FAMILY PLANNING UPTAKE AMONG FEMALE SEX WORKERS IN KAWEMPE DIVISION KAMPALA

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UGANDA CHRISTIAN UNIVERSITY

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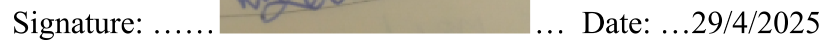
DECLARATION

I, **BERINA KAMAHORO** do hereby declare that the information given in this dissertation is my original work and has never been presented by any student for the award of any qualification whatsoever.

Signature: ……… Date: …29/4/2025

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APPROVAL

This is to certify that this dissertation has been under my supervision and is now ready for examination in fulfillment of the requirement for the award of Masters of Public Health degree of Uganda Christian University.

Signature: Date: 30th April 2025

Dr. Edward Kibikyo Mukooza

DEDICATION

This work is dedicated to the almighty God, my loved husband, my dear children and my sisters and brothers, my in-laws whose love, care and support I shared both morally and physically. Above all I want to honor, respect and appreciate my friends and colleagues for their love and mentorship.

To God the glory.

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LIST OF ABREVIATIONS

FSW	Female Sex Workers
HIV	Human Immune-deficiency Virus
H/C	Health Centre
RH	Reproductive Health
DHIS II	District Information Management System 2
DHO	District Health Officer
HMIS2	Health Management Information System 2
KII	Key Informant Interview
MOH	Ministry of Health
UDHS	Uganda Demographic and Health Survey
ANC	Antenatal Care
WHO	World Health Organization
PNFP	Private Not for Profit
PFP	Private for Profit
KCCA	Kampala Capital City Authority

DEFINITION OF TERMS

Reproductive Years: The average years in which a woman is able to have children

Uptake: The act of accepting or taking up something on offer or something available

Female commercial sex workers: women selling sex in exchange for money or goods

Prevalence of female sex workers: The proportion of FSW in the estimated sample size

Direct Female Sex Workers: These are typically women who do define themselves as sex workers and earn their living by selling sex

Indirect Female Sex Workers are women for whom sex work is not the first source of income

ABSTRACT

Introduction

The study aimed to investigate the factors associated with Family Planning uptake among Female Sex Workers of reproductive age (15-49 years) in Kawempe division. The study objectives were; 1)to assess the proportion of FSW utilizing Family Planning in Kawempe Division, 2) to determine factors affecting utilization of Family Planning among commercial sex workers in Kawempe Division, and 3) to explore barriers to utilization of Family Planning among female commercial sex workers in Kawempe Division.

Method

The study adopted a descriptive and correlational research design with both qualitative and quantitative data collection method. A total of 334 commercial female sex workers were randomly selected from the community. Data was collected using a pretested questionnaire, and administered by the research assistant that were trained to conduct this survey. Qualitative data was collected from 5 key informant interviews. Quantitative data were analyzed using logistic regression to establish factors affecting uptake of Family Planning.

Results

The findings indicated that out of 332 respondents, 251 (75.6%) of them reported that they were currently using family planning, majority 120(47.8%) reported using condom, followed by 91(36.2%) of the respondents who reported using injecta plan

The multivariate logistic regression analysis reveals , age(AOR=4.6; 95% CI: 1.22- 7.12; p= 0.000),, marital status (AOR=0.8; 95% CI: 1.44- 8.09; p= 0.002), educational level(AOR=4.6; 95% CI: 0.01- 8.67; p= 0.001),, distance to the facility(AOR=6.2; 95% CI: 1.73- 9.85; p= 0.002), reasons for not using family planning(AOR=0.8; 95% CI: 1.80- 4.43; p= 0.000),and waiting time at the facility(AOR=5.2; 95% CI: 2.06- 9.88; p= 0.000), independently influenced the uptake of family planning among female sex workers. P-value <0.05

The barrier to family planning among were fear of health risks like cancer, stigmatization from health professionals, lack of knowledge about service locations, time constraints, and financial issues among others

Conclusion

This study established that the uptake of family planning among female sex workers stood at 75.6%. This below the target considering the fact that it is expected that 100% of female sex

workers should be on some family planning method. Female sex workers experience exclusion in utilizing reproductive healthcare services. As such, healthcare services are advised to adopt a nonjudgmental approach, to enhance physical accessibility and to train nurses and other healthcare professionals on reproductive health needs of female sex workers.

CHAPTER ONE: INTRODUCTION

1.1 Background

World Health Organization defines Family Planning as "the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility" [WHO, 2008]). Family Planning is important to individuals, as well as to families, communities, and societies (AGI, 2003). Family Planning serves three critical needs: (1) it helps couples avoid unintended pregnancies; (2) it reduces the spread of sexually transmitted diseases (STDs); and (3) by addressing the problem of STDs, it helps reduce rates of infertility (AGI, 2003). Family Planning use is divided in two methods namely; use of dual method like contraception and other barrier method like condom use, however it should be noted that contraceptives only (Single method) do not protect one from getting sexually transmitted infections including HIV.

Global Commitments have been made with countries to integrate the WHO eligibility criteria Family Planning wheel and related tools and guidelines into health systems to expand access to and quality of life, addressing barriers, and strengthen programs and working with countries with the highest levels of unmet needs to examine inequalities, vulnerabilities and reasons for un met need for Family Planning (WHO, 2012)

Worldwide, there are estimated to be over 40 million commercial sex workers who engage in this work for financial benefits and in some countries sex workers have been indoctrinated in it. It is thought that 80% of such commercial sex workers in the world are women, ranging from 13 to 25 years (Taylor-Robinson *et al., 2021*)

It is also worth noting that many engage in this work happily through choice and because it may be financially rewarding , there are still some people in certain parts of the world where choice is not necessarily an option.

The known hindrances to Family Planning services among commercial sex workers are rooted from different angles that involve; the health system attitude of health care workers towards commercial sex workers, community related like un supportive policy environment, potential threat of legal consequences , and individual factors like perceived stigma and discrimination, inadequate negotiation skills to use condoms, condom bursting and too much alcoholism surrounding their work which takes away their ability to make informed

decisions, increased violence, ravaging poverty, ignorance of the available maternal services , peer pressure, cultural beliefs, education levels, age among others (Mbonye et al' 2013).

While evidence from Sub-Saharan Africa is limited on this particular group, studies in Zambia, Uganda, and Cote D'Ivoire have shown that unwanted pregnancy among FSWs is common; in Zambia, more than half of surveyed FSW reported at least one unplanned pregnancy. Qualitative research in Ethiopia found that missed injections, skipped pills, and inconsistent condom use were the major factors for unintended pregnancy among FSWs. A recent study in Tanzania among FSW living with HIV found that while most wanted to prevent pregnancy, only 4% were using dual methods, and only 5% reported using condoms consistently (**Bec**kham et al, 2021**).**

In sub–Saharan Africa (SSA) Female sex workers (FSW) are at a heightened risk for unintended pregnancy as well as for HIV and other sexually transmitted infections (STI), demonstrating a high unmet need for Family Planning (FP). Reducing the vast unmet need for Family Planning remains a massive challenge to countries and the global health community, Uganda inclusive. Services are still poor quality and sometimes unavailable in many settings while service delivery and social constraints persist (Ekpenyong, 2011)**.** Sex work is common in sub- Saharan Africa, estimated at 1.4%-8.7% of women admitting that they have exchanged sex for money or goods or favors with higher concentration in urban areas, port cities and major highways (Vandepitte, 2006)

In Uganda female commercial sex workers fall under the category of key population with limited power to negotiate for safer and protected sex leaving the sole decision to their partners.

Compromises by the FSWs are prompted by the higher payments offered by the male sexual partners as opposed to protected sex which is costly lowly. Unsafe sex practices lead to unplanned pregnancies and sometimes results in unsafe abortions. Studies indicate that whereas Family Planning methods exist, not every woman is provided with a conducive environment to utilize them. The enforcement trends of laws affecting sex workers show mixed signals with strict and overzealous enforcement of selected criminal provisions and a general apathy towards Female commercial sex workers where the media often takes their pictures during and after their arrests and publish these images exposing them as sex workers. The exposure of a dual identity increases their vulnerability resulting into stigma, oppression and violations of sex workers rights and hence disrupting their access to Family Planning services (Frances et al., 2016).

Studies conducted among the fishing communities along lake Victoria indicate that 39 per 1,000 females aged 15-49 were involved in abortion in 2013.This figure indicates around 314,300 abortions which was far higher than the East African region rate at 34 per 1000 in 2010 and 2014. More over treating post abortion complications pose a huge challenge for a country like Uganda with already weak health care system that is burdened by other epidemics and morbidities (Matovu. et al 2021)

Kawempe Division is one of the five Kampala City Divisions with a total population estimated at 265, 0000 ,with heavily congested households, taking lead among the divisions in Kampala with slums and high human activity, exposing residents to a number of challenges including teenage pregnancies, commercial sex work, and unsafe abortion. (National population census 2002).

In a study commissioned by KCCA in May 2013 through the Alliance of mayors and Municipal leaders Uganda, found out that Kawempe is a division with the most sex worker hot spots estimated at 23% which is the highest number compared to other divisions like Rubaga with 17 %. (Kagolo, 2013). Kawempe is ranked second with 21% (297) of health facilities where Family Planning services are offered among other clinical care services.

In terms of facilities available per facility, low is a table detailing the comparison in distribution of health facilities in Kampala Capital City Authority?

Table 1. 1. Distribution of health facilities in Kampala Capital City Authority

Division	No. Of Government Facilities	No. Of Private For-Profit Facilities	No. Of Private Not For Profit Facilities	Total
KAWEMPE	4	284	9	297
RUBAGA	2	275	12	289
MAKINDYE	4	369	9	382
NAKAWA	7	251	11	269
KAMPALA CENTRAL	9	196	14	219
TOTAL	26	1375	55	1456

Kawempe has 4 health facilities which are government aided, 284 are PFP (Private for profit), 9 are PNFP, Rubaga has 285 (20%) government aided are 2, PFP are271 and PNFP are 12, Makindye has 378 (26%) with only 4 government aided,365 PFP, and 9 PNFP, Nakawa with 269 (19%) 7 government aided, 251 PFP and 11 PNFP, Kampala Central with 219 (15%)9 government aided,196 PFP, and 14 PNFP (KCCA CENSUS REPORT, 2017)

A Survey conducted in May 2022 indicates that Kawempe division is ranked highest with 23% (61) sex worker hot spots, followed by Rubaga,17% (56), Central with 55, Makindye with 52, and finally Nakawa has 44 sex worker hot spots. Kimombasa in Bwaise Kawempe Division ranked among the top five booming hot spots for sex work (Catherine, 2022). Majority of the sex workers use alcohol and other substances as a coping mechanism against the emotional and physical challenges that they face while engaging with multiple sexual contacts, leading to violence, and sometimes death. (Martin, et al' 2013)
UDHS 2022 estimates 310–438 women die of pregnancy-related causes per 100,000 live births, and non-use of Family Planning services among FSWs may contribute to this high maternal mortality estimated at 189/100,000. Moreover, treating post abortion complications poses a huge challenge for a country like Uganda with an already weak health care system that is burdened by other epidemics and morbidities.

1.2 Problem Statement

There is low Family Planning services uptake among FSWs in Kampala and in Uganda as a whole. Given the work of the FSWs with high levels of exposure to pregnancy and STIs, the ideal would be that all of them should be using Family Planning to prevent disease and unwanted pregnancy.
However, literature estimates Family Planning uptake at 67% of the FSWs who are using any one form of Family Planning leaving out 33% not using any form of Family Planning to prevent pregnancy and disease (Hakim, et al., 2022), yet given the nature of the work and the risks involved in by Female Sex workers, Family Planning utilization should be more than 67%
Government has established health facilities in every sub-county and divisions by accrediting H/C II to H/CIII and then H/III to H/VI, developed good maternal care guidelines and policies to increase access to maternal services (Hakim, et al., 2022). Kawempe Division has 297 health facilities but it is not clear why uptake of Family Planning by FSW is still low at 67% despite availability of FP services (KCCA Census Report, 2017).

Moreover, Sex trade is a well-established business in Kampala City, and the Ministry of Health puts this trade as highest in Kawempe Division with an estimated 2,540 sex workers, followed by Rubaga with 1,687, and lowest in Nakawa division (Catherine,2022)

It is therefore against this background that a study on factors affecting use of family planning among female sex workers in Kawempe was carried out

1.3. General objective

To explore factors associated with Family Planning uptake among Female Sex Workers of reproductive age (15-49 years) in Kawempe division.

1.3.1: Specific Objectives

1) To assess the proportion of FSW utilizing Family Planning in Kawempe Division
2) To determine factors affecting utilization of Family Planning among commercial sex workers in Kawempe Division.
3) To explore barriers to utilization of Family Planning among female commercial sex workers in Kawempe Division

1.4. Research Questions

1) What is the proportion of utilization of Family Planning among Female sex workers in Kawempe Division?
2) What are the factors that affect uptake of Family Planning services among Female Sex Workers in Kawempe Division?
3) What are the barriers to utilization of Family Planning among Female Sex Workers in Kawempe Division?

1.5. Justification

The study findings generated evidence needed by the ministry of health and other stakeholders to inform appropriate interventions to promote Family Planning uptake among FSWs and to reduce maternal mortality in Kawempe division, and the whole country.

1.6. Scope of the study

1.6.1. Content scope

This study looked at family planning uptake among female sex workers in Kawempe division Kampala

1.6.2. Geographical scope

The study was carried out in Kawempe one of the divisions of Kampala

1.6.3. Time scope

The study was carried out in the months of September-October 2024

1.7. Conceptual frame work

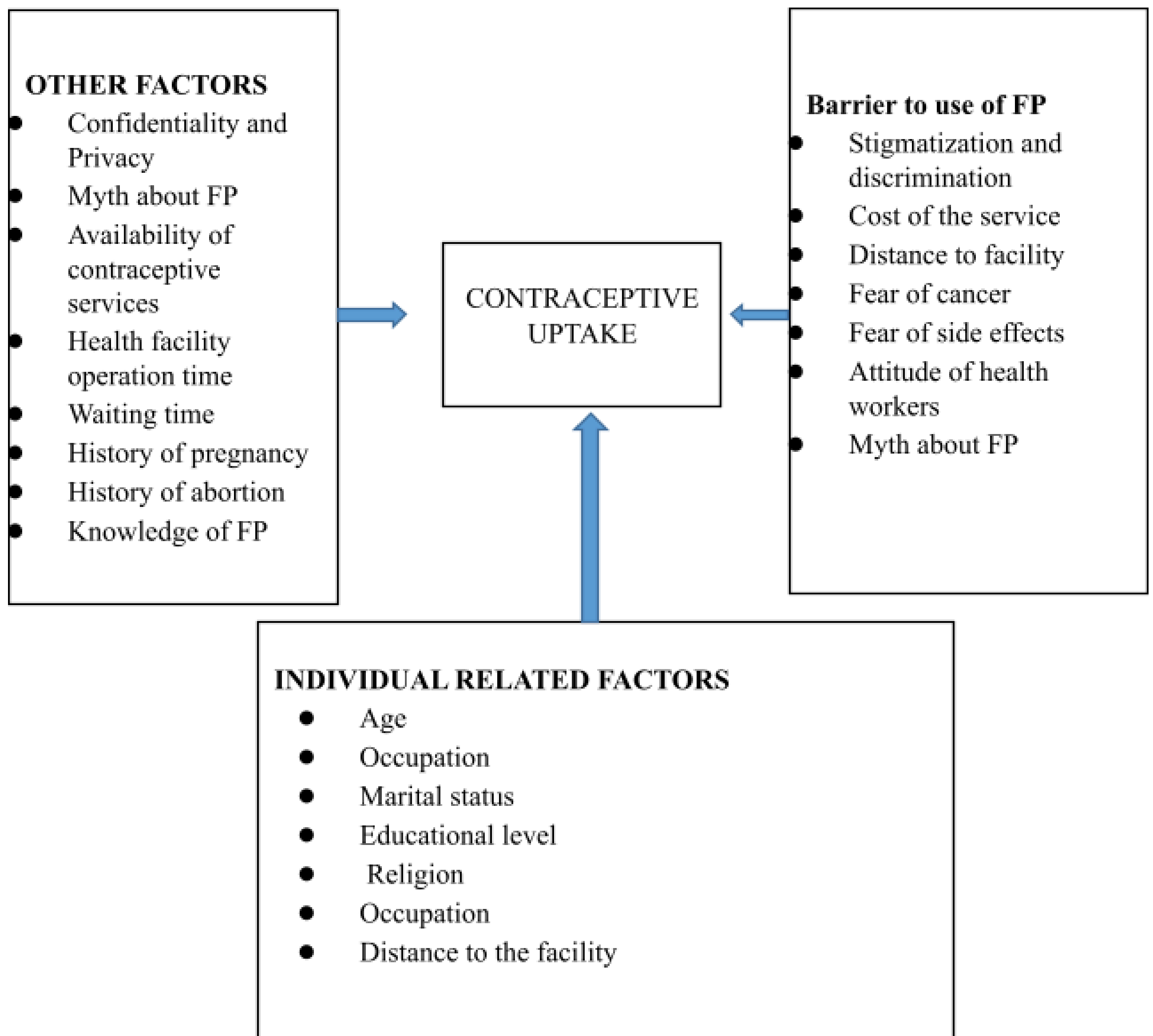

Figure 1. 1; Conceptual frame work showing relationship between uptake of contraceptive services and associated factors. Framework adapted from Andersen's behavioral Model Andersen and RM.1995

1.7.0 Conceptual Framework Narrative

The conceptual framework adapted from (Andersen, Ronald 1995) highlights the Individual factors, Community factors and Health System related factors that affect uptake of Family Planning services among the female commercial sex workers.

1.7.1. Dependent Variable

The dependent variable in this study was utilization of Family Planning. The emphasis was on current use of family planning

1.7.2 Independent Variables

The independent variables include; confidentiality, and availability of Family Planning services, stigma and discrimination, age, gender, marital status, and occupation among others. These variables are categorized into health system, individual and barriers to use of family planning.

The above conceptual frame work is based on the Health Belief Model (HBM) which suggests that individuals are more likely to engage in health-promoting behaviors if they perceive a threat to their health (perceived susceptibility and severity), believe that a specific behavior will be effective in reducing the threat (perceived benefits), and feel confident in their ability to perform the behavior (self-efficacy), while also perceiving few barriers to taking action. As such uptake of family planning among FSW will largely depend on the perceived susceptibility to pregnancy where those at high risk are expected to report a high uptake.

Also the FSW who believed that family planning is more effective in preventing unwanted pregnancy and STI, recorded a higher uptake compared to those who report fear for use of family planning because of related side effects and myth

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

The WHO defines sex workers as individuals (male, female, or transgender) aged 18 and above who receive money or goods in exchange for sexual services, either regularly or occasionally. This definition emphasizes that sex work involves adults and consensual acts, excluding acts involving deceit, fraud, coercion, or violence (WHO, 2022)

Globally, Female Sex workers face disproportionately greater challenges in accessing and utilizing sexual and reproductive health (SRH) services, including Family Planning contributing to poor sexual and reproductive health (SRH) outcomes including unintended pregnancies (Bukenya at al., 2019)
In sub Saharan Africa, studies indicate that the proportion of FSWs who experience un wanted pregnancies vary according to countries, for example in Gambia its estimated at 23.8%,Kenya estimated at 24.0%, Ethiopia at 28.6%,Uganda 44.0% and Zambia at 61.6% (Bukenya et al 2019).The over aching dynamics surrounding Female sex work with associated difficulties in utilisation of Family Planning and un safe sex practices results into un wanted pregnancies some of which ends up in unsafe abortion ,HIV/STI infections, stigmatization, morbidity and mortality. UNAIDS Report 2014 indicates that HIV prevalence among Sex Workers is 12 times greater than among the populations.This analysis was conducted in SSA where HIV prevalence was estimated at 37% among sex workers.
The utilization of Family Planning is still low at 51% among sexually active unmarried women despite having free Family Planning services in public health facilities. In Uganda, a study conducted in Gulu district, among 400 FSWs indicated that dual contraception was at 45.0% while only 49.9% had ever used hormonal contraceptives. The same study, showed a high number of unplanned pregnancies reported among FSWs that ended in abortions (Bukenya et al, 2019)
Further studies indicate that the poor and vulnerable especially female commercial sex workers experience a greater burden of disease and moreover, with lower access to health services than the less poor. Barriers to access arise from both the service providers and the consumers, Distance to service points, perceived quality of care , availability of drugs, lack of skilled staff in public facilities, late referrals, health worker attitude, costs of care and lack of knowledge of existing Family Planning services are key determinants of utilization (Kiwanuka, et al., 2008)

More studies from Kenya indicate Family Planning use and abortion history among Nairobi FSWs. From Octor 2010 to January 2011, statistics show that 15% had had an abortion and 6% had a positive pregnancy test. The study concluded that FSWs in Nairobi may have substantial unmet need for contraception and are at heightened risk of unwanted pregnancy and vertical HIV transmission. Strengthened integration of reproductive health and HIV prevention interventions are needed in this population (Frances et al, 2016)
Further, findings indicate that utilization of Family Planning is still low at 51% among sexually active unmarried women despite having free Family Planning services in public health facilities. In Uganda, a study conducted in Gulu district, among 400 FSWs indicated that dual contraception was at 45.0% while only 49.9% had ever used hormonal contraceptives. The same study, showed a high numr of unplanned pregnancies reported among FSWs that ended in abortions (Bukenya et al, 2019)
In Uganda, studies indicate that whereas Family Planning methods exist, not every woman is provided a conducive environment to utilize them. The enforcement trends of laws affecting sex workers show mixed signals with strict and overzealous enforcement of selected criminal provisions and a general apathy towards Female commercial sex workers. The study finds that, whether enforced or not, the presence of laws which affect sex work feeds into the stigma, oppression and violations of sex workers prompting them to acquire un intended pregnancies, contributing to the current high mortality rate in Uganda estimated at 343/100,000 Live births, increased HIV transmission and un safe abortion (Frances et al, 2016)

Despite interventions on ensuring availability of Family Planning services and other Reproductive, maternal and adolescent services, a proportion of female commercial sex workers of reproductive age continue to face utilization challenges. Hence disproportionately affecting them making them more vulnerable and at risk to many other reproductive health related illnesses. Further literature indicate that the rights of sex workers are frequently violated in Kampala with frequent arrests by the Ugandan police and subsequently impeding their uptake of Family Planning services (Enviado et al' 2016)
Therefore, commercial sex workers like other vulnerable and marginalized are entitled to equality of healthcare access under international law which emphasizes that uptake to health care which includes Family Planning, is a human right and that governments should mindful of their obligations to all their citizens. The constitution of Uganda also emphasizes the right to health care in Chapter 2 Article 21 clause 1) stating that; without prejudice of this article, a

person shall not discriminate against on the ground of sex, race, colour, ethnic origin, tri, birth, creed or religion, or social or economic standing, political opinion or disability"
Further literature in post conflict northern Uganda indicates that up to 49% of all pregnancies in the low- and middle-income countries were unintended. This hence possess a high magnitude of unintended pregnancy in the LMICs possessing a public health challenge to the national healthcare systems. Among the female sex workers (FSWs), unintended pregnancy is a common issue estimated at a rate of 27.1 per 100 person-years. However, most of these unintended pregnancies among the FSWs result in induced abortions that lead to severe and often life-threatening post-abortion complications. Another predisposing factor is multiple sexual partners, with high frequencies of sexual intercourse where power to negotiate for safer sex is not vested in their hands, and hence contributing to unintended pregnancy among FSWs (Nazarious et' al ,2022)
while several studies have en conducted among FSWs in Low and Middle income countries where Uganda is among, critical attention aimed at increasing access to Family Planning among FSWs, need to considered to increase the proportions of FSWs who use the more effective and reliable Family Planning methods, to fulfill their contraception needs especially in urban slum settings. Increasing the uptake of Family Planning among FSWs in urban slum settings requires a good understanding of the factors affecting Family Planning uptake, which remains understudied at length in Kampala City. This study therefore, aims to find out the factors affecting Family Planning uptake among the FSWs in Kawempe Division, Kampala district. Increasing the uptake of Family Planning was contribute to a reduction in the high rates of unintended pregnancy and induced abortion among FSWs and thus improving their overall sexual and reproductive health outcomes (Yam, et' al 2019).

This study was aim at exploring critical barriers to Family Planning uptake among FSWs operating in Kawempe Division Kampala City, Uganda. The study findings were generate the evidence needed by the Ministry of Health and other stakeholders to inform appropriate interventions to promote Family Planning uptake among FSWs.

2.2. Family Planning uptake scholarly view

In most countries in Africa commercial sex workers operate illegally with threats of imprisonment or police harassment. This global problem is highlighted by a campaign from Amnesty International which begun in 2016. However, there are differing models of social control with respect to commercial sex workers enacted into legislation. These laws vary from Nordic countries, where it is illegal to buy sex, but not to sell the use of one's own body

(Sweden), through various local governmental regulatory models (The Netherlands, Germany, Austria) to decriminalization (New Zealand and specific states of Australia).

While the Netherlands has not decriminalized commercial sex work, it has a regulatory model that brings it within the surveillance of local municipal agencies. The policy on commercial sex work in Netherlands is relatively flexible, compared to other countries, because it provides for sex workers to earn a taxable but pensionable wage, have access to social security and do not have to worry about police brutality, cause society for the most part of the country has recognized that they perform a function for the oppressed, confused, psychologically disturb or even just the curious who consciously choose to engage their bodies for sexual services.

Most commercial sex workers in other countries apart from Netherlands, around the world are vulnerable, often underage and need to protected and supported to access reproductive services especially Family cause there is no amount of Legislation that was ever stamp out such work, as it still occurs even in the strictest regimes today (Taylor, *et al 2021)*

According to a study on Family planning use and correlates among female sex workers in a community empowerment HIV prevention intervention in Iringa Beckham et al established that Among the 339 participants with follow-up data on family planning, 60% reported current family planning use and 6% reported dual use of modern contraception and condoms. In the same study Beckham et al showed that Around 84% of participants had ever used contraception and over 60% were currently using contraception. (Beckham et al, 2021)

In the study of Factors associated with the uptake of long-acting reversible contraception among female sex workers in post-conflict Northern Uganda, Ouma et al established that the prevalence of LARC among FSW stood at 58.6%. Compared to this study, higher proportions of FSWs were using the LARC in Zambia (66.6%), Kenya (64.6%), and Ethiopia [69.2%]

2.2. Factors affecting utilization of family planning

Allen et al 2019 established that the relationship between education and the use of family planning is mixed. They established that Young women with no education were slightly less likely than women with secondary or higher education to use a modern method of family planning (93% versus 100%) (Allen et al 2019)

Kushwah et al who showed that the use of family planning was slightly higher among women with secondary or higher education (17%) than among women with no education (15%), while use is lowest among women with primary education (11%) (Kushwah,2020)

In a study of factors influencing utilization of family planning among females of reproductive age at maristopes –kavule in kampala, Racheal .N revealed that the majority 36 (45%) of the respondents were graduates. This possibly means that the females who are utilizing family planning have attained knowledge and awareness about family planning methods. It also stresses the possible fact that education has enabled females to get employed therefore making them able to easily access and incur costs of FP (Racheal .N, 2023)

In a study of Factors associated with the uptake of long-acting reversible contraception among female sex workers in post-conflict Northern Uganda by Ouma et al, it was established that there was a relationship between age and uptake of family planning to the extent that most of the newer FSWs are adolescents and young women who have restricted access to modern contraceptives. The study, revealed that that the older FSWs with two or more children had a higher prevalence of family planning use compared to the younger FSW with fewer children (Ouma et al 2022)

In a study by Prata et al who in their study of differences in factors associated with current modern contraceptive use among youth and adult women established that women aged 25–49 years (66%) were more likely to be currently using modern contraceptives than women aged 15–24 years (48%) (patra et al 2016). Similarly, Nieves et al in their study of The influence of partnership on contraceptive use among HIV-infected women accessing antiretroviral therapy in rural Uganda established that women age 15-19 were markedly less likely to be using any method of family planning than women age 20-24 (5% and 23%, respectively) (Nieves et al 2020)

According to a study of Use of long-acting reversible contraception in a cluster-random sample of female sex workers in Kenya by Ampt et al, it was established that uptake of family planning was independently associated with previous pregnancy, positive attitude to and better knowledge of family planning, younger age, and lower education. In this study those who had history of previous pregnancy were more likely to use FP compared to FSW who reported no history of pregnancy . the same study established that the younger FSW had

a lesser odd of using family planning compared to the older FSW so was the case with FSW with lower level of education (Ampt et al,2019)

Marital status significantly impacts family planning use among female sex workers (FSW). In a research by Bukenya et al it was established that FSW, regardless of marital status, face high rates of pregnancy and STDs, and often experience barriers to accessing and consistently using effective contraception. While unmarried FSW may have higher initial rates of contraceptive use, especially with methods like condoms, they may also experience higher discontinuation rates. Married FSW, particularly those with partners living elsewhere, may face lower demand for family planning services due to reduced sexual activity (bukenya et al, 2019)

A study by sato et al in their study of Effect of distance to health facilities and access to contraceptive services among urban women they established that the effect of distance to a health facility on contraceptive use significantly differed according to contraceptive availability at the facility. They established that further distance to a health facility decreased the use contraception (sato et al 2021)

Bilikisu et al a study of the distance-quality trade-off in women's choice of family planning provider in North Eastern Tanzania showed that only 33% of woman received contraception from a health facility nearest to them. According to their study, Women, may not seek contraception from the nearest facility, rather opting for a more distant facility with better quality services or to ensure greater privacy and anonymity (Balikusu et al 2022)

2.3. Barriers affecting to utilization of Family Planning

In a study by Kassim et al, it was established that long waiting times at a health facility, particularly for family planning services, can negatively impact a woman's willingness to use them. These delays are perceived as a barrier to achieving reproductive goals and can impact the quality of care received in study of barriers to access of family planning among sex workers (kassim et al 2022)

According to a study of barriers to use of family planning, Kassim et al established that several factors were found to negatively affect the family planning literacy of women of childbearing age in the communities under review. These factors were low levels of education, religious affiliation, and low family income. Other factors that were also found to negatively affect women's family planning literacy include fertility preference, negative

perceptions of family planning, preference of unproven family planning methods, limited access to reliable sources of family planning information, household responsibilities, and poor male partner support on family planning matters (Kassim et al 2022)

Studies have shown that, Sex work has many faces with considerable differences tween populations, in the way sex work is organized, in levels of visibility, and in risk. Sex work has en defined as the provision of sexual services in exchange for money, goods, or other benefits. Most sex work has a strong economic basis with motivations ranging from survival, debt alleviation, drug dependency, coercion, or a desire for wealth. Sex work is usually classified as "direct" (open, formal) or "indirect" (hidden, clandestine, informal).

Direct Sex Workers are typically women who do define themselves and earn their living by selling sex. Indirect FSW are women for whom sex work is not the first source of income. They may work as waitresses, hairdressers, tailors, massage girls, street vendors, or promotion girls and supplement their income by selling sex on a regular basis or occasionally. They do not consider themselves as sex workers and often work outside of known venues for sex work.

Therefore, they are even more difficult to reach than those known as direct sex workers. As a consequence, the absolute size of the FSW population remains largely unknown. (Vandepitte et' al 2006)

Once pregnant, these same challenges might constitute barriers to accessing antenatal care (ANC) or prevention of mother-to-child transmission (PMTCT) services. More evidence on the predictors and correlates of Family Planning use (or nonuse) of reproductive health (RH) and FP services is needed to ensure that the provision of appropriate Family Planning services that address the burden of unplanned pregnancy among this vulnerable group are in place and easily accessible by all categories of women of reproductive age. . (Vandepitte et' al 2006)

Research and programming for FSW has largely focused on HIV and STI prevention without taking into consideration their reproductive Health and Family Planning needs. FSW's Family Planning needs are similar to all other women of reproductive age, but they also present unique challenges due to heightened HIV/STI risks, multiple partnership types with whom they may have differing fertility desires, coupled with inability to control condom use in some situations, and constrained access to healthcare or FP services. The program intervention mechanisms and strategies for HIV prevention for FSWs is substantially visible, but RH and FP services tailored for the needs of FSW are urgently needed, particularly in

low- and middle- income countries. Incorporating RH and FP services into existing HIV services or leveraging HIV prevention efforts to provide FP for FSWs may potentially improve FP use and reduce unintended pregnancies among female sex workers (ckham et al, 2021).

While HIV prevention interventions are often not specifically designed to improve Family Planning use, FP is increasingly incorporated into HIV care for those living with HIV, as HIV testing and PMTCT services are similarly already integrated into antenatal care (ANC) in SSA. Furthermore, the World Health Organizations' (WHO) four-prongs of PMTCT (HIV prevention; prevention of unintended pregnancies; HIV treatment during pregnancy, Labor, and breastfeeding; and caring for women and their children and families) inherently intertwines HIV and reproductive health services. Emitting tailored reproductive health services that are sensitive to FSW's RH needs within HIV programming may improve effective means of providing inclusive RH services while targeting to cover the marginalized and excluded groups of women like the female commercial sex workers (ckham et al, 2021).

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This section presents the methodology that was used in the study as indicated below, and the study design, study area, study population, inclusion criteria, sample size determination, sampling procedure, data management and research ethics.

3.1. Study design

This was across-sectional study design that employed a mixed method. Both quantitative and qualitative methods of data collection were employed. Cross-sectional; because information from respondents was gathered all at once. The quantitative approach was used on descriptive and explanatory data obtained from respondents while the qualitative approach involved interpretation of data from the respective sources. Therefore, the mixed method used here helps in triangulation of data.

A case study approach was used for qualitative method. Sex work workers were individual asked to respond to questions that pertains to their work as sex workers.

3.2. The area of study.

The study was conducted in Kawempe Division targeting two communities namely; Kimombasa and Tula. These are areas with high concentration of commercial sex workers compared to other communities in Kawempe. Following a Survey conducted in May 2022, highlighting Kawempe division as highest with 23% (61) of the hot spots where sex workers operate from followed by Rubaga,17%, (56) Central with 55, Makindye with 52, Makindye and finally Nakawa has 44 hot sex worker hot spots. In this case Kimombasa in Bwaise, Kawempe Division ranked among the top five booming hot spots for sex work in Kampala (Catherine, 2022)

3.2. Study population

The study was focus on female commercial sex workers operating in key hot spots in Kawempe division under the age bracket of 15-49 years. The LC1 chairpersons from Tula Parish and Kimombasa, hot spot group leaders, the Mayor, the Division Health Officer, Division Bio- statistician, health facility in charges, Family Planning Focal person Village Health Teams, Women representative.

3.3: inclusion criteria

3.3.1. Inclusion criteria

The study targeted only those female commercial sex workers of reproductive age 15-49 living and practicing their work in Kawempe division. The hot spot leaders must have been in that role for at least a year, able to speak the local language (Luganda), were sex workers

themselves in the same community, and know how to communicate well with study participants.

3.3.2. Exclusion criteria

Female sex workers above or below the age bracket of 15-19 years and not operating within kawempe were excluded from the study

Also female sex workers who at the time of interview were too ill to sustain the interview were excluded from the study

3.4. Sample Size Determination

The sample size for the study participants was determined from the table by Krejcie & Morgan**.** Guided by the table to determine the sample size in this study of the uptake of Family Planning among Female Sex worker in Kawempe Division, estimated at 2,540, Confidence interval of 95% and Margin of error at 5%, the sample size was 334 as the study participants (Krejcie & Morgan 1976).The Formula used to determine the sample size in the according to Kreijcie and Morgan 1960 is as below;

$$n = \frac{X^2 * N * P * (1-P)}{(ME^2 * (N-1)) + (X^2 * P * (1-P))}$$

Where:

n = sample size

X^2 = Chi – square for the specified confidence level at 1 degree of freedom

N = Population Size

P = population proportion (.50 in this table)

ME = desired Margin of Error (expressed as a proportion)

Where n is the samples size,

X2 is the Chi-square for the specified confidence level at 1 degree of freedom (= 3.84)

N is the population size (= 2540)
P is the population proportion (= 0.5)
ME is the desired margin of error (expressed as a proportion) (= 0.05)
deff is the design effect (= 0.54)

n= 334

Qualitative sample, 9 key informants were purposively selected based on their knowledge and experience of the subject matter.

3.5. Sampling technique

Snow Ball method is usually used in qualitative designs, but this is mixed design and quantitative data was collected, but given the difficulty of getting FSW, snowball was used and it has been used by other researchers to collect quantitative data (Kissian, 2022).

The KI were purposively chosen based on their knowledge and experience of the subject matter.

3.6. Study variable

3.6.1. Dependent variable.

The dependent variable was the uptake of family planning

3.6.2. Independent variables were

Age, sex, marital status, educational level distance to the facility, waiting time at the facility, presence of privacy and confidentiality, if ever been pregnant, if ever had abortion, experience using family planning among other variables

3.7. Data collection procedure

Three research assistants with a minimum qualification of a diploma were trained to help in data collection.

The Data was collected using a validated and pre-tested structured questionnaire. Interviews with selected KI were conducted by the principal trained research assistants with supervision from the chief investigator to collect socio-demographic data and other variables associated with the uptake of FP among female sex workers, this was after obtaining written consent from respondents/study participants.

For the respondents who could not read and write, the questions and respective responses were read to them and they were asked to choose the option that applies to them and the research assistants would circle the responses as guided by the respondents.

The researcher cross-checked for errors and sought clarity before proceeding to the next respondents

3.7: Data Collection and tools

3.7.1. Quantitative data

Quantitative data was collected using interviewer administered printed questionnaires which was pre-coded and designed as closed ended standard questions based on the objectives of the study. The data collection took place in safe places within the hot spot where identified sex workers were referred for interview. For the sex workers who could read and write, the questionnaires were given to them to fill in their responses. For those who could not read and write the questions were read to them and with the help of research assistants, their responses were captures. The questionnaires were also translated into the local language (Luganda) and back translated into English by people without prior knowledge of the instrument. This was done to cater for commercial sex workers who were not conversant with the English language. The back translation helped in checking whether the original meaning of the questions in the instrument was maintained when the questionnaire was administered in the local language. Questionnaires was administered by trained Research Assistants who were selected through headhunting with a basic qualification of a bachelor's degree in Social Work and Social Administration and with a past experience in data collection.

3.7.2. Qualitative data

Qualitative data was collected by the principle investigator using Key Informants (KI) interview guide.the interview was conducted in English language. The KI included health workers who were purposively selected (These included In-charge FP clinic, In-charge of HCIII and H/C IV at the division level, ADHO MCH who is also focal person at the Division). The interviews were exploring health workers perceptions on barriers of utilization of FP among Female sex workers. The KII was audio recorded by the interviewer (principal investigator) in addition to note taking.

3.8: Data Management and Analysis

3.8.1. Data management

All quantitative data was entered in Microsoft excel edited, coded cleaned using before fore analysis cleaning involved removing missing data, duplicates, wrong data and incomplete data manually. Quantitative data was checked for consistency and coding clearly to identify the variables required for data Analysis

3.8.2. Qualitative Data analysis

Qualitative data from the key informants was analyzed manually using content analysis. The transcripts from the audio records were the basis of content analysis. The transcripts were read several times to get clear understanding of emerging issues and these was coded. The similar codes were grouped together into categories and later the themes was generated from the categories.

3.8.3. Quantitative Data analysis

Data was first checked manually for completeness. Data was cleaned, coded, and entered into Excel. The data was then exported to Statistical Package for Social Scientists (SPSS) version 20 for statistical analysis. The analysis was done at Univariate, Bivariate, and Multivariate levels.

At the univariate level, the researcher obtained summaries, frequencies, percentages of the variables under study.

At the bivariate level, Pearson's Chi-square (x^2) tests were used to determine the relationship or association between the dependent and independent variables. The corresponding P-values were obtained, variables with P-values less than 0.05 were considered statistically significant.

At the multivariate level, logistic regression of variables that were statistically significant at the bivariate level was analyzed. The corresponding P-values, Adjusted Odds ratio, and Confidence Intervals were also obtained.

3.9. Quality control.

3.9.1 Training of research assistants

To ensure a quality study, two Research Assistants with Bachelor's degree in social sciences fluent in Luganda and English were trained for two days and equipped with various interpersonal and interviewing skills like probing and proper information recording. All efforts was made to ensure that they understood the study objectives and methodology.

3.9.2. Pre-testing

The designed pre-coded interview guide was pre-tested among the commercial sex workers in one hot spot in Makerere Kavule which was not included in the study, and adjustments was made to the questions where necessary. Duration used to complete the interview guides was noted and used to plan the time during the study. Pre-testing of the tools was addressing validity, relevance, comprehensiveness and degree of robustness of the interview tools.

3.9.3 Supervision

The Principal Investigator worked closely with the Research Assistants throughout the data collection period by ensuring daily supervision of data collectors this helped in addressing challenge encountered during data collection

3.9.4 Field editing of data

During the study, field editing of data was done by the Principal Investigator at the end of each day; checking with the Research Assistants to ensure completeness, accuracy and consistency was systematically maintained. This helped to standardize the quality of data collected. Missing and incorrect information in the questionnaires was immediately rectified.

3.10: Ethical Considerations

Formal approvals from the University Research Ethics Committee at Uganda Christianity University was obtained. This was followed by the permission to conduct the study from the Kampala Capital City Authority (KCCA) Division office Kawempe. The study participants were also individual contacted to get their consent to participate in the study.

The benefits and risks of the study were also explained to the respondents and participants.

The study participants were informed of their right to withdraw from the study at any stage and that by doing so, it will not affect them or the services they receive at the health facility.

The study participants/respondents were assured of confidentiality. They were told not to write their names on the questionnaires so that the answers given cannot be linked to a particular respondent, they were also told that the data collected from them shall be kept securely only be accessed by authorized person and the data collected shall only be used for this academic research.

3.11. Dissemination plan

The findings from this study will be submitted as a dissertation to Uganda Christian University and a copy of the study report will be disseminated through local and international conferences, the researcher also intends to write and submit a manuscript for publication in a credible peer-reviewed journal.

3.12. Study limitation

We conducted a cross-sectional study that elicited associations but not causation. Secondly, the information collected may have been influenced by recall bias since we asked FSWs about their past also some of the implored information relating to sex work were sensitive and difficult to provide. However, the interviewers had close working relationships with the FSWs.

CHAPTER FOUR: FINDINGS AND RESULTS

4.0. Introduction

This chapter provides data analysis and discussions in relation to the study questions discussed in Chapter 1 above. It provides statistics about the percentage of Family Planning (FP) use among Female Sex Workers (FSW) in Kawempe Division, as well as the factors that influence FP uptake and obstacles that prevent its use.

4.1. Demographic characteristics of the respondent

Table 1. Demographic characteristics of the respondent

Variable	Frequency	percentages
Age n=332		
15-19	38	11.4
20-24	94	28.3
25-29	149	44.9
30-34	32	9.7
35-39	13	3.9
40+	6	1.8
Marital status		
Married	23	6.9
Separated/divorced	101	30.4
Single	188	56.6
Widow	20	6.1
Highest level of education attained		
Primary	178	53.6
Secondary	127	38.3
Tertiary	26	8.1
Religion		
Catholics	153	46.1
Protestants	97	29.2
pentacostals	6	1.8
muslims	59	17.8
others	17	5.1
What is the distance from your home to the nearest family planning site		
<5km	304	91.6
>5km	28	8.4
Income level per month		
<100,000sh	64	19.3
100,000-200,000sh	191	57.5
>200,000	77	23.2

From the table above, majority 149(44.9%) of the respondents were age 25-29 years, majority 188(56.6%) of them married and had attained primary level of education.

Nearly half 153(46.1%) of the respondents were Catholics and nearly all 304(91.6%) of the respondents resided less than 5km away from the facility

In regards to income level more than half 191(57.5%) of the respondents earned between 100,000sh and 200,000sh and only 64(19.35%) of the respondents earned less than 100,000sh

4.2. Percentage of female sex workers who use family planning

Table 2: Showing the percentage of female sex workers in Kawempe Division who use family planning.

Variable	Frequency	Percentage
Have you ever used family planning		
Yes	264	92.3
No	68	7.7
Are you currently using family planning		
Yes	251	75.6
No	81	24.4
If yes,which family planning method are you using n=251		
Injecta plan	91	36.2
Condoms	120	47.8
Pill plan	29	11.6
Inter uterine device (IUD)	5	2
Mood beads	3	1.2
Others	3	1.2

Source: Primary Data

According to the table above, 264(92.3%) of the respondents had never used FP services, whereas 68(7.7%) of the respondents reported never ever using FP.

Slightly more than three quarters251 (75.6%) of the respondents reported that they were currently using family planning and 81(24.4%) of the respondents reported using any family planning currently

Of those who reported current use of family planning, majority 120(47.8%) reported using condom, followed by 91(36.2%) injecta plan then 29(11.6.1%) reported using pill plan.3 (1.2%) of the respondents reported using mood bead and other methods mainly withdrawal and tuba ligation.

4.3. Factors affecting the use of family planning among female sex workers

Table 3. Factors affecting the use of family planning among female sex workers

Variable	Frequency	Percentage
Have you ever heard about fp method 332		
Yes	**321**	**96.7**
No	**11**	**3.3**
Where did you get the information about Family Planning Services? Choose only one source 321		
Health worker	148	**46.1**
Friends & peers	127	**39.6**

Radio	18	5.6
Relative	17	5.3
Social media	10	3.1
Other	1	0.3
What do you know about Family Planning Services? 321		
Taking pills to prevent pregnancy	169	52.6
Taking any Family Planning method of your choice after making a decision on your own without being forced by anyone	53	16.6
	96	29.9
Taking pills after having unprotected sex to prevent pregnancy	3	0.9
Others		
Do you know a place in Kawempe where you can find family planning services 321		
Yes	316	98.4
No	5	1.6
Name the family planning that can prevent both pregnancy and STI 321		
Pill plan	5	1.6
Injecta plan	12	3.7
Intra uterine devices	9	2.8
Condom	293	91.3
Others	2	0.6
Have you ever been pregnant		
Yes	303	91.3
No	29	8.7
How many pregnancies have you had 303		
1-2	179	59.1
3-4	96	31.7
More than four	28	9.2
In all pregnancies you have had, how many were unwanted 303		
All	193	63.7
1-2	78	25.7
3-4	32	10.6
Have you had abortion		
Yes	298	98.3
No	5	1.7
How many abortions have you had 298		
1	53	17.8
2	149	50
More than 2	96	32.2
Do you have any other job besides sex work 332		
Yes	95	28.6
No	237	71.4
Are there myth about family planning		
Yes	308	92.8
No	24	7.2

On average what is the waiting time at the facility when you go for service		
Less than an hour	113	34
More than an hour	219	66
Are health workers available at all time to offer the services		
Yes	56	16.9
No	276	83.1

Majority 321(96.7%) of the respondents had ever heard about family planning. Majority 148(46.1%) reported getting information from heath workers, 127(39.6%) had friends and peers as their source of information about family planning.

Slightly more than half 169(52.6%) of the respondents reported that they take pills to prevent pregnancy

Also majority 316(98.4%) of the respondents reported that they knew where to get family planning, nearly all 293(91.3%) of the respondents correctly mentioned condom as a family planning method that can protect one against pregnancy and STI

When asked if they had ever been pregnant, nearly all 303(91.3%) of the respondents reported ever being pregnant and only 29(8.7%) of the respondents reported never being pregnant

More than half 179(59.1%) of the respondents reported that they had had 1-2 pregnancies and only 28(9.2%) of the respondents reported having more than four pregnancies

Majority 298(98.3) of the respondents had ever had abortion and half 149(50%) of those who had had abortion reported having heard 2 abortions

Besides sex work, majority 237(71.4%) of the respondents reported not having a side job besides sex work

Nearly all 308(92.8%) of the respondents reported that in the community, there are myth about family planning

It was further revealed by the KI that most of the people in the community including FSW have myths and misconceptions on Family Planning which affects their utilization of the FP services. A better way would be gotten to clean up all these myths to increase the uptake

"……..there is a lot of Myths and Misconceptions related to Family Planning. Some say ''When I take Family Planning it will make me acquire Cancer of the uterus/blood" (A 38 years old KI)

Majority 219(66%) of the respondents reported a longer waiting time of more than an hour at the facility.

In regards to availability of health workers at the facility, more than three quarter 276(83.1%) of the respondents reported that health workers were not available at all the time to offer the service and only 56(16.9%) of the respondents reported availability of health workers

4.4. Barriers to use of family planning method

Table. 4 Barriers to use of family planning method

Variable	Frequency	Percentage
What was your experience using family planning 256		
I felt relieved of pregnancies Experienced menstrual pain Reduced sexual feelings Increased sexual feelings others	124 9 71 48 4	48.4 3.5 27.7 18.8 1.6
Why do you think not all FSW are using FP 332		
Scared to get cancer Afraid of stigma from health workers I have not time No money to buy FP Others	81 177 59 12 3	24.4 53.3 17.8 3.6 0.9
Do you think the Family Planning services offered at the health facilities encourage commercial sex workers to get involved		
Yes No	91 241	27.4 72.6
If no why 241		
Lack of Privacy Lack of confidential High cost of FP Counsellors/health workers are unapproachable Others	94 79 12 51 5	39 32.8 4.9 21.2 2.1
Is there privacy and confidentiality at the facility		
Yes No	59 273	17.8 82.2
Does the facility have special days and time for sex workers		
Yes No	29 303	8.7 91.3
Is fp given free of charge		
Yes No	297 35	89.5 10.5
What is the attitude of health workers towards providing fp to FSW		
Positive Negative	216 116	65.1 34.9

Attitude of the community towards use of fp by sex workers		
Positive Negative	69 263	20.8 79.2

Majority 124(48.4%) of the respondents reported relieved of pregnancy when about their experience of using family panning others 71(27.7%) reported reduced sexual feeling, 48(18.8%) reported increased sexual feelings

When asked about reason for not using family planning, more than half 177(53.3%)of the respondents reported being afraid of stigma from health workers, followed by 81(24.4%) who reported being scared to get cancers and only 4(1.6%) of the respondents reported fear of side effects among other reasons

Similarly, some key informants also reported stigma among female sex workers as the reason for low uptake of family planning

"…..*Commercial sex work is regarded as an abomination and by law they operate illegally in Uganda. They engage in an activity that contradicts with the values of society and hence comes with a lot of stigma associated with it……"* (A 32 year old male KI)

Similarly, the key informant gave reasons such myth that family panning causes cancer, fear of side effects such as bleeding and weight gain, rude health workers as the reason as to why they don't use family planning

Also some of the KI i revelaed that various factors such as religion, poverty and lack of time to go for Family Planning are crucial in their uptake. The first class FSW escort top officials and move most of the places and find no time for FP

"…….Most Commercial sex workers earn from hand to mouth and when they need to take Family Planning it becomes very costly. Also some sex workers do not believe Family Planning because their religions tell them to produce and fill the world. Although really this is debatable and root cause for children unable to attain school and end up as criminals. . Some have no time. Most of the first class sex workers are always accompanying the top

*officials to trips and have no time to access Family Planning services……."(*A 28 year old KI)

Majority 241(72.6%) of the respondents reported family planning services offered at the health facilities does not encourage sex workers to use the facility and majority 179(71.8%) of the them reported lack of privacy and confidentiality as the reasons as to why they think the health facilities does not encourage the use of family planning among other reasons

Nearly all 303(91.3%) of the respondents reported that the health facilities doesn't have special days and time for sex workers however majority 297(89.5%) of the respondents reported that family planning is given free of charge

In line with the above, also majority of the KI reported that most facilities don't have specific days and time at the facility that is designated for sex workers

"……Female Sex Workers have no specific clinic days designated for them to come freely to utilize Family Planning services. Most of them come to the Antenatal clinic in hiding for fear of being known, and this affects their choice of the best option given their nature of work……." (A 36 year old KI)

Majority 216(65.1%) of the respondents reported a positive attitude of health workers towards providing family planning to FSW. To the contrary, majority 263(79.2%) of the respondent reported a negative attitude of community towards use of family planning by sex workers

4.5. Bivariate analysis of demographic variables

Table 5. Bivariate analysis of demographic variables

		use of Family Planning				
Variable	Frequency	No 81(24.4%)	Yes 252(75.6%)	X^2	df	P-value
Age n=332						
15-19	38	18	20	17.77	5	0.000
20-24	94	22	72			
25-29	149	13	136			
30-34	32	21	11			
35-39	13	5	8			
40+	6	2	6			
Marital status						
Married	23	2	21	21.91	3	0.000

Separated/divorced	101	21	80			
Single	188	56	132			
Widow	20	2	18			
Highest level of education attained						
Primary	178	46	132	13.78	2	0.001
Secondary	127	33	94			
Tertiary	26	2	24			
Religion						
Catholics	153	57	96	4.56	3	0.056
Protestants	97	18	79			
Pentecostals	6	2	4			
muslims	59	1	58			
others	17	3	14			
What is the distance from your home to the nearest family planning site						
<5km	304	62	242	16.64	1	0.000
>5km	28	19	9			
Income level per month						
<100,000sh	64	29	35	2.40	2	0.67
100,000-200,000sh	191	48	143			
>200,000	77	4	73			

From the bivariate analysis table above age (X^2=17.77, df =5, P-value=0.000),marital status X^2=21.91, df =3, P-value=0.000),educational level X^2=13.78, df =2, P-value=0.001) and distance to the nearest facility X^2=16.64, df =1, P-value=0.000) were found to be statistically significant p-value <0.05

4.6. Bivariate analysis of factors affecting the use of family planning among female sex workers

Table 6. . Bivariate analysis of factors affecting the use of family planning among female sex workers

		use of Family Planning				
Variable	Frequency	No 81(24.4%)	Yes 251(75.6%)	**X^2**	**df**	**P-value**
Have you ever heard about fp method 332						
Yes	321	**73**	**248**	**12.07**	**1**	**0.003**
No	11	**8**	**3**			
Where did you get the information about Family Planning Services? Choose only one source 321						

Health worker	148			5.39	5	0.060
Friends & peers	127	5	143			
Radio	18	49	78			
Relative	17	7	11			
Social media	10	11	6			
Other	1	8	2			
		1	0			
What do you know about Family Planning Services? 321						
Taking pills to prevent pregnancy	169	17	152	4.22	3	0.970
Taking any Family Planning method of	53	28	25			
your choice after making a decision on your own without being forced by anyone	96	31	65			
Taking pills after having unprotected sex to prevent pregnancy	3	2	1			
Others						
Do you know a place where you can get family planning?						
Yes	316	78	238	3.71	1	0.602
No	5	3	2			
Name the family planning that can prevent both pregnancy and STI 321						
Pill plan	**5**	3	2	1.07	4	0.748
Injecta plan	**12**	4	8			
Intra uterine devices	**9**	3	6			
Condom	**293**	64	229			
others	**2**	1	1			
Have you ever been pregnant						
Yes	303	53	250	9.09	1	0.041
No	29	28	1			
How many pregnancies have you had 303						
1-2	179	49	130	2.346	2	0.751
3-4	96	21	75			
More than four	28	11	17			
In all pregnancies you have had, how many were unwanted 303						
All	193	53	140	5.789	2	0.602
1-2	78	10	68			
3-4	32	18	14			
Have you had abortion 303						
Yes	298	80	218	13.990	1	0.002
No	5	1	4			
How many abortions have you had 298						
1	53	9	44	6.037	2	0.051
2	149	21	128			
More than 2	96	49	47			

Do you have any other job besides sex work 332						
Yes	95	12	83	9.361	1	0.061
No	237	69	168			
Are there myth about family planning						
Yes	308	74	234	1.882	1	0.911
No	24	7	17			
On average what is the waiting time at the facility when you go for service						
Less than an hour	113	9	104	19.743	1	0.001
More than an hour	219	72	147			
Are health workers available at all time to offer the services						
Yes	56	4	52	4.614	1	0.058
No	276	77	199			

From the bivariate analysis table above if ever heard about family planning X^2=12.07, df =1, P-value=0.003),if ever been pregnant (X^2=9.09, df =1, P-value=0.041),if ever had abortion (X^2=13.990, df =1, P-value=0.002) and waiting time at the facility X^2=19.743, df =1, P-value=0.001),P-value <0.05

4.7. Bivariate analysis of barriers to use of family planning methods

Table 7. Bivariate analysis of barriers to use of family planning methods

		Use of Family planning				
Variable	Frequency	No 81(24.4%)	Yes 251(75.6%)	X^2	df	P-value
What was your experience using family planning 256						
I felt relieved of pregnancies	124	17	107	2.011	4	0.072
Experienced menstrual pain	9	6	3			
Reduced sexual feelings	71	47	24			
Increased sexual feelings	48	9	39			
others	4	2	2			
Why do you think not all FSW are using FP 332						
Scared to get cancer	81	29	52	11.782	4	0.001
Afraid of stigma from health workers	177	35	142			
I have not time	59	12	47			
No money to buy FP	12	4	8			
Others	3	1	2			

Do you think the Family Planning services offered at the health facilities encourage commercial sex workers to get involved						
Yes	91	7	84	3.397	1	0.069
No	241	74	167			
If no why 241						
Lack of Privacy	94	29	65	2.094	4	0.059
Lack of confidential	79	17	62			
High cost of FP	12	7	5			
Counsellors/health workers are unapproachable	51	24	27			
Others	5	4	1			
Is there privacy and confidentiality at the facility						
Yes	59	6	53	12.332	1	0.001
No	273	75	198			
Does the facility have special days and time for sex workers						
Yes	29	2	27	21.042	1	0.000
No	303	79	224			
Is fp given free of charge						
Yes	297	68	229	1.753	1	0.064
No	35	13	22			
What is the attitude of health workers towards providing family planning to FSW						
Positive	216	12	204	16.880	1	0.060
Negative	116	69	47			
Attitude of the community towards use of fp by sex workers						
Positive	69	29	40	11.650	1	0.072
Negative	263	52	211			

From the bivariate analysis above ,reasons for not using FP (X^2=11.782, df =4, P-value=0.001), if there is privacy and confidentiality at the facility (X^2=12.332, df =1, P-value=0.001), if the facility have special days and time for sex works (X^2=21.042, df =1, P-value=0.000), attitude of health workers toward providing family planning to FSW(X^2=16.880, df =1, P-value=0.000) and attitude of the community towards use of family

planning by sex workers (X^2=11.650, df =1, P-value=0.002) were found to be statistically significant. P-value <0.05

4.8. Multivariate analysis of factors affecting the use of family planning among female sex workers

Table 8. Multivariate analysis of factors affecting the use of family planning among female sex workers

Variable	AOR	95 CL	P-value
age			
15-19	1.8	1.06-3.31	0.000
20-24	4.6	1.22-7.12	
25-29	2.2	0.03-2.67	
30-34	1.4	2.31-4.04	
35-39	1.1	1.01-1.99	
40+	1		
Marital status			
Married	1		
Separated/divorced	0.6	1.91-2.88	
Single	0.2	1.03-2.10	
Widow	0.8	1.44-3.09	0.002
Educational level			
Primary	1		
Secondary	2.8	1.88-4.64	
Tertiary	4.6	0.01-8.67	0.001
What is the distance from your home to the nearest family planning site			
<5km	6.2	1.73-9.85	0.002
>5km	1		
Have you ever heard about fp method			
Yes	1		
No	0.8	2.48-3.96	0.052
Reason for not using Family planning			
Scared of getting cancer	0.8	1.80-4.43	0.000
Afraid of stigma from health workers	0.6	1.66-3.02	
I have no time	0.1	1.91-2.47	
No money to buy FP	0.9	1..11-2.90	
Others	1		
Have you ever been pregnant			
Yes	6.8	1.88-9.04	0.79
No	1		
Have you had abortion			
Yes	4.1	1.70-6.66	0.063
No	1		
Is there privacy and confidentiality			
Yes	2.9	1.77- 4.09	0.053
No	1		
Does the clinic have Special days and time			
Yes	2.3	2.8-3.99	0.07

No	1		
On average what is the waiting time at the facility when you go for service			
Less than an hour	5.2	2.06-9.88	0.000
More than an hour	1		

From the multivariate analysis table above, age(AOR=4.6; 95% CI: 1.22- 7.12; p= 0.000), FSW aged 20-24 years were 4.6 times more likely to use family planning compared to those aged above 40 years, marital status (AOR=0.8; 95% CI: 1.44- 8.09; p= 0.002), the widowed FSW were 0.8 times less likely to use family planning compared to the married, educational level(AOR=4.6; 95% CI: 0.01- 8.67; p= 0.001), FSW with tertiary level of education were 4.6 times more likely to use family planning compared to their counterparts with primary level of education, distance to the facility(AOR=6.2; 95% CI: 1.73- 9.85; p= 0.002), the adjusted odds ratio of 6.2 for distance to the facility implies that the FSW who stay less than 5km away from the health facility were 6.2 times more likely to use family planning compared to the sex workers that stayed more than 5km away from the health facility reasons for not using family planning(AOR=0.8; 95% CI: 1.80- 4.43; p= 0.000), implying that those who reported that they were scared of getting cancer, being afraid of stigma from health workers, having no time and No money to buy FP were less likely to use FP and waiting time at the facility(AOR=5.2; 95% CI: 2.06- 9.88; p= 0.000), also influenced the use family planning among female sex workers where by those who spent less than an hour at the facility were 5.2 times more likely to use family planning compared to those who spent more than an hour at the facility

CHAPTER FIVE: DISCUSSION OF FINDINGS

5.0 Introduction

This chapter presents the, discussions of the results presented in chapter four in line with the objectives of the study.

5.1 use of family planning among sex workers

This study established that 251 (75.6%) of sex workers are currently using family planning. this finding similar to a finding in a study of Factors associated with the uptake of long-acting reversible contraception among female sex workers in post-conflict Northern Uganda,in which Ouma et al established that the prevalence of LARC among FSW stood at 58.6%. Compared to this study, higher proportions of FSWs were using the LARC in Zambia (66.6%), Kenya (64.6%), and Ethiopia (69.2%)

This distribution reveals a widespread use of family planning services among female sex workers in Kawempe division, indicating possible interventions that are currently ongoing by both government and private service providers. However, considering the risks involved in this type of work, all the FSW should ideally be using family planning and hence expected to be at 100%. The proportion of non-users emphasizes the importance of focused training initiatives and outreach activities to remove barriers and promote all inclusive affordability and accessibility of family planning services.

5.2 Factors affecting utilization of Family Planning among commercial sex workers.

This study established that age (AOR=4.6; 95% CI: 1.22- 7.12; p= 0.000) was independently associated with the use of family planning where by those aged 20-24 yeara were 4.6 times more likey to use family planning compared to those aged 40 plus. This finding is not

consistent with a finding in a study by Ampt et al who established that the younger FSW had a lesser odd of using family planning compared to the older FSW so was the case with FSW with lower level of education (Ampt et al,2019)

Marital status

In a study by Bukenya et al, it was found that while unmarried FSW may have higher initial rates of contraceptive use, especially with methods like condoms, they may also experience higher discontinuation rates. The study also established Married FSW, particularly those with partners living elsewhere, may face lower demand for family planning services due to reduced sexual activity. This finding is not consistent with the finding in this study that established that compared to the married, the singles, widowed and divorced/separated were less likely to use family planning.

This study established that educational level was independently associated with the use of family planning where by those with tertiary level of education had a higher odd of using family planning over those with primary or secondary level of education. This finding is consistent with the finding in a study by Allen et al 2019 who in their study established that the relationship between education and the use of family planning was mixed. They established that Young women with no education were slightly less likely than women with secondary or higher education to use a modern method of family planning (93% versus 100%) (Allen et al 2019) also in agreement with the above findings, Kushwah et al who showed that the use of family planning was slightly higher among women with secondary or higher education (17%) than among women with no education (15%), while use is lowest among women with primary education (11%) (Kushwah, 2020)

A study by sato et al in their study of Effect of distance to health facilities and access to contraceptive services among urban women they established that the effect of distance to a health facility on contraceptive use significantly differed according to contraceptive availability at the facility. They established that further distance to a health facility decreased the use contraception (sato et al 2021) this finding is line with a finding in this study that established that sex workers who stayed less than 5km away from the health facility had 6.2 odd of using family planning over those who stayed over 5km away from the facility.

However, Bilikisu et al in their study of the distance-quality trade-off in women's choice of family planning provider in North Eastern Tanzania showed that only 33% of woman received contraception from a health facility nearest to them. According to their

study, Women, may not seek contraception from the nearest facility, rather opting for a more distant facility with better quality services or to ensure greater privacy and anonymity (Balikusu et al 2022) this finding is not consistent with a finding in this study.

5.3 Barriers to utilization of Family Planning among female commercial sex workers

This study established that the barriers to use of family planning were being scared of getting cancer, Afraid of stigma from health workers, having no time, having no money to buy FP among others. This finding is consistent with the finding in a by study McLachlan & Dune who established that sex workers often experience stigma and discrimination, feeling shame when accessing healthcare alongside the general population, and facing judgmental attitudes from healthcare providers (McLachlan & Dune, 2020). This stigma is exacerbated when providers inquire about their involvement in sex work and sexual history.

In astudy by kassim et al, it was established that long waiting times at a health facility, particularly for family planning services, can negatively impact a woman's willingness to use them. This finding is in agreement with the finding in this study that established that longer waiting time at the facility, negatively affected the use of family planning. This study established that those who waited for the service in less than an hour were 5.2 times more likely to use family planning compared to those who waited for more than an hour

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This section of the report presents the conclusions drawn from the findings in light with the objectives of the study. This section makes vital recommendations to different stakeholders in far as family planning uptake is concerned.

6.1 Conclusions

This study established that the uptake of family planning among female sex workers stood at 75.6%. This below the target considering the fact that it is expected that 100% of female sex workers should be on a family planning method. Female sex workers experience exclusion in utilizing reproductive healthcare services globally. As such, healthcare services are advised to adopt a nonjudgmental approach, to enhance physical accessibility and to train nurses and other healthcare professionals on reproductive health needs of female sex workers

The factors that were independently associated with use of family planning were age, marital status, educational level, distance to the facility and waiting time at the facility.

Barriers to use of family planning were, fear of health risks like cancer, stigmatization from health professionals, lack of knowledge about service locations, time constraints, and financial issues among others.

6.2 Recommendation

In line with the above findings the study recommends the following to the different stakeholders

To address the high level of unmet need for family planning among female sex workers (FSWs), Health Ministries, Non-Governmental Organizations (NGOs), Community-Based Organizations (CBOs) should develop and implement comprehensive education and awareness campaigns. These initiatives should educate FSWs on the complete spectrum of available contraceptive alternatives, their advantages, and how to obtain them. Tailored educational campaigns should be developed to dispel misconceptions and myths about

contraception use. Outreach activities should include community-based workshops and peer education to reach FSWs who may be hesitant to engage in conventional healthcare settings.

To tackle the barriers related to accessing family planning services, Health Ministries, Local Government Authorities, Healthcare Providers should work to improve the availability and accessibility of these services. This includes establishing or expanding family planning clinics in areas frequented by FSWs, reducing travel distance and associated costs. Mobile clinics and outreach initiatives could be used to offer services directly to FSWs' homes and workplaces, overcoming logistical and financial hurdles. Furthermore, integrating family planning services with existing health services can assist to improve access and minimize the stigma associated with obtaining care.

Efforts should be made to combat the stigma and judgment that FSWs face when accessing healthcare services. Healthcare provider training programs should include sensitivity training to promote nonjudgmental attitudes and better interactions with FSWs. Creating a supportive and inclusive healthcare atmosphere can lessen feelings of guilt and reluctance among FSWs, encouraging them to seek and use family planning services. This can be achieved through continuous professional development and implementing policies that promote respectful and equitable treatment for all patients.

To enhance the effectiveness of family planning programs, stakeholders such as Health Ministries, NGOs, Healthcare Providers, Referral Centers should focus on strengthening referral systems that connect FSWs with comprehensive reproductive health services. This entails establishing strong networks between drop-in centers, specialty clinics, and community-based organizations to enable efficient referrals and follow-up. Adequate support should be offered at referral sites, including financial aid and information about the locations of referral centers, to ensure that FSWs may obtain the necessary services without further hurdles.

Family planning programs should be customized to address the specific needs and circumstances of FSWs based on their marital status and socioeconomic factors. For instance, programs could offer targeted support for widows, who may face unique challenges in accessing family planning services compared to married or separated/divorced individuals. Furthermore, socioeconomic support, such as subsidizing the cost of contraception and giving transportation assistance, can help to reduce financial obstacles and increase service adoption.

Understanding and addressing these contextual issues allows for more effective and equitable family planning strategies..

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APPENDICES

Appendix: 1 Informed Consent Form

Study Title: Uptake of Family Planning services among Commercial sex workers in Kawempe Division

Investigator: Berina Kamahoro

Purpose of the study

This study is being conducted by Ms. Berina Kamahoro, a student of Uganda Christian University, School of Public Health as partial fulfilment for the award of a Master of public health. The survey was assess the factors associated with uptake of Family Planning services among commercial Sex Workers in Kawempe Division. Results from this research was useful for policy makers in the government departments to provide information on the need to plan inclusive and targeted Family Planning intervention services in Uganda. You was asked to participate if you are a commercial sex worker, aged 15-49 and has expressed interest in participating in this study.

Procedures

If you decide to participate in this study, we was first need to confirm your eligibility by ascertaining your age in years. Also, if you are low the age of 15 years, you are therefore asked to share information on factors associated with uptake of Family Planning services among commercial sex workers. Your responses to the structured questions will marked alongside the answer options provided and additional opinions will be filled in the spaces provided by the Research Assistant. This information is important at the start of the study so that we can ensure the conduct of research is appropriate and that the risk reduction methods discussed are suitable for you.

Potential risks and discomforts

The design of this study does not involve any medical intervention except that you was required to provide verbal responses to standard questions in the questionnaire. The Research Assistant will make sure all the questions are asked appropriately and was not cause any emotional distress. Any negative reactions or distress that you experience during the study will be assessed immediately. Although the study was make all attempts to keep the information you provide confidential, a violation or loss of confidentiality is possible.

Potential benefits to subjects and/or to society

Participating in this study may not have any direct benefits for you; however, if you participate in the study as a respondent you may increase your knowledge of Family Planning services and know how they can of direct benefits irrespective of your status. Your

participation also was help to inform programs aimed at improving targeted interventions on Family Planning services for commercial sex workers and other people considering using them.

Incentive for participation

You will not receive any financial rewards for participating in the study except for a soft drink for your refreshment that will be given at the study visit when the questionnaire is being administered.

Confidentiality

The results of the study filled in the questionnaires was kept confidential. Any identifying information that you provide (such as your name, and where you live) was kept separate from the filled questionnaires and in a locked cabinet or secured computer file. Only the principal Investigator and Research Assistants who are members of the study team was have access to the questionnaires. The information you give to the study will not be made available to anyone outside of the study team. A version of the study data in which all identifying information is removed may be made available for use by other scientists for the purpose of further research.

Voluntary participation and withdrawal

Your participation in this study is voluntary and you may withdraw your consent in the course of the interview without any penalty even after you have agreed to participate.

Rights of research participants

You may choose not to participate in the study or discontinue your participation at any time without loss of benefits to which you are otherwise entitled. You are not giving up any legal claims or rights cause of your participation in this research study. If you have questions regarding your rights as a research participant, contact Dr. Mukooza Edward on 0772957345, Chair of the Institutional Review Committee at Uganda Christian University, School of Public Health . If you have any questions or concerns about the research, please contact the study investigator, Berina Kamahoro on 0772567142.

Consent to participate

I have read (or someone has read to me) the information provided above, and I understand it. I have en allowed to ask questions. All of my questions have en answered to my satisfaction. I voluntarily agree to participate in this research study.

I have en given a copy of this form.

Signature/ thumbprint of participant ________________________________

________________________ ________________________________

Signature of research staff member Date

Appendix 2. Questionnaire

STUDY OF UTILISATION OF FAMILY PLANNING SERVICES AMONG FEMALE SEX WORKERS AGED 15-49 YEARS IN KAWEMPE DIVISION

General information

Name of the interviewer……………. Date…………….

Questionnaire No………… …………… Parish………….

Village……………………

Identification No. ……………………………

A. RESPONDENT CHARACTERISTICS

1. Age of the respondent in years …………………

2. What is the highest level of education attained? Please Tick appropriately
   a) 1None […].
   b) 2 primary [….].
   c) 3secondary [….].
   d) 4Tertiary [….].

3. Religion:
   a) Catholic […].
   b) Protestant […].
   c) Pentecostal […].
   d) Moslem […].

   4=others (specify) …………………………………….

4. What is your marital status? Tick appropriately
   a) Single [….].
   b) Married [….].
   c) Separated/divorced [.....]
   d) widow [ ]

5. What is the distance from your home to the nearest family planning site?
   a) <5km
   b) >5km

6. Income level per month
   a) <100,000sh
   b) 100,000-200,000sh
   c) >200,000

B. UTELIZATION OF FAMILY PLANNING

Have you ever used family planning?

a) Yes

b) No

Are you currently using family planning?

a) Yes

b) No

If yes, which method are you currently using?

a) Injecta plan
b) Condoms
c) Pill plan
d) Inter uterine device (IUD)
e) Mood beads
f) Others (specify)………………

C. FACTORS AFFECTING THE UTILIZATION OF FAMILY PLANNING

Have you ever heard about family planning method?

a) Yes

b) No

Where did you get the information about Family Planning Services? Choose only one source

a) Health worker
b) Friends & peers
c) Radio
d) Relative
e) Social media

Other

What do you know about Family Planning Services?

a) Taking pills to prevent pregnancy
b) Taking any Family Planning method of your choice after making a decision on your own without being forced by anyone
c) Taking pills after having unprotected sex to prevent pregnancy
d) Others (specify)………………

Do you know a place in Kawempe where you can find family planning services?

a) Yes

b) No

Name the family planning that can prevent both pregnancy and STI

a) Pill plan

b) Injecta plan
c) Intra uterine devices
d) Condom
e) Others (specify)…….

Have you ever been pregnant?

a) Yes

b) No

If you have ever been pregnant, how many pregnancies have you had?

a) 1-2
b) 3-4
c) More than four

In all pregnancies you have had, how many were unwanted

a) All
b) 1-2
c) 3-4

Have you had abortion?

a) Yes

b) No

If yes, how many abortions have you had?

a) 1
b) 2
c) More than 2

Do you have any other job besides sex work?

a) Yes

b) No

Are there myth about family planning?

a) Yes

b) No

On average what is the waiting time at the facility when you go for service

a) Less than an hour
b) More than an hour

Are health workers available at all time to offer the services?

a) Yes

b) No

D. BARRIERS TO UTILIZATION OF FAMILY PLANNING

What was your experience using family planning?

a) I felt relieved of pregnancies

b) Experienced menstrual pain
c) Reduced sexual feelings
d) Increased sexual feelings
e) Others (specify)…………….

Why do you think not all FSW are using FP

a) Scared to get cancer
b) Afraid of stigma from health workers
c) I have not time
d) No money to buy FP
e) Others (specify)…………………

Do you think the Family Planning services offered at the health facilities encourage commercial sex workers to get involved?

a) Yes

b) No

If no, why

a) Lack of Privacy
b) Lack of confidential
c) High cost of FP
d) Counsellors/health workers are unapproachable
e) Others (specify)………………….

Is there privacy and confidentiality at the facility?

a) Yes

b) No

Does the facility have special days and time for sex workers

a) Yes

b) No

Is family planning given free of charge in this facility

a) Yes

b) No

What is the attitude of health workers towards providing family planning to FSW?

a) Positive
b) Negative

Attitude of the community towards use of family planning by sex workers

a) Positive
b) Negative

THANK YOU FOR PARTICIPATING!

Appendix 3. Key Informants Interview Guide

General information

Name of the interviewer……………. Date…………….

Questionnaire No………… Sub-county…………… Parish………….

Village……………………

Identification No. ……………………………

Biodata Information

1. What is your occupation?

…………………………………………………………..

2. Where do you live?

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3. In your own views, why do female commercial sex workers deserve Family Planning services?

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4. In your own perceptive,what factors affect Family Planning uptake among commercial sex workers.

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5. What barriers do sex workers face while accessing and utilizing Family Planning services

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6. What avenues do you have in which female sex workers can use to demand for quality Family Planning services?

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7. What recommendations would you suggest to policy makers to effectively offer inclusive Family Planning services to all female sex workers?

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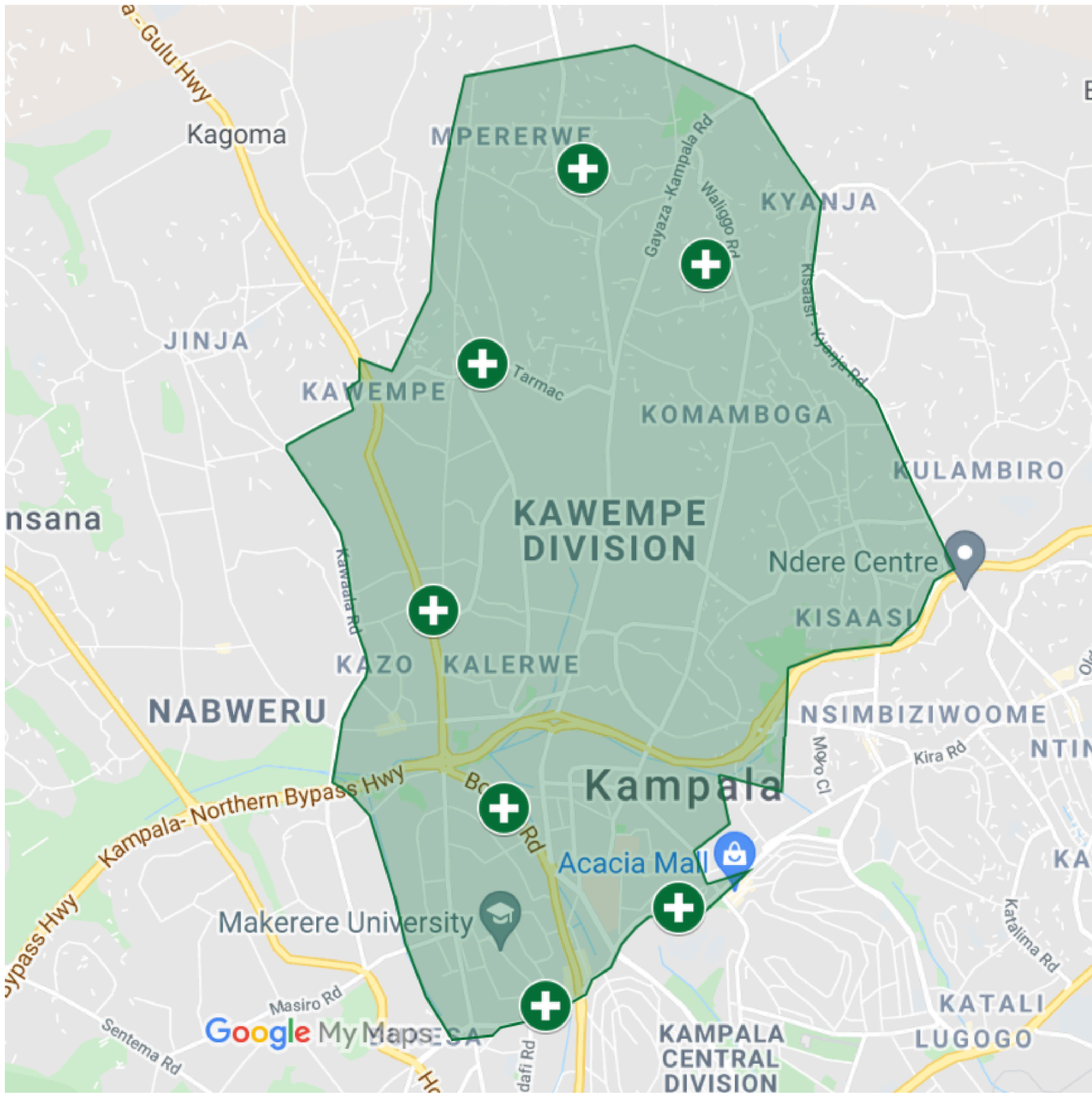
Thank you for sparing your valuable time to participate in this study

Appendix 4. Google map showing the location of the study area



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