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Abortion services for sex workers in Uganda: successful strategies in an urban clinic

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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. We sought to understand sex workers’ experiences with induced abortion services or post-abortion care (PAC) at an urban clinic in Uganda. We conducted nine in-depth interviews with sex workers. All in-depth interviews were audiotaped, transcribed, translated, computer recorded and coded for analysis. We identified several important programmatic considerations for safe abortion services for sex workers. Most important is creating community-level interventions in which women can speak openly about abortion, creating a support network among sex workers, training peer educators, and making available a community outreach educator and community outreach workshops on abortion. At the health facility, it is important for service providers to treat sex workers with care and respect, allow sex workers to be accompanied to the health facility and guarantee confidentiality. These programmatic elements help sex workers to access safe abortion services and should be tried with all women of reproductive age to improve women’s access to safe abortion in Uganda.

Keywords: sex workers; reproductive health services; Uganda; abortion

Background

Abortion is common in Uganda despite the fact that the abortion laws are restrictive. The estimated abortion incidence in Uganda in 2003 was 54 abortions per 1000 women of reproductive age (ages 15–44), which is much higher than the 2008 East Africa estimate of 38 and the 2008 global rate of 28 (Guttmacher Institute 2012; Sedgh et al. 2012; Singh et al. 2005). Abortion is permitted in Uganda when the woman is severely mentally ill, the pregnancy threatens the health of the woman, there is a severe foetal abnormality, the woman has cervical cancer, is HIV-positive or if the pregnancy was the result of rape, defilement or incest (Center for Reproductive Rights 2012). Many women incorrectly believe that consent of husbands or providers is required for married women or minors to receive an abortion, and many service providers incorrectly believe that they must consult with one or more other providers before providing an abortion (Center for Reproductive Rights 2012).

The confusion about the abortion laws and the legal provision of services in Uganda leads many women to seek alternative and often unsafe abortion providers, even when they may be legally entitled to abortion in a public or private health facility (Guttmacher Institute 2013). The World Health Organization (2010) defines unsafe abortion as a
procedure for terminating a pregnancy either by persons lacking the necessary skills, or in an environment lacking the minimal medical standards, or both. Unsafe abortion accounts for 26% of all maternal deaths in Uganda according to estimates from the Ugandan Ministry of Health (Guttmacher Institute 2013). Women who are poor, less educated, live in a rural area, young or unmarried are more likely to have an unsafe abortion compared to wealthier, more educated women living in urban areas. Of poor, rural Ugandan women who had an abortion in 2003, approximately 70% experienced complications, compared to 17% for wealthier, urban women (Guttmacher Institute 2013).

The high numbers of abortion complications are likely due to women seeking abortion services from unskilled providers or through traditional healer application of herbs or self-induction. In a study of community behaviours and abortion in Kampala, women reported using the herbs ennanda and kamunye from traditional healers, pills called Aspro, emergency contraception, detergents, wires, piercing the uterus, tea leaves, the root of a plant called mulinga, mumbwa clay mixed with local herbs and Ariel soap to induce abortion (Ipas 2012). These methods are at the least ineffectual but can potentially be toxic and dangerous, leading to haemorrhage, uterine rupture, infertility, poisoning and death. The costs of these methods were not asked in the study, however, research in Kenya showed that women used 30 different methods to induce an abortion and the cost ranged from as little as US $0.72 to purchase quinine to as much as US $60.00 to procure an abortion from a doctor (Marlow et al. 2013). Women resort to these methods because the abortions provided by skilled healthcare providers are prohibitively expensive, thus they turn to traditional healers or self-administer abortifacients because of the lower cost.

In Uganda, unintended pregnancies are common, modern contraceptive use is low and excess fertility is high, all of which contribute to an increased need for safe abortion services. Over 40% of all births in Uganda are unintended and rates of unintended pregnancies are even higher among rural, poor and less educated women (UBOS and ICF International 2012). Many unintended pregnancies in Uganda are the result of lack of modern contraceptive use. Only 26% of sexually active married women and 38% of sexually active unmarried women use a modern contraceptive method (UBOS and ICF International 2012). Further, the total fertility rate of 6.2 is much greater than the desired fertility rate of 4.5 (UBOS and ICF International 2012). Women seek abortion services as a means to end an unwanted pregnancy and to control their fertility.

The need for safe abortion services for sex workers in Uganda is even greater than for the population of women of reproductive age. Sex workers are vulnerable to unwanted pregnancies because of their number of sexual contacts, their sometimes inconsistent use of contraceptive methods and their increased risk of forced sex, rape or other forms of physical and sexual violence (Gysels, Pool, and Nnalusiba 2002; Scorgie et al. 2012). In several studies, more than half of sex workers surveyed had undergone at least one abortion in their lifetime and many of these abortions were under unsafe conditions (Bautista et al. 2008; Elmore-Meegan, Conroy, and Agala 2004; Lau et al. 2007; Nessa et al. 2004; Scorgie et al. 2013; Todd et al. 2006). In a study of sex workers in Uganda, Gysels et al. (2002) found that all 34 sex workers interviewed came from impoverished backgrounds, had unstable family situations, and that many had experienced forced sex and/or rape, all factors that contribute to an increased risk for unsafe abortion in Uganda. Under such circumstances, sex workers are not always able to negotiate condom use with clients or have limited access to contraceptive methods. Women who have experienced physical or sexual violence are more than twice as likely to have an abortion (WHO 2013). Sex workers’ risk is further compounded because sex work is illegal in Uganda and punishable by seven years imprisonment, thus further increasing sex worker vulnerability.
because of their inability to report violence to the police or seek redress for rape or sexual assault (Gysels, Pool, and Nnalusiba 2002; Scorgie et al. 2012).

Sex work is penalised under Ugandan Criminal Law and women or their dependents can be incarcerated for up to seven years for living ‘wholly or in part on the earnings of prostitution’ (Tamale 2011, 2). Street-based and brothel-based sex workers are routinely harassed by the police. Police abuse sex workers, perpetrate violence against them and bribe them. Sex workers work in different places and establishments in Kampala, including the street, brothels, hotels, lodges, bars, clubs, residential homes and massage parlours (Tamale 2011). Their class and economic situation varies greatly, with some more vulnerable than others. Some sex workers are higher-class call girls who suffer less harassment from the police compared to street-based and lower-class sex workers, yet all sex workers face potential violence from clients. Almost all sex workers report economic survival as the main reason they entered into sex work in the first place and many sex workers have children, are married, or try to conceal their involvement in sex work by setting up alternative businesses, such as a market stall (Tamale 2011). Sex workers’ background, venue of work, level of harassment and vulnerability vary in Kampala.

Research into African sex workers’ experiences accessing sexual and reproductive health services in the public sector reveals that the majority of sex workers are treated poorly or not treated at all, their privacy is frequently violated, they are blamed for their illnesses and are often asked inappropriate questions (Scorgie et al. 2013). For these reasons, when funds are available to them, many sex workers prefer to use private healthcare facilities. However, sex workers in South Africa and Zimbabwe attending clinics designed specifically for sex workers and run by non-governmental organisations reported respectful care and positive experiences with clinic staff and providers (Scorgie et al. 2013).

More research is needed in Uganda to understand sex workers’ experiences seeking and utilising available abortion services in order to better meet sex workers’ needs for safe abortion care. As part of a larger study in Uganda to understand stigma related to abortion at the community, institutional and individual levels, we sought to understand the unique experiences of sex workers’ with induced abortion services or PAC at an urban, private health clinic in Uganda. From the sex workers’ experiences, we then make recommendations about strategies used to reach sex workers and their implications for abortion services.

Methods
Fifty-eight in-depth interviews were conducted with women of reproductive age after they had sought induced or PAC services at public and private healthcare facilities in rural and urban Uganda. Criteria for inclusion in the in-depth interviews included: being aged 18 years or older, having just received either an induced abortion or PAC and the provision of written informed consent. Women were recruited initially by service providers, who asked them if they were willing to participate in an interview immediately following the procedure. If they agreed, an interviewer approached the women in the recovery area and informed them of the study and elicited their consent. Women were given a drink worth 5000 Ugandan shillings (US $2) for their participation. For this analysis, we included in-depth interviews from nine self-identified sex workers who attended one clinic in one of the largest urban slums in Kampala, Uganda. The clinic was originally designated for sex workers only but has since expanded to serve all surrounding community members. The clinic is known in the community to serve sex workers, but is also patronised by other community members and is now less stigmatised as a ‘sex worker’ clinic. This one
particular clinic is referred to as ‘the clinic’ in the remainder of this paper. In-depth interviews were utilised to understand women’s personal experiences with induced or PAC and because of the sensitive nature of the topic of abortion. Participants actual names were not used in the paper, rather, they were given pseudonyms.

Two semi-structured in-depth interview guides were developed in English and translated into Luganda, one for women who received induced abortion care and one for women who received PAC. The in-depth interview guides covered the following topics: how the woman found out about the services offered at the facility, reasons for seeking abortion care, description of the abortion care process at the facility, feelings about having the abortion procedure and whether anyone accompanied the woman to the facility. In-depth interviews were conducted in a private location by a trained interviewer who was not affiliated with the facility in Luganda or English, depending on women’s preference, immediately following the procedure. In-depth interviews lasted one-to-two hours and were tape recorded, transcribed and translated (where necessary). The methods and procedures were approved by the Allendale Investigational Review Board, Allendale, USA, and by Makerere University School of Public Health in Uganda.

The first author read all of the in-depth interview transcripts in English for initial code identification. After reading the transcripts, a codebook was created with codes and their definitions, and it included deductive codes from the in-depth interview guide as well as inductive codes emergent from the data (Berg 2004). All in-depth interview transcripts were uploaded into NVivo 10 and coded by the first author using the codebook (QSR International 2012). Codes and themes were reviewed by the other authors after coding by the first author. Once all transcripts were coded, the codes were grouped into themes. The unit of analysis was the individual.

Findings
Five women came to the clinic for post-abortion care (PAC) and four women came for an induced abortion. All but one of the women had children, with an average of two children each (range: 1–4). Four of the nine women dropped out of school when they were in primary school or the first year of secondary school. The other women did not mention their level of educational attainment. All of the women seeking PAC services at the clinic took a local herb to induce abortion at home before arriving at the clinic. Four women took the herb ennanda and one of the women who took ennanda also took the herb oluwoke. The fifth woman who took local herbs said that the woman supplying the local herb would not tell her the name of the herb. Two women who came to the clinic for an induced abortion were advised by friends to take local herbs, but the women instead decided to come to the clinic for induced abortion and had not taken any herbs.

Reasons for seeking an abortion
Five of the nine sex workers sought an abortion because they did not know the man responsible for the pregnancy. Inherent to sex work, according to the women, is an inability to identify the ‘owner’ of the pregnancy because of their many clients. One sex worker describes this:

My reason for opting for an abortion mainly was because I didn’t know the father. We meet different kinds of men and after knowing about the pregnancy, I couldn’t tell who was responsible for it. I currently have four children, none of them knows their father. (Abbo, induced abortion)
Another woman said she did not know the man responsible because she had been raped by a group of men, and therefore wanted to end the pregnancy. She describes events thus:

I was raped by a gang of boys when I was on my way back [from a night of clubbing]. Later on I found myself pregnant. I could not even tell where the boys came from or who exactly made me pregnant. This is why I terminated the previous pregnancy. I could not afford having a child without a father. (Kissa, PAC)

The second most common reason given for seeking an abortion was that the women could not afford to raise an additional child. Four of nine sex workers expressed that they could not bear the additional expenses of another child. One sex worker explains:

I terminated the pregnancy because I was unable to meet the needs of the unborn baby. As I told you, I am a single mother and I already have two kids. I am the father and mother of my children. I earn a meagre income through sex work, but it is not a reliable source of income. I don’t have enough money to support all those children. (Masani, induced abortion)

Other reasons the sex workers cited for seeking abortion included incest and wanting to continue their education:

The most important reason was that I did not want to drop out of school. I knew if I retained the pregnancy that would be the end of my education. I decided to terminate the pregnancy in order to continue with my education. Secondly, I had gotten involved in an incest kind of relationship. The owner of the pregnancy belonged to same clan as my mother. I could not imagine the shame I would go through if my mother and relatives got to know about it. They would look at me as a disrespectful girl in the family. The man was like a maternal uncle to me. For the sake of respecting my parents, I decided to terminate the pregnancy. (Nabirye, induced abortion)

Information sources about where to seek an abortion

All of the sex workers consulted their fellow sex workers, friends, peer educators or community outreach educators when deciding how and where to induce an abortion. Because of the nature of their work, sex workers reported that they talk openly about abortion:

Abortion information is so available in our community. Many girls I stay with or associate with are prostitutes, so we talk about these issues. Most times when one gets pregnant, there’s nothing much to do but opt for an abortion because of our situation. (Mangeni, PAC)

I was consulting my fellow sex workers. They know our problems and we support each other with information. Today it’s me, tomorrow it’s someone else. (Nabulungi, PAC)

Four of the five women who came to the clinic for PAC had initially been advised by a friend or fellow sex worker to use herbs. The lower cost of taking herbs compared to the perceived cost of seeking services at the clinic often swayed women in their decision. After experiencing complications due to the use of herbs, these women were able to get advice about coming to the clinic for PAC, which in most cases saved the woman’s life. Two women who initially took herbs based on their friend’s advice later sought other advice and were encouraged to go to the clinic for PAC:

When I discovered I was pregnant, I consulted my friends for advice. They asked me if I knew the owner. I told them I did not. I was raped. They advised me to abort. They also knew I did not have money to pay for abortion services. They advised me to do it the local way like other friends. My friends knew about a local herb called *ennanda*, which is used by many of the sex workers to terminate pregnancies. After I had terminated the pregnancy [at home], I had severe bleeding and stomach cramps. I could not bear the pain I was going through.
I approached one of my friends and asked for advice. I asked her if she knew of a place I could seek help. She advised me to go to [the clinic] that provides services to sex workers. She was not sure whether they offered the service, but wanted me to go and find out from the providers. I followed her advice. (Kissa, PAC)

We used to have peer educators [from the clinic] that came to sensitis people about health issues. I got to know about the services from these people. They used to tell us they had services for sex workers. They treated sexually transmitted diseases and had abortion services. Unfortunately, I did not know how much they charged for their services, especially for abortion care. I decided to seek abortion services from local providers. I had a friend who recommended a local lady to me. This was a lady selling local herbs treating all illnesses. I feared going to [the clinic to] ask for a service I could not afford. Good enough I knew where one of the peer educators [from the clinic] stayed. I went and asked him whether the facility offered abortion services and how much they charged. I was told they offered it but he encouraged me to seek more information from the providers at the clinic. He encouraged me to go [to the clinic for PAC]. (Nabulungi, PAC)

These women’s experiences highlight the complexity in their decision-making process and reveal that they consulted multiple people when seeking abortion services. Sex workers’ experiences also highlight the fact that information about safe abortion services is not sufficient to get them to the clinic, but that they also needed information about the cost. Many sex workers sought herbs because they did not know the cost of services at the clinic and believed that the herbs were less expensive and more accessible to them.

The four women who received induced abortion at the clinic never used herbs, but were instead able to find safe and affordable services at the clinic. The friends of two sex workers advised them to use local herbs, but one woman did not use them because she was afraid that to do so was not safe and another woman, with the support of her friend, then sought services from a private provider (who was too expensive) and finally ended up at the clinic:

[In order] to make the decision to terminate the pregnancy, I got support from a friend. She advised me to be strong when making up my mind. She knew this was not an easy decision. She encouraged me to follow my heart. She even went further to find me a person to do it. She had recommended [that I] do it the local way with herbs. Although she knew of a local person to do it, I feared the safety of the process. I decided to look for an alternative I thought was much safer. Then I sought help from a community educator whom I trusted who would suggest something that is safer. (Nabirye, induced abortion)

I had contacted selected friends for advice. They all encouraged me to use local herbs to induce the miscarriage. [Interviewer: Why did they propose using local herbs?] The reason why they suggested [herbs], it is one of the cheapest ways of terminating a pregnancy. They knew seeking care from medical personnel would be very expensive. However, I had another friend who had encouraged me to seek service from medical practitioners. We went together to consult the practitioner she knew, unfortunately she charged 150,000 Ugandan Shillings [US$59]. I could not afford the cost of her services. I decided to run to [the clinic] which I knew offered healthcare services to sex workers. (Masani, induced abortion)

A different woman was referred directly to the clinic by her friends and a community outreach educator and this enabled her to go straight to the clinic for induced abortion services. She described this process as follows:

I found out about the abortion services offered here from my friends, most of them were already familiar with this place and therefore introduced me to [a community outreach educator]. I often saw [him] in our suburb but didn’t know how helpful he was to the girls. [Interviewer: Who did you first talk to about seeking pregnancy termination information and care?] I first talked to [him]. He used to mobilise girls who worked at night [prostitutes]. I talked to him, asked him how I could attain help from the clinic, he advised me to come to the clinic and seek help. (Abbo, induced abortion)
Community outreach to sex workers about abortion services

Eight out of nine sex workers interviewed reported that they knew about PAC services or induced abortion services at the clinic because of clinic workshops in the community, through community outreach educators living in the community, or through peer educators who are sex workers and trained by the clinic staff. The clinic outreach efforts to reach the sex worker community clearly succeeded in reaching sex workers with information about abortion services, as almost all sex workers interviewed cited these outreach efforts as reasons why they were able to attain services at the clinic. Furthermore, sex workers who learned about safe abortion services from the clinic outreach efforts were able to refer other sex workers through their own networks even though they had not attended any clinic outreach activities, thus multiplying the clinic outreach programme effect. One woman explained:

I didn’t have to seek out information, most of my friends were familiar with this clinic and [the community outreach educator] also gave us information about abortion. One doesn’t have [to do much to get] abortion information, the [sex workers] are now familiar with the services here at the clinic. Since we are open about this issue, we normally recommend [that] our friends come here in case of any complication. (Abbo, induced abortion)

Key to the success of the outreach to sex workers was one community outreach educator affiliated with the clinic who was trusted by the sex workers. Even if the sex workers were unsure about where to seek abortion services, they trusted this individual because he had educated them about other reproductive health topics or was recommended by fellow sex workers:

[Thank goodness] I had been counselled by the clinic staff who occasionally visited our community to carry out sensitisations on health issues. They used to come to places where we work and teach us about prevention of HIV and other STDs. I decided to approach [the community outreach educator] to find out if he had any solution for me. I did not fear telling him my problems [because] he was a friend to many sex workers in the area. (Nabirye, induced abortion)

I was so comfortable asking [the community outreach educator] about abortion information because I was not the first person [he] had helped. We trust [him] a lot in our communities and therefore in case of any problem, we run to him, he then refers us to this clinic. [He] helps us a lot. He normally organises for [the sex workers] to attend trainings on women’s issues. We learn a lot from this training. (Abbo, induced abortion)

One of the sex workers who had an induced abortion knew about the services because she was a peer educator herself. She also worked to sensitise other sex workers:

I learned about [the clinic’s] abortion services when I worked [with the clinic] as a peer educator. I used to go out in communities to sensitise fellow sex workers on health issues and available services at [the clinic]. (Namono, induced abortion)

Although two sex workers reached by the clinic’s community outreach programme knew about reproductive health services offered in general, they were unclear whether the clinic also offered abortion and how much it cost. This uncertainty led these sex workers to induce abortion at home with herbs and then seek PAC at the clinic:

I came to know about the clinic from the peer educators who occasionally visited our community. They used to sensitise us about family planning, HIV and STD prevention. They also supplied us with free condoms. Before I came here to seek PAC services, I did not know they offered abortion services. (Nasiche, PAC)

We used to have clinic peer educators that came to sensitise people about health issues. I got to know about the clinic services from these people. They used to tell us they had services for sex workers. They treated sexually transmitted diseases and had abortion services.
Unfortunately, I did not know how much they charged for their services especially on abortion care. When I consulted some of my friends whether I should seek services there, they did not know how much they charged for the service. I feared going to ask for a service I could not afford. (Nabulungi, PAC)

These women’s experiences underscore the importance of including abortion-specific information as part of the clinic’s community outreach efforts and including the costs of the abortion procedure as part of that information.

**Women’s accompaniment to the health facility**

A friend, peer educator or community outreach educator accompanied over half of the women to the clinic. The five women who were accompanied were comforted by the emotional and moral support that their friend or the community outreach educator provided. One sex worker explained:

I was escorted by a friend I stayed with who worked at the clinic as a peer educator. She is the one that recommended I get post abortion services from the clinic. She took it upon herself to support me to get the right treatment. She picked me up from home every day to go back for appointments. However, she did not follow me to the treatment room. She waited for me outside, but would always inquire about the follow up arrangements I had with the providers. She would support me and respond as required. (Nabulungi, PAC)

None of the friends, peer educators or the community outreach educator was allowed to enter the counselling or procedure room with the women, however, the women still reported that they were pleased that someone accompanied them at all. Two women came to the clinic alone because they feared that persons accompanying them would breach their confidentiality about the abortion. The two women describe this:

I was not accompanied by anyone. I felt it was not safe for me. I feared the possibility of someone spreading the news to the whole community. (Namono, induced abortion)

I came to seek the service alone. [Interviewer: But do you think it is good to be accompanied?] It may be good to have accompaniment. This person is likely to support your walk back home in case you were weakened by the process. But the challenge is on confidentiality. How would you ensure s/he does not disclose to the other people what happened on that day? (Masani, induced abortion)

**Confidentiality**

Maintaining confidentiality about the abortion was extremely important to all of the sex workers. Sex workers only spoke with friends, peer educators or community outreach educators whom they trusted not to disclose their intentions to have an abortion to anyone else. Some women did not tell anyone except for the provider because they feared a breach of confidentiality:

It was my own decision to terminate the pregnancy. I consulted the clinic providers when I was already determined to remove it. I only needed their support in performing the process safely. I wanted it to be a secret between the providers and me. (Namono, induced abortion)

I decided to keep the problem to myself. I did not want other people to know. [Interviewer: Why did you not want other people to know?] I know abortion is not a new thing in our communities. A number of girls and women have done it. It’s so funny that even those who had ever done it shun whoever is victimised, as if it is a strange action. I decided not to seek help from people. (Nasiche, PAC)
Sex workers receiving abortion services also underscored that it was very important that the providers maintain their confidentiality. When the provider assured confidentiality, the sex workers felt confident about their decision:

I didn’t feel like I was treated any differently from the rest. Just like every patient, my issue was kept confidential and therefore no one outside the room had to know anything about what was going on. (Abbo, induced abortion)

When I reached here I found the service providers welcoming. This was my first time here but they treated me well. The provider who attended to me ensured confidentiality of the information I provided. She paused the conversation whenever other providers entered the room. I had time to make consultations with this provider. (Nabulungi, PAC)

**Service provider treatment of women**

All of the sex workers reported excellent treatment by the clinic providers when seeking abortion services, whether induced abortion or PAC. Many sex workers were reluctant to seek services at the clinic because they expected to be treated poorly, rebuked or turned away because they were sex workers or because they were seeking an abortion, or both. One sex worker explained her surprise at the excellent treatment:

Before I came for the service, I expected rude treatment and neglect from the providers. I used to think all service providers would be rude to women who seek abortion services. At the clinic it is a different case, you interact with the providers freely. They are willing to help you out. I would say I received maximum care from the providers. I was given good care from the beginning until I have recovered. They treated me like any other patient. (Nabulungi, PAC)

All of the sex workers were pleasantly surprised by the caring and high quality treatment they received from the clinic providers. The service providers did an excellent job building rapport with the sex workers and, in the case of the PAC clients, were able to make them feel comfortable enough to disclose whether they had taken anything to induce the abortion before coming to the clinic. Service providers listened to the sex workers, showed that they cared and treated them as they would treat any other client. Two women describe their positive experiences:

The care was overwhelming, everyone treated me well, the doctors talked to me well, they were encouraging, they generally showed a lot of care. (Abbo, induced abortion)

The providers here are good. They are not rude to clients. They handle you with care and listen to you. The day I came here for the abortion service, I was scared about the response of the nurses towards my action. I was happy to see that the nurse I first approached attended to me. (Kissa, PAC)

**Discussion**

The most important finding from this preliminary study was that women consulted many people when deciding how to access abortion services, but that the first consultation was often the most important. It is critical that sex workers receive correct information about safe abortion care from the first person they consult about their decision to have an abortion. Sex workers often turned first to a friend and fellow sex worker, and when that friend knew about the clinic and referred the sex worker to it, there was a positive outcome. However, when that friend referred the sex worker elsewhere, usually to an herbalist, the sex worker had a poor outcome, which endangered her life and forced her to
seek additional services. In other research studies, women reported first speaking with friends or close family members about their decision to have an abortion and where to go (Marlow et al. 2013). This first contact is crucial to sending women on a path toward a safe abortion or to a riskier abortion. Ideally, the first person the sex worker consults should provide the correct information about where to access safe abortion care.

We also found that saturating the community with information about where safe abortion is available is imperative to ensuring that sex workers receive safe abortion care. Through multiple interventions in the community, the clinic was able to promulgate information about safe abortion to the sex workers. The interventions included workshops, peer educators and a community outreach educator affiliated with the clinic and accessible to sex workers in the communities where they live. Peer education was found to be effective in Kenya, where an intervention with sex workers trained as peer educators showed that sex workers who attended four or more peer education sessions in the previous six months had fewer sexual partners and higher levels of protected sex compared to sex workers who attended fewer sessions (Luchters et al. 2008). We also found peer educators were key to helping their fellow sex workers access safe abortion services. Further, the ability of sex workers to speak openly about abortion with one another allowed them to seek information about services from a network of other sex workers. Sex workers trusted the peer educators and the community outreach educator and felt they could share their situation with them. Through the peer educators, the community outreach educator and workshops, sex workers received information about safe abortion care and referrals to the clinic. Sex workers accessing these resources then became a resource themselves to other sex workers, thus increasing the saturation of information about safe abortion among the sex worker community.

Knowledge about the cost of safe abortion services is a vital piece of information that women need in order to decide where to seek services. We found that when sex workers did not know the cost of the safe abortion services at the clinic, even when a friend or fellow sex worker referred them, they were reluctant to seek services at the clinic. Ensuring that peer educators, the community outreach educator and in workshops that the cost of the abortion services is known will encourage sex workers to go to the clinic.

The respectful treatment of sex workers and maintaining confidentiality by clinic staff are key to the provision of high quality safe abortion services to sex workers. We found that at the clinic sex workers were treated as any other client should be treated, with respect and dignity. Sex workers in our study expected to be treated poorly at the clinic, particularly if they revealed that they were sex workers, and even more so because they were seeking abortion services, and yet they were pleasantly surprised by how well they were treated by the clinic staff. It is not surprising that sex workers expected to be treated poorly, as research with sex workers in other African countries showed that, more often than not, sex workers are treated poorly and their confidentiality is violated (Scorgie et al. 2013). Sex workers also appreciated the provider’s sensitivity about maintaining their confidentiality about the abortion and their sex worker status. This excellent treatment encourages sex workers to recommend the clinic’s services to other sex workers.

The findings in this paper are, of course, limited by the small number of sex workers interviewed. However, we are confident that the depth of the interviews allowed for data saturation of women’s abortion experiences at the clinic. While the findings are not generalisable beyond the study setting, they can, however, be used to strengthen programmes for sex workers in other parts of Uganda and in other countries.
Conclusion

Although sex workers’ are a unique population, understanding their experiences with induced abortion and PAC is critical to meeting their greater need for abortion services compared to the general population. The need for safe abortion services for sex workers in Uganda is greater because of their many sexual encounters, their increased levels of forced sex, rape and violence and their financial and social vulnerability. We identified several important programmatic considerations for safe abortion care for sex workers that can be applied to all women of reproductive age in Uganda. These programmatic components include creating community-level interventions where women can speak openly about abortion with one another, creating a support network among women, training peer educators and making available a community outreach educator in the community and community outreach workshops on abortion. The important programmatic components for the health facility are ensuring that providers treat women with care and respect, allowing women to be accompanied within the health facility and guaranteeing women’s confidentiality. If these programmatic changes have helped sex workers, a highly stigmatised population, to access safe abortion services, the same programmatic elements should be tested with populations of women of reproductive age to help them to access safe abortion services in their communities as well. In addition, more programmes for sex workers should incorporate these programmatic strategies to increase sex workers’ access to safe abortion services in other parts of Uganda.

Note

1. Under Ugandan law, defilement is the act of having sex with a girl under 18 and rape is having sex with a woman without her consent, usually by force.

References


Résumé

En raison du nombre de leurs contacts sexuels, de leur utilisation irrégulière des méthodes contraceptive et de leur risque accru de subir des rapports sexuels forcés, des viols ou d’autres formes de violence physique ou sexuelle, les travailleuses du sexe en Ouganda ont des besoins en services d’avortements sans risque plus importants que ceux des femmes en âge de reproduire dans la population générale. Pour tenter de comprendre l’expérience des services d’avortement provoqué ou de soins post-avortements vécue par des travailleuses du sexe dans un centre de santé urbain en Ouganda, nous avons conduit neuf entretiens en profondeur avec des femmes qui exercent le commerce du sexe. Ces entretiens ont été audio enregistrés, transcrits, enregistrés sur des ordinateurs et codés pour l’analyse des données. Nous avons identifié sept éléments programmatiques importants concernant les services d’avortement sans risque, destinés aux travailleuses du sexe. Les plus importants sont la nécessité d’élaborer des interventions au niveau communautaire qui permettent aux femmes de s’exprimer ouvertement sur l’avortement, de créer un réseau de soutien parmi les travailleuses du sexe, de former des paires-éducatrices, de rendre disponibles un éducateur communautaire de proximité et des ateliers communautaires de proximité centrés sur l’avortement. Au niveau de l’établissement de santé, il est essentiel que les prestataires de services traitent les travailleuses du sexe avec soin et respect, les autorisent à être accompagnées vers cet établissement et soient garants de la confidentialité. Ces éléments programmatiques aidaient les travailleuses du sexe à accéder aux services d’avortements sans risque et devraient être testés par toutes les femmes en âge de procréer pour améliorer l’accès des femmes aux services d’avortement sans risque en Ouganda.

Resumen

En Uganda, debido a la cantidad de contactos sexuales, al uso incoherente de los anticonceptivos y al mayor riesgo de sexo obligado, de violación o de otras formas de violencia física o sexual que deben
enfrentar, las sexoservidoras tienen más necesidad de servicios de aborto seguro que el resto de la población de mujeres en edad reproductiva. Los autores se propusieron comprender las vivencias de las sexoservidoras en torno a los servicios de aborto inducido o de atención posaborto (apa) en el contexto de una clínica urbana de Uganda. Con este objetivo, realizaron nueve entrevistas a profundidad a sexoservidoras, las cuales fueron grabadas, transcritas, traducidas, capturadas en computadora y codificadas para su análisis. A partir de las mismas se identificaron varias consideraciones programáticas de importancia, relativas a los servicios de aborto seguro para las sexoservidoras. Las más relevantes tienen que ver con la generación de intervenciones a nivel comunitario en las que las mujeres puedan hablar con libertad sobre el aborto, con la creación de una red de apoyo entre sexoservidoras, con la formación de educadoras entre sus semejantes, con la presencia de una educadora comunitaria, y con la realización de talleres comunitarios sobre el aborto. Asimismo, resulta importante que en el ámbito de la unidad de salud las trabajadoras brinden un trato cuidadoso y respetuoso a las sexoservidoras, que a éstas se les permita asistir acompañadas a la unidad y que se les garantice la confidencialidad. Tales aspectos programáticos contribuirán a que las sexoservidoras tengan acceso a servicios de aborto seguro, los cuales deberán estar disponibles para todas las mujeres en edad reproductiva, a fin de mejorar el acceso de las mismas a dichos servicios en Uganda.