**

There was also further inquest about the reasons why those who did not seek professional services, decided so. The four (04) dominant reasons as listed in the table above show that 50% of the FSWs did not access the services because were unaware of its availability as well as worried about the high cost. This brings out the key hinderances to FSWs accessing abortion related professional health services.

5.7 The Study challenges and Limitations

1. Work schedules of Sex workers were incovienienced during the research. Many FSWs preffered to be interviewed from their workplaces and during less busy hours which were largely nights
2. Language barrier was an issue in some areas given the unanticipated movement and resetellemnt of sex workers whose languages were different from the region. The research team abandoned some sessions due to communication challenges.
3. Many of the sampled research spots were distant and with very bad roads. It was always long and expensive to travel in some places which strained the research budget.
4. The research topic; abortion among FSWs - was very sensitive to many respondents (urban or rural). Even when greater levels of personal confidentiality was observed, some FSWs rejected participation – even after consent - for personal reasons.
5. It was visibly apparent during the discusions and interviews that several FSWs in the survey were reserved and tense. The research team related and interpreted this as a sign of extreme stigma among FSWs on key issues in reproductive health like abortion.
6. There was general lack of basic knowledge on HIV/ AIDS and STDs by FSWs especially those operating in rural areas. This also implied general lack of knowledge on abortion
7. There was limited references and literature on FSWs and abortion. A lot of the literature was old and foreign. The team quoted these for references including a few new ones.

CHAPTER SIX:
CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

The research was intended to establish the number of female sex workers that conduct abortion in Uganda, understand abortion and reproductive health challenges they face and generate policy needs and gaps that require advocacy to improve Sexual Reproductive Health in Uganda. Notably, findings established that abortion is very high among female sex workers at a rate of 43.7%. There is critical need for comprehensive reproductive health services (including abortion and post-abortion care).

To find their way out of unintended and unwanted pregnancies, the study figures indicate that a higher number of female sex workers resort to induced abortions using crude methods that expose them to serious health complications which often incrementally drive their vulnerability to HIV and AIDS, Sexually Transmitted Diseases and a revolving cycle of poverty caused by long treatment periods and inability to work.

Available strategies and interventions to address high rates of abortion in Uganda are being hindered by unfriendly and unclear policy environment. This limits availability, access and utilization of services by the female sex workers.

6.2 Reccomendations

Key Population CSOs, Human Rights, Policy agencies and Human Rightsts should identify and address the legal lacuna and policy puzzle surrounding abortion in Uganda. There is adequate information both legal and medical to cease cease the opportunity to engage at policy level.

The need for information, knowledge and access to reproductive health services, family planning and HIV prevention is still so huge among FSWs. Agencies engaged in advocacy and human rights need to intergrate and roll out related Information, Education and Communication to this community. This is exhibited by the study findings that indicate;

- Hight rate of FSWs conducting abortion
- Different ways and methods female sex workers conduct abortion
- Reasons among female sex workers for conducting abortion
- Implications abortion has on female sex workers
- Availability and accessibility to services for female sex workers for abortion care

1. The Ministry of Health needs to take lead in providing capacity and policy guidance as related to addressing the widening reproductive health and family planning services gap. This will involve further research, training specialised health workers, boosting the policy

discussions to come up need based working guidelines and protocols, provision of relevant kits and the required medications and encouraging use of modern, more effective and less invasive methods of reproductive health particularly misoprostol.

2. The coverage of reproductive and family planning services needs to be expanded to reach women with specific reproductive health vulenrabilities; rural women, female sex workers and those is restricted settings like prisons, camps and institions of learning. This is because these are more prone to undesired pregnancies, hence the pressure to conduct abortion. In the process, they will face complications as they experience difficulty in accessing health services to obtain obtain medical care. In the study, for distant districts like Kasese and Kamwenge, it came out that even basic centers to access reproductive health services; even as basic as mere information are very scarc, inaccessible or lack the specialised personnel, equipment and friendliness (confidentiality and experience) for vulnerable women like SWs to openly access the services.

3. There is need to train and create further awareness of the health practioners of the needs and gaps of PAC and have them incorporated into their routine service provision. During the FGDs with health professionals specifically in Bundubugyo and Kamwenge Districts, they too admitted that its very difficult for SWs to get treatment in public medical facilities on issues concerning abortion or post abortion complications. These health professionals believed that stigma, discrimination, victimization, redicule and fear of mistreatment at health care facilities is a primary barrier for women seeking Post Abortion Care services.

4. The Ministry of Health should lead the orientation of all health workers to eneble them provide voluntary, informed choice family planning and safer conception counseling to women. For FSWs, targeted interventions should be implemented to expand their access to antenatal care, including HIV testing and retesting during pregnancy, and increase their enrollment and retention in prevention of mother-to-child transmission (PMTCT) services. Given their disproportionately high rates of abortion, members of key populations have a high unmet need for safe abortion services and post-abortion care but this should serve as an entry point for family planning services or referrals.

5. Policy makers, Ministry of Health and health care workers are required to increase their curiosity and knowledge about womens' cultural health practices and ensure that they tailor health interventions in a way that is culturally sensitive and responsive to health services when caring for FSWs. The Government of Uganda, development partners, research institutions and CSOs should support and conduct further research that explores specific traditional and complementary medicines, practices and products to establish its implications or effects in terms of safety, effectiveness, appropriateness as treatment option for reproductive health related diseases. Traditional and herbal medicine in Uganda serves as a form of primary health care for more than 80% of the populations. This too includes the sex workers as the study indicates that use is wide

and popular especially in the context of missing or expensive reproductive heahth care services.

6. Since the law and policies in Uganda governing abortion lack clarity and consistency, it is difficult for providers and women to know what to do when faced with an abortion decision, leaving many FSWs to consider obtaining unsafe alternatives. In service of helping more FSWs avoid risking their health and lives, the laws and policies around abortion should be better clarified and there should be efforts to increase awareness of these policies among the medical community, the judiciary system and the women themselves. Health authorities both government and private should also ensure that safe services are available and affordable, that health facilities are equipped appropriately, and that health care providers are trained to provide adequate quality of care.

7. WONETHA in the short run, needs to widely disseminate this study report and its findings and encourage its staff, stakeholders; government agencies, CSOs and donors to intergrate relevant findings into programming for sex worker community interventions. Such programs may involve intensified condom promotion activities, training and sensitization on HIV and AIDS prevention and treatment, intergration of reproductive health into community outreaches among others.

8. WONETHA needs to strengthen its research capacity as an intergral unit of the agency. This will help the organisation generate more health related facts and information as regarding FSWs which information as noted in the challenges is a critical gap.

9. WONETHA also needs to raise more funds and resources to conduct further research on some key issues raised in this research and findings but appear inconclusive hence require additional investigation; effects of income levels on abortion among FSWs, causes and drivers to increased abortion among FSWs, the relationship between abortion and HIV/AIDS among female SWs in Uganda and others

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