CONDOM USE AMONG COMMERCIAL SEX WORKERS IN KAWEMPE DIVISION, KAMPALA DISTRICT.

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A DISSERTATION SUBMITTED AS PARTIAL FULFILMENT FOR AN AWARD OF THE MASTERS OF PUBLIC HEALTH DEGREE OF MAKERERE UNIVERSITY

AUGUST 2004
DECLARATION

I hereby declare that the work presented in this book is original and has never been presented anywhere either partially or in total for any academic award or publication unless otherwise stated. This report is hence forth submitted for the award of the degree of Masters of Public Health of Makerere University, Kampala Uganda.

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This dissertation has been submitted for examination with the approval of the following supervisors:

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2. Mr. Lynn Atuyambe
DEDICATION

To my father Israel Lukwago and my late mother Idah Nalule for making me what I am today. To my brothers, sisters, nieces and nephews for their continuous encouragement and support when pursuing this course.
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May the Almighty God bless you all!
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<td>Assistant District Director of Health services</td>
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<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
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<td>AMREF</td>
<td>Africa Medical Research foundation</td>
</tr>
<tr>
<td>CAO</td>
<td>Chief Administrative Officer</td>
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<td>CDC</td>
<td>Centre for Disease Control</td>
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<td>CSW</td>
<td>Commercial Sex Worker</td>
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<td>DDHS</td>
<td>District Director of Health Services</td>
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<td>DISH</td>
<td>Delivery of Improved Health Services</td>
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<td>FGD</td>
<td>Focus group discussion</td>
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<td>HIV</td>
<td>Human Immuno Deficiency Syndrome</td>
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<td>IPH</td>
<td>Institute of Public Health</td>
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<td>KI</td>
<td>Key informant</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>NGO</td>
<td>Non Government Organisation</td>
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<td>PI</td>
<td>Principal Investigator</td>
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<td>RA</td>
<td>Research assistant</td>
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<td>Sexually Transmitted Disease</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>UNAIDS</td>
<td>Joint United Nation Programme on HIV/AIDS</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>Uganda Youth Development Link</td>
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OPERATIONAL DEFINITIONS

Prostitute. A prostitute is a person who in public or elsewhere, regularly or habitually holds himself or herself out as available for sexual intercourse or other sexual gratification for monetary or other material gain. In this study, prostitutes have also been referred to as sex workers.

Legalisation. Legalisation of prostitution means that prostitution is recognised by the law. Legalised systems often include special taxes, restricting prostitutes to working in brothels or in certain zones, licenses, registration of prostitutes and government records of individual prostitutes, and health checks for quarantine purposes.

Sexually Transmitted Infection. This is an infection without signs and symptoms of an infectious disease caused by one or more microorganisms transmitted from one person to another through unprotected sexual contact with an infected person. The infectious agent may be bacterial, viral, protozoal or fungal.

Sexually Transmitted Disease. This is the presence of signs and symptoms of an infectious disease caused by one or more microorganisms which are transmitted from one person to another through unprotected sexual contact with an infected person. Examples are HIV, gonorrhoea, and genital ulcer diseases.

Safer sex. This is any sexual activity which does not involve a high risk of transmitting STDs and HIV. Examples are masturbation, kissing and sexual intercourse with a condom. In this study, sexual intercourse with a condom has been referred to as protected sex while sexual intercourse without a condom has been referred to as unprotected sex.

A client. This is a person who demands for sexual services from a sex worker
Regular client. This is a habitual buyer of sexual services from a particular sex worker.

An irregular client. This is a client who rarely uses sexual services of a particular sex workers.

Condom. This a barrier method and a contraceptive against STDs and unwanted pregnancy respectively. Condoms are of two types; the female and the male condom.

Consistent condom use. This is condom use with every sexual encounter with a client.

Inconsistent condom use. This is condom use with some clients.

Brothel. A house that is designated for commercial sex work activities only.

Self efficacy. This is a person’s belief whether he or she can perform or refrain from a behavior and can cope with barriers that may hinder actual performance of a behavior.
ABSTRACT

Background: In Kampala district, commercial sex workers (CSWs) have been reported with high incidence of sexually transmitted diseases (Ministry of Health 1998). As one of the methods of STDs/HIV prevention, the level of condom use in Uganda’s general population has been documented while that of CSWs is not well documented.

General objective The study aimed at generating information on the level of condom use and the factors influencing condom use among CSWs in order for the District Health Team to develop strategies to ensure safer commercial sex.

Methodology: A community based cross-sectional study that employed quantitative and qualitative methods of data collection was conducted. A total of 114 CSWs were interviewed using a semi structured questionnaire. Focus group discussion and key informant interviews were also conducted. The study participants were identified by community peer educators and consecutively enrolled for the study. Quantitative data was analysed using EPiINFO 6.0 version and presented in tables and figures. Qualitative data was analysed using a master sheet and presented in text form.

Results: Most (63.7%) of the respondents were between 15-24yrs, single (65.8%), attained ordinary level secondary education (47.4%). Majority (96%) of CSWs reported to use condoms during sexual encounters with clients. However only 64% (73/114) reported to consistently use condoms. Preventing STDs and unwanted pregnancy were the major reasons for consistent condom use while desire for more money obtained from unprotected sex was a major reason for inconsistent (23/37) and no condom use (3/4). Knowledge on indications for condom use was; to prevent STDs (84.2%) and unwanted pregnancy (77.2%). Most (92%,105/114) of the respondents had a positive attitude towards condom use and perceived themselves to be at risk of STDs/HIV (75%).
Conclusion. The level of condom use among CSWs was high but consistent condom use was 64%. Respondents had high knowledge on indications for condom use, had a positive attitude towards their use and perceived themselves at risk of STDs/HIV. However desire for higher monetary gains from unprotected sex was the major obstacle for consistent condom use.

Recommendations: The DHT should target CSWs and their clients when disseminating STDs/HIV information on importance of consistent condom use. The DHT should encourage CSWs to create more alternative income generating activities to supplement commercial sex work an intervention aimed at increasing the level of consistent condom use.
CHAPTER ONE:

1.0 INTRODUCTION AND BACKGROUND

1.1 The global and regional HIV/AIDS epidemic

The HIV/AIDS epidemic still remains a global challenge despite efforts to widely spread knowledge on HIV risk behavior and prevention. By the end of year 2002, the World Health Organisation (WHO) estimated 42 million people living with HIV/AIDS worldwide. 38.6 million of these as adults, 19.2 million are women and 3.2 million are children under the age of 15 years. Sub-Saharan Africa with 10% of the world population has the highest number of HIV positive individuals (29.4 million people living with HIV/AIDS) followed by South and South-East Asia (6 million). Each year approximately 333 million new cases of other STIs also occur in adults world wide (Population report 1999).

1.2 Prevention of Sexually transmitted diseases and HIV

Sexual transmission of HIV is enhanced in presence of sexually transmitted diseases (STDs) especially syphilis, chancroid, genital herpes that cause genital ulceration. Therefore STD treatment is one of the interventions in the control of HIV. Other prevention methods in control of STDs and HIV such as abstinence (and delay of first intercourse) especially among young people, being faithful (monogamy and reduction in the number of sexual partners) and condom use during sexual intercourse have been used with great success in Uganda (Population action International 2003).

Programmes aimed at controlling sexual transmission of HIV have mainly targeted the general public. However HIV prevention programs must be flexible to target different high risk populations. There is evidence that programmes to reduce HIV infection among...
HIV high risk populations like sex workers (CSWs) and their clients are feasible, effective and have led to successful risk reduction in HIV infection in countries like Thailand (UNAIDS 2001). Statistics suggest that preventing one case among core HIV transmitter groups such as sex workers will save ten times the amount of future transmissions compared to preventing one transmission in general population (Blaire 1997).

The STD and HIV prevention activities that are implemented among CSWs in Kampala district range from behavior change messages such as reducing the number of sexual partners, quitting commercial sex, CSW involvement in alternative income generating activities, education and distribution of condoms, sexual health services like voluntary HIV counseling and testing and treatment of STDs (Africa Medical Research Foundation 2004). Among these activities, however, condom use remains an immediate and effective STD/ HIV control and contraceptive measure. The effectiveness of condoms can be enhanced with correct use through education, familiarity and consistent condom use which decreases the probability of condom failure.

1.3 Condom use among the population

The global HIV epidemic report of the year 1999 indicates a wide variation in condom use around the world, and even within communities (Cherney 1999). On the whole, more men were reported to use condoms than women. Both sexes were more likely to use condoms with casual partners than with a spouse or a regular partner. Young people were more likely than their elders to use condoms to protect themselves and their partners against HIV infection.
The Uganda Demographic Health Survey results of 2000/2001 indicate condom use among women with non cohabiting partners to be high especially those with secondary education (61%) and those in urban areas to be 58% (UBOS 2000/2001). The same report indicates that condom use was moderately high among women aged 15 to 19 years (50%), those who had never married but were having sex (50%) and women in the central region (49%). Among men, condom use with non cohabiting partners was high among men in their early twenties (71%), those in urban areas (81%), and those with secondary education (72%).

In Kampala district, where Kawempe division, the study area is located, an increasing trend of condom use with non regular partners (short term relationships of less than a year) has been reported (MOH 2002). Condom use ranged from 57.6% in 1995 to 76% in 1998 and was 85% in 2001. While condom use among the general population in Uganda has been documented by the MOH and Uganda Demographic Health Surveys, condom use among CSWs, an STD/HIV high risk population is not well documented.

1.4 Practice of commercial sex

Sex work is one of the oldest professions of man though not recognised as work by labour unions. While sex work is a global phenomenon, the practice is often illegal and therefore clandestine, making it difficult to determine the extent of sex work industry (UNAIDS 2002). Sex workers are often victims of stigma and discrimination, exploitation and violence, and have limited access to health services. However, sex work is a significant social and economic sector in many countries. According to the
International Labour Organization's (ILO) estimates, the sex work industry accounted for more than 2% of gross domestic product in four South-East Asian countries in the late 1990s (Centre for AIDS prevention studies 1996).

In Uganda commercial sex is not recognised by law. Obtaining money or gifts in exchange for sex is an offence making it a secret and hidden phenomenon and women (more reported as CSWs than men) will not readily admit their involvement in the trade which is also socially unacceptable. Despite being illegal, sex work has continued to flourish in border towns like Busia, Malaba and stop over towns like Masaka and Mbale (Todd Ritter 2000). Residents in these towns trade with rural traders, truck drivers and other passengers as they provide services in restaurants, bars and lodges. Commercial sex work activities also takes place in these areas. Therefore these towns are prime locations for STDs and HIV transmission.

In Kampala district, CSWs have been noted to mainly reside in slum areas where there are affordable basic needs of life such as food and housing (Uganda Youth Development Link 2003). The most notable slum areas are Kisenyi, Katwe located in Kampala central division, Nateete in Rubaga division, Kalerwe, Bwaise and Katanga zones located in Kawempe division. These slums are densely populated, overcrowded and therefore favour the growth of the commercial sex industry. Therefore information on safer sex practices among the CSW population who reside in these densely populated areas is paramount.
CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Situation analysis of the HIV/AIDS epidemic in Uganda

By the end of year 2001, the Ministry of Health Uganda estimated a cumulative total of 2 million Ugandans who had been infected with HIV since the beginning of the epidemic most of them being within 15-49 years. The Ministry of Health also indicates that HIV/AIDS disproportionately affects women and especially young women of 15-19 years who are five times more likely to be HIV infected than men in the same age group. This discrepancy is due to; age mixing between young women and older men who have had more sexual experience and are much more likely to expose these girls to HIV, easy infection of women during vaginal intercourse with an infected partner than men, women lack full control over sex and reproduction, women have less access to HIV prevention information, the growing poverty that encourages early marriages to older infected men and prostitution (Cherney 1999).

2.2 HIV prevalence among sex workers

Sex workers studied in the early 1980s in Uganda had an HIV infection rate of about 80% but in 2000, sex workers tested in Kampala had a rate of 28% (World Health Organisation 2002). This HIV prevalence is higher than the estimated national HIV prevalence of 5% reported by Ministry of Health Uganda. Similarly the Indian states of Maharashtra, Andhra Pradesh and Tamil Nadu (each with at least 55 million inhabitants), have registered HIV prevalence rates of over 2% among pregnant women in one or two sentinel sites and over 10% among STD patients. These rates are far higher than India’s
national HIV prevalence of less than 1% (UNAIDS 2001). Low national HIV prevalence rates therefore can be very misleading. They often disguise serious epidemics that are initially concentrated among specific population groups and that threaten to spill over into the wider population. Therefore national HIV/AIDS prevention programmes need to target special groups with high HIV rates in order to further reduce the national HIV prevalence rates and also prevent emerging epidemics.

2.3 The role of sex workers in STD and HIV transmission

The most important determinant of STD transmission is the rate of new sexual partner acquisition per unit of time. When the number of new partner acquisition is high, the rate of new infections in the community is high. Sex workers in Kampala district were reported to have an average number of sexual partners of 3.2 per night and 15.9 partners in a week (MOH 1998). This high rate of sexual partner change among CSWs is likely to play a key role in maintaining STD and HIV transmission within communities.

2.4 HIV prevention activities among CSWs

The HIV/AIDS epidemic has highlighted the need for responses on three levels: Prevention of entry into sex work, protection of those involved in sex work and assistance in exiting from sex work. Each of these is in turn addressed on three levels: individual, community and policy making (UNAIDS 2002). However, the challenges for governments are; making HIV prevention and care available to all CSWs since sex work is stigmatised and therefore clandestine, formulating and implementing policy and legal frameworks that do not discriminate against sex workers, setting up programmes that
empower young women with education, income generating activities, and addressing factors that force men and women to join commercial sex work. (Lin Lean 2001).

2.5 Condom use successes among sex workers

Internationally many HIV prevention efforts aimed at sex workers have addressed structural and policy considerations. The policy on 100% condom use in all brothels was born in Thailand in 1991 after detecting high HIV infection levels among sex workers in that country. Health authorities used results of periodic STI tests of CSWs to determine whether sex establishments were complying with the programme (Horizons report 2002). The 100% condom use programme has been successful in Thailand where new HIV infections have dropped by more than 80% since the peak of the HIV/AIDS epidemic that was reported in the year 1989. Condom use by CSWs and their clients increased from 14% to more than 90% in the sex establishments.

Monitoring of condom use through periodic screening of STIs is a better indicator for condom use success than reports on increased demand of condoms or claims of condom use by CSWs. This was demonstrated by a study on CSWs in Kampala district where 95% of CSWs reported to have used condoms in the previous sexual encounter with a client before the study was conducted (Asiimwe-Okiror 1998). However, 51% of them reported an incidence of abnormal vaginal discharge and genital ulcer disease in the previous 12 months preceding the study. This contradicted the reported high condom use among this population. This study therefore raised questions on consistency of condom use among CSWs in Kampala district.
2.6 Factors that influence condom use among CSWs.

2.6.1 Condom promotion

Condom promotion can help to lower HIV infection rates. In Senegal, for example, government promotion of condoms started soon after AIDS was discovered in the country and has helped keep HIV prevalence down to less than 2% of adults, one of the lowest rates in sub-Saharan Africa. In the same country the prevalence of STIs among sex workers has been reduced by more than half, from 45% in 1991 to 20% in 1996 (Population report 1999).

In 1990, a nationwide HIV awareness campaign was initiated in Uganda that aimed at promoting safer sex through abstinence, fewer sex partners, and condom use especially among young people. There was a subsequent rise in age at first sexual intercourse, increased condom use with non regular partners and reduction in the number of sexual partners (MOH 2001).

However a study on 200 STD patients in Mulago hospital revealed that although knowledge of condoms and their role in STD/HIV prevention was high, consistent use remained low in this high-risk population (Walker 1993). All respondents except one had heard of condoms. Knowledge of the role of condoms in STD and HIV prevention was high (80%). However only 30% of the respondents had ever used condoms, 21% had used a condom in the past year, and only 0.5% always used a condom. Common myths included; condoms getting stuck in the vagina, resulting in surgery and or death (68%).
only unfaithful partners use them (66%), condoms can give you AIDS (29%). Other reasons for condom non-use were; religious objections (44%) and wanting children (32%).

The above study findings suggest that success in condom promotion and their use should therefore involve understanding and overcoming negative attitudes and beliefs about condoms among individuals in a population. Continuous empowerment with knowledge is the basis for being able to recognise, promote and defend one's own health as well as that of one's community and country.

2.6.2 Professional versus private sex.

In 2002, a study done by Guardian examined the socio-cultural and economic determinants of condom use among 100 female South African CSWs. The study demonstrated considerable contrast between factors influencing condom use in professional versus private sex situations. With clients, practical issues such as financial strain were the major obstacles to condom use. With private sex partners, sex workers avoided condoms due to their negative symbolism. Condoms were seen as suggestive of filth, disease, infidelity, and mistrust. HIV/AIDS awareness had minimal impact on condom use. HIV/AIDS was viewed as a remote threat, overridden by immediate practical and emotional concerns.
The population report of the year 1991 indicates that world wide condoms rank near the bottom among contraceptive methods used by married couples. The same report indicates that in developing countries, the prevalence of condom use among married women of reproductive age to be between 2% and 6% while 60% of all condoms are used outside marriage. This includes condom use in extramarital sex and condom use among the unmarried people.

2.6.3 Self efficacy

A CSW’s belief in her ability to insist that clients use condoms is one of the most important predictors of consistent condom use. A study on consistent condom use among female sex workers in Nigeria revealed that CSWs who asked all clients to use condoms were 39 times more likely to consistently use condoms than those who did not ask all clients to use condoms (Muyiwa 2001). However negotiation for condom use may be affected by gender power relations. Most sex workers are women and their clients are men. Clients of sex workers may use various tactics ranging from financial incentives, dominant attitude to violence to avoid using condoms during sexual encounters. Female sex workers, who lack the leverage to convince clients to use condoms, may have little choice but to put themselves and their partners at risk for HIV and other STIs. In situations in which men provide gifts or financial support to young women (who are not sex workers) in exchange for sex, young women may compromise on condom use to receive material goods (Zellner 2003)
2.6.4 Health risk perception.

The way people perceive themselves to be at risk or not at risk of contracting HIV determines their sexual behavior patterns. A study of respondents drawn from Kabale, Kampala and Lira districts in the year 2003 found HIV risk perception to be associated with condom use in addition to religion, educational attainment, marital status, residence, number of sexual partners and having contracted an STD (Union for Africa Population Studies 2003). Mistrust of partners, past social history, having many sexual partners, and having undergone blood transfusion were the main reasons why people considered themselves at risk of contracting HIV. Respondents who did not consider themselves at risk of contracting HIV and those who had never contracted STDs were less likely to use condoms. Post-primary education and urban residence were strong contributors to condom use.

Researchers from the Society for Family Health in Abuja, Nigeria, suggested that religious beliefs could be contributing to rising rates of HIV infection in the brothels. While many of the sex workers engaged in unprotected risky sex, they incorrectly judged their risk as low because many felt their belief in God offered them protection from infection (Edsusman 2002). Statistics from the same study indicate that faith-based protection was failing. In 1991-1992 about 17 percent of sex workers in Nigeria were HIV-infected and in 1995-1996 that infection rate rose to around 35 percent.

2.6.5: Clients and condom use

The sex industry is demand-driven and one of the solutions to combating HIV/AIDS therefore is to look at the demand side, the clients, and explore ways to change their
behaviour. In the year 2002, qualitative data was collected by conducting focus group discussions and in-depth interviews among female sex workers and pimps in Indonesia (Endang 2002). Around 53% of sexual acts reported to be protected, and 12% of the protected sex was preceded by clients' argumentation against it. Only 5.8% of sex workers consistently used condoms for a 2-week period of observation, and this figure decreased to 1.4% for a 4-week period. Reasons for not using condoms from the client's side, as mentioned by the sex workers, were perceived less pleasure due to the condom and the belief that clients who are acquainted with the sex workers do not need protection against STDs and AIDS.

The main reasons given by female sex workers for not using condoms were; the CSW's beliefs that boyfriends, native Indonesians and healthy-looking clients cannot spread STDs and some CSWs had already taken other preventive measures like taking antibiotics. The research also showed that pimps were not very supportive of condom use programs in Indonesia and considered them a threat to their business.

In a case study of long distance truck drivers travelling the route inland from Africa's busiest port city of Durban, 95% of truckers interviewed were sexually active, 70% always had penetrative sex and 71% of them never used a condom. Their sexual partners ranged from wives to CSWs at roadside truck-stops (Dempster 2000).

Findings from the above studies show that when designing HIV prevention interventions, it's important to involve all people involved in sex work industry. These range from CSWs, clients to CSWs, middle men and managers of sex establishments since they influence adoption of preventive STD/HIV measures by CSWs and clients.
CHAPTER THREE:

3.0 PROBLEM STATEMENT, STUDY JUSTIFICATION, CONCEPTUAL FRAMEWORK

3.1 PROBLEM STATEMENT

In Kampala district, CSWs have been reported to have a high prevalence of STIs and HIV/AIDS. This was revealed by a KAPB study in Kampala district where 51% CSWs reported an incidence of acute vaginal discharge and genital ulcer disease in the previous 12 months preceding the study (Asiimwe-Okior 1998). In 2002, the Uganda AIDS Commission estimated the HIV prevalence rate among CSWs to be 28% (WHO 2002).

Sex workers therefore are a core group with a high risk of transmitting STIs/ HIV to their clients because of the large number of sex partners and a high rate of sexual partner change. The clients to CSWs are a source of STDs and HIV to the general population such as girl friends, wives and other CSWs who may also transmit HIV to other clients.

In Kawempe division, the District Health Team (DHT) and non government organisations such as AMREF are implementing STD/HIV prevention activities among CSWs. The activities include; Condom distribution, STI treatment, VCT and vocational skills training. Though CSWs in Kawempe division have been targeted for HIV prevention activities, adoption of non risk sexual behaviors such as condom use is not clearly known. Therefore questions on condom use, consistency of condom use, condom accessibility and other factors that influence condom use among CSWs in Kawempe division need to be answered. In addition, condom use among CSWs in Kampala district is not well documented.
3.2 STUDY JUSTIFICATION

Uganda is one of the countries that have demonstrated a reduction in HIV infection rates in the general population. However, core groups such as CSWs have high STD rates and HIV and therefore act as reservoirs of STDs and HIV to the general population. There is need therefore to make commercial sex work safer from HIV and other STDs. Use of condoms has shown to be effective in the control of STDs and HIV/AIDS.

The study therefore aimed at documenting condom use practices and factors that influence condom use among CSWs. Information obtained will enable stakeholders formulate interventions to ensure safer commercial sex. Adoption of proper and consistent condom use by CSWs will reduce transmission of STDs and HIV by CSWs to their clients and to the general population by clients of sex workers. This will contribute to further reduction of prevalence of STDs and HIV in the general population.
3.3 CONCEPTUAL FRAMEWORK

3.3.1 Theoretical conceptual framework on factors influencing condom use among CSWs.

3.3.1.1 Direct factors. These are the immediate factors that predict condom use.

Individual factors. Condom use varies with the age, marital status, education, level of income and religion. The CSW should perceive herself at risk of STDs and HIV in order to adopt STD/HIV preventive measures like condom use. The CSW should also be able to insist on using condoms even when clients demand for unprotected sex.

Condom related factors. In order to use a condom, the CSW should have knowledge on indications for condom use, should have the right beliefs on the effectiveness of condoms and skills on how to use them. The condoms should be physically accessible for the CSW to be able to use them, they should be affordable and of desirable types and brands.

Clients factors. Decision to use a condom involves consent of a CSW and client. However in violent acts of rape there may be no negotiation for condom use. A client may take a decision on whether to use or not use a condom in situations of gender power imbalances, regular clients may refuse condoms or negotiate not to use condoms, clients may be scarce so a CSW may accept clients who don’t desire to use condoms in order to earn an income.
3.3.1.2 Indirect factors

Condom promotion. Condoms can be promoted through provision of information, education, distribution and encouraging their use. Condom promotion activities are implemented by Ministry of Health and other stakeholders such as non-government organisations.

Alternative income generating activities. Sex workers are likely to negotiate for condom use, reduce the number of clients or quit commercial sex work in case of an alternative source of income.

A combination of all the above factors predict condom use by CSWs. These factors are inter-linked vertically and horizontally. From the above conceptual framework, research questions were derived.

Outcome and impact of condom use among CSWs and the general population

Condoms are effective in preventing STDs/HIV and unwanted pregnancy when used correctly and consistently. Condoms therefore play a role in reduction of burden of STDs, HIV and the total fertility rate among CSWs and the general population.

The above factors influencing condom use are summarised in the diagrammatic conceptual framework on the next page.
3.3.2 FIGURE 1  CONCEPTUAL FRAME WORK ON FACTORS INFLUENCING CONDOM USE AMONG CSWS.

Indirect factors:

MOH/other stake holder factors
- Condom promotion
- Alternative income generating activities

Direct factors:

CSW socio-demographic factors
- Education
- Income
- Religion
- Marital status
- Age
- Occupation

Sex worker factors
- Condom awareness
- Knowledge on indications of condoms
- Beliefs, fears and misconceptions about condoms
- Health risk perception
- Negotiation skills for condom use

Client to CSW factors
- Sexual violent acts like rape
- Clients decision on condom use
- Regular clients
- Scarcity of clients

Access to condoms
- Source of condoms
- Cost of condoms
- Condom types and brands

Out come

CONDOM USE AMONG CSWS

Impact

- Reduction in the burden of STDs/HIV and total fertility rate among CSWs
CHAPTER FOUR:

4.1 RESEARCH QUESTIONS
1. Do sex workers use condoms during sexual encounters with their clients?
2. What is the level of condom use among sex workers?
3. Do sex workers use condoms consistently with every sexual encounter with a client?
4. What types and brands of condoms do sex workers use?
5. What is the knowledge of sex workers about condom use?
6. What is the attitude of CSWs towards condom use?
7. Are condoms accessible to the sex workers?
8. What are other factors that influence condom use among CSWs?

4.2 GENERAL OBJECTIVE
To establish the level of condom use and factors influencing condom use among CSWs in Kawempe division in order to generate information that will enable the DHT to formulate interventions to ensure safer commercial sex.

4.3 SPECIFIC OBJECTIVES
1. To establish the level of condom use among commercial sex workers.
2. To assess knowledge on condom use among commercial sex workers.
3. To assess attitude towards condom use among commercial sex workers.
4. To establish the level of access to condoms among commercial sex workers.
5. To establish other factors that influence condom use among commercial sex workers.
CHAPTER FIVE

5.0 METHODOLOGY

5.1 STUDY AREA

The study was conducted in Kawempe division, one of the five divisions located in the northern part of Kampala district. The division borders other divisions namely; Rubaga division (south east), Nakawa division (north east), Mpigi district (north east) and central division (south west). Kawempe division has a population of 268,659 people (male = 128,624, females = 140,035) and an annual population growth rate of 3.8 (National population Census 2002).

Kawempe division has 19 parishes and over 90 zones. Six parishes are well known to harbour sex workers namely; Bwaise II and III, Makerere II and III, Kyebando and Kawempe I parishes. However, the total number of CSWs in Kawempe division is not clearly known.

5.2 STUDY POPULATION

The study population was female CSWs aged 15 to 45 years who were residents of Kawempe division and who self confessed to practice commercial sex work. A total of 114 respondents were recruited for the quantitative part of the study. Sex workers who consented for the study and could speak Luganda and or English were recruited for the study. Sex workers who did not consent for the study though had satisfied the above criteria of selection of respondents were not enrolled for the study.
Six Focus Group Discussions (FGDs) were conducted with an average of 6 participants. The FGD participants were CSWs who self confessed, consented for the study and had not been interviewed during the quantitative part of data collection. All except one FGD had less than 8 participants because some respondents feared to participate.

5.3 STUDY DESIGN

A community based cross sectional study that employed quantitative and qualitative methods of data collection was conducted in March and April 2004.

5.4 DATA COLLECTION TOOLS

For quantitative data, an interviewer administered semi-structured questionnaire was used to collect data.

The questionnaire had questions on:

- Socio-demographic characteristics of respondents such as age, education level, marital status, religion
- Nature of sex work
- Knowledge on condom use
- Level of condom use among CSWs
- Attitude towards condom use
- Other factors that influence condom use among CSWs that is; client related factors and health risk perception.
Qualitative data was collected using FGD and key informant (KI) guides. The FGD guide was used to explore for more knowledge, deep routed beliefs, attitudes, perceptions on condom use, health risk perception resulting from commercial sex work, client factor influencing condom use and affordability of condoms. The KI guide was used to obtain knowledge on HIV prevention activities among CSWs like condom promotion. The FGDs and KI findings were also used to confirm and clarify findings from qualitative data.

5.5 SAMPLE SIZE DETERMINATION

5.5.1 Sample size for quantitative data:

The sample size was calculated using a standard formula for cross sectional study.

\[ \text{Sample size (n)} = \frac{Z^2pq}{d^2} \]

Where \( Z \) = The \( Z \) value corresponding to 95% confidence interval for a standard normal distribution curve =1.96

\( P \) = 95% condom use in the previous sexual encounter between a CSW and a client (MOH 1998)

\( Q = 1-0.95 = 0.05 \)

\( D = \text{Degree of precision} = 4\% \).

\[ 1.96 \times 1.96 \times 0.95 \times 0.05 \]

On substitution, \( n = \frac{1.96 \times 1.96 \times 0.95 \times 0.05}{0.04 \times 0.04} = 114 \text{ respondents} \)
5.5.2 Sample size for qualititative data

5.5.2.1 Sample size for FGDs

A total of 6 FGD groups, two from each of the three parishes that are known to harbour majority of sex workers in Kawempe division (Bwaise II, III and Makerere II parishes) were conducted. By the 6th FGD, there was no new information generated from the study participants.

5.5.2.2 Key informants

A total of 11 key informants were selected. These were 3 peer educators, 3 social workers, coordinators of the Africa Youth Alliance HIV/AIDS programme, MOH and AMREF, 2 DHT members from Kampala district public health department. The key informants were selected because they are part of the health team that carry out HIV prevention activities among CSWs in Kawempe division.

5.6 SAMPLING PROCEDURE

Purposive sampling was used to select the study areas. Six parishes that were known to harbour CSWs in Kawempe division were selected. These were; Makerere II, Bwaise II and III, Kawempe and Kyebando and Makerere III parishes.

The study participants were identified through local leaders and community peer educators and they also self confessed to practice commercial sex. About fifty CSWs were identified from each of the 3 parishes: Makerere II, Bwaise II and III parishes. Thirty respondents were consecutively chosen from each of the above parishes to participate in quantitative data collection. The remaining CSWs from each parish
participated in FGDs (2 FGDs per parish). Less than 15 CSWs were identified from the remaining 3 parishes: Kawempe, Kyebando and Makerere III parishes and were all enrolled for quantitative data collection. The study unit was a CSW in a selected household who self confessed to practice commercial sex.

5.7 STUDY VARIABLES

The dependent variable was: Condom use among CSWs.

Independent variables were:

i) Socio- demographic characteristics of sex workers such as age, religion, marital status, occupation, education level, tribe.

ii) Knowledge on protective effect of condoms, health risk perception, fears and misconceptions about condom use, negotiation skills.

iii) Condom access factors such as source, cost, condom types and brands.

iv) Client factors such as rape, demand for unprotected sex, regular clients, scarcity of clients

iv) The MOH and other Stake holder factors like condom distribution, condom promotion and other HIV prevention interventions.

5.8 DATA COLLECTION

An interviewer administered semi-structured questionnaire was used to collect quantitative data from respondents by three research assistants. Qualitative data collection from key informants was done by the principal investigator (PI).
The FGDs were conducted by two research assistants and the principal investigator. Qualitative data from FGDs was tape recorded in order to capture all information from participants and was transcribed after each discussion.

5.9 DATA QUALITY ASSURANCE

The PI trained four research assistants (RAs) who were fluent in Luganda and English since respondents could speak either or both languages. Community peer educators guided RAS to residences of CSWs. The PI trained RAs on interviewing techniques, coding and editing of data. The questionnaire and FGD guide were also reviewed.

Pre-testing of questionnaires was done in Rubaga division since the setting of the division is similar to that of the study area. The pre-testing exercise aimed at knowing if RAS and respondents would understand the questions and to establish relevance of the questions to the study objectives. Data obtained from 10 pre-tested questionnaires was analysed to yield information which led to adjustment of the questionnaire accordingly.

The PI closely supervised the RAs and ensured that the interview procedures are properly followed. Daily meetings between the PI and the research assistants were held to review filled questionnaires for accuracy and completeness in answering questions. Problems encountered during data collection were also discussed on a daily basis. Double data entry in the computer was done in order to minimise errors in data entry.
5.10 DATA MANAGEMENT AND ANALYSIS

5.10.1 Data management

The quantitative data was first edited on a daily basis by the research team. The filled questionnaire were finally edited, coded before data entry into the computer. Data was entered in the computer using EPiINFO 6.0 version. Data was checked for accuracy and completeness through double data entry and use of the check programme. Univariate and bivariate analysis was done using the same computer software.

5.10.2 Data analysis

Quantitative data

Univariate and bivariate data analysis was done. Univariate data analysis aimed at getting a summary of the results. Frequencies for all variables were obtained and the findings are presented in frequency tables, graphs and pie charts. Measures of central tendency: the mean, median and mode were also obtained.

Bivariate analysis aimed at getting associations between the dependent and the independent variables. Associations between independent socio-demographic variables and outcome (dependent) variables; level of condom use, attitude towards condom use and HIV risk perception were determined using Odds ratio, Pearson’s chi-squared and Fischer’s exact tests for categorical variables. A 5% level of precision and a 95% confidence interval were used.


Qualitative data management

Transcripts obtained from FGD and KI were read many times in order to become familiar with the results and to generate emerging themes. The generated themes were merged according to the objectives of the study. Sub themes under each theme were also obtained and arranged accordingly. Qualitative data was analysed using a master sheet and presented in text form.

5.11 ETHICAL CONSIDERATIONS

The investigator sought ethical clearance from the ethical review board of Makerere University Institute of Public Health. She also ensured that ethical guidelines are followed throughout the implementation of the study. Permission to carry out the study was sought from the DDHS, local council chairpersons and the respondents. Written informed consent was obtained from each respondent before carrying out the interview. Confidentiality of the respondents information was ensured during data collection by anonymous identification and private interviews. Data was stored in a cupboard that was only accessible to the PI, during data analysis access to data was restricted to the research team directly involved in conducting the study. The information obtained will be used for purposes of this study only.

5.12 DISSEMINATION OF RESULTS

The results of this study will be disseminated to the school of post graduate studies of Makerere University and the Institute of Public Health as partial fulfillment of an award of Masters of Public Health. A dissemination seminar involving the DHT, IPH, MOH and study participants will also be conducted.
## RESULTS

### 6.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

6.1.1: The table below indicates the socio-demographic characteristics of 114 respondents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency (n = 114)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>72</td>
<td>63.7</td>
</tr>
<tr>
<td>25-34</td>
<td>37</td>
<td>32.7</td>
</tr>
<tr>
<td>35-44</td>
<td>5</td>
<td>3.5</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>36</td>
<td>31.6</td>
</tr>
<tr>
<td>Protestant</td>
<td>35</td>
<td>30.7</td>
</tr>
<tr>
<td>Muslim</td>
<td>37</td>
<td>32.5</td>
</tr>
<tr>
<td>Adventist</td>
<td>5</td>
<td>4.4</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>75</td>
<td>65.8</td>
</tr>
<tr>
<td>Married</td>
<td>5</td>
<td>4.4</td>
</tr>
<tr>
<td>Separated</td>
<td>21</td>
<td>18.4</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>Cohabitng</td>
<td>8</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>7.0</td>
</tr>
<tr>
<td>P1 – P7</td>
<td>25</td>
<td>22.0</td>
</tr>
<tr>
<td>S1 – S4</td>
<td>54</td>
<td>47.4</td>
</tr>
<tr>
<td>S5 - S6</td>
<td>16</td>
<td>14.0</td>
</tr>
<tr>
<td>Tertiary</td>
<td>10</td>
<td>8.8</td>
</tr>
<tr>
<td>Does not know</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>35</td>
<td>30.7</td>
</tr>
<tr>
<td>Student</td>
<td>15</td>
<td>13.2</td>
</tr>
<tr>
<td>Bar maid</td>
<td>38</td>
<td>33.3</td>
</tr>
<tr>
<td>Hair dresser</td>
<td>15</td>
<td>13.2</td>
</tr>
<tr>
<td>Food vendor</td>
<td>4</td>
<td>3.5</td>
</tr>
<tr>
<td>Shop attendant</td>
<td>5</td>
<td>4.4</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Tribe</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muganda</td>
<td>45</td>
<td>39.5</td>
</tr>
<tr>
<td>Musogoa</td>
<td>23</td>
<td>20.2</td>
</tr>
<tr>
<td>Munyankole</td>
<td>20</td>
<td>17.5</td>
</tr>
<tr>
<td>Others</td>
<td>26</td>
<td>22.8</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>64</td>
<td>56.1</td>
</tr>
<tr>
<td>1 – 2</td>
<td>40</td>
<td>35.1</td>
</tr>
<tr>
<td>4 – 7</td>
<td>10</td>
<td>8.8</td>
</tr>
</tbody>
</table>

*None of the respondents had 3 children*
Majority (63.7%) of respondents were in the age range of 15-24 years (Mean = 23.4). The lowest age was 16 years while the highest age was 39 years. Most of the respondents were muslims (32.5%), Baganda (39.5%), single (65.8%) and had no children (56.1%). Most of the respondents (47.4%) attained ordinary level education and were employed as bar maids (33.3%).

6.1.2 Nature of sex work

Information on nature of sex work is presented in the table below.

Table 2 Nature of sex work by respondents in Kawempe division, March 2004

<table>
<thead>
<tr>
<th>Nature of sex work</th>
<th>Frequency (N = 114)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Years as CSW</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 1</td>
<td>10</td>
<td>8.8</td>
</tr>
<tr>
<td>1-3</td>
<td>69</td>
<td>60.5</td>
</tr>
<tr>
<td>4-6</td>
<td>28</td>
<td>24.6</td>
</tr>
<tr>
<td>&gt;7</td>
<td>7</td>
<td>6.1</td>
</tr>
<tr>
<td><strong>Place of service provision</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lodge</td>
<td>104</td>
<td>91.2</td>
</tr>
<tr>
<td>Sex worker’s home</td>
<td>28</td>
<td>24.6</td>
</tr>
<tr>
<td>Bar</td>
<td>19</td>
<td>16.7</td>
</tr>
<tr>
<td>Client’s home</td>
<td>17</td>
<td>14.9</td>
</tr>
<tr>
<td>Street</td>
<td>9</td>
<td>7.9</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Nature of male clients</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>91</td>
<td>79.8</td>
</tr>
<tr>
<td>Single</td>
<td>87</td>
<td>76.2</td>
</tr>
<tr>
<td>Others</td>
<td>12</td>
<td>10.5</td>
</tr>
<tr>
<td><strong>Clients per day</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3</td>
<td>62</td>
<td>54.4</td>
</tr>
<tr>
<td>4-6</td>
<td>44</td>
<td>38.6</td>
</tr>
<tr>
<td>7-9</td>
<td>8</td>
<td>7.0</td>
</tr>
</tbody>
</table>

* Multiple responses were allowed.

Majority (60.5%) of respondents had been practicing commercial sex for a period of 1-3 years (mean: 2.9, median: 2), receive an average number of 3.5 clients (median: 3). Majority (79.8%) of their clients are married men who are served in lodges (91.2%).
All FGDs reported that there are no organised groups of CSWs. Each individual was reported to recruit her own clients.

"We work as individuals because we don’t understand each other. Each one of us has her own problems. With money, no two people can agree" (FGD, Bwaise II parish)

6.2 LEVEL OF CONDOM USE AMONG RESPONDENTS

The level of condom use among respondents was established by asking respondents if they use condoms during their sexual encounters with their clients. Reasons why they use or don’t use condoms were also established. Practice on how often condoms are changed during sexual encounters with clients and problems encountered with condom use were also established.

Results on level of condom use are presented in the figure below.

![Figure 2: Condom use among respondents and their clients](image)

Ninety six percent (110/114) of the respondents reported to use condoms with clients, however only 64% (73/114) of them consistently use condoms with clients. The major reasons for consistent condom use by 64% respondents were;

- To prevent unwanted pregnancy by 72.6% (53/73) respondents
• To prevent STDs by 93.2% (68/73) respondents
• One respondent reported to consistently use condoms because some clients are dirty.

All FGDs reported to consistently use condoms during sexual encounters with clients in order to prevent STDs and HIV and unwanted pregnancy.

"We use condoms with all our clients even the regular ones. We don't allow unprotected sex because men will not trust us and even no HIV check has been done for these clients" (FGD, Bwaise III parish).

The KIs reported a high demand condoms by CSWs which could imply high utilisation by the same people. The KIs also reported that some CSWs negotiate for condom use with clients even when clients opt to pay highly for unprotected sex.

"Many CSWs have children whose fathers are not known so they have adopted safer sex because of self consciousness. The STD /HIV prevalence among CSWs who utilise AMREF drop in health centre services has also reduced (Key informant, AMREF)"
6.2.1: Respondents who inconsistently use condoms with clients

Thirty two percent (37/114) respondents reported to sometimes use condoms with clients.

The reasons for using condoms with some clients are presented in the table below.

<table>
<thead>
<tr>
<th>Reason for using condoms</th>
<th>Frequency (n=37) *</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>To prevent acquiring STDs</td>
<td>11</td>
<td>29.7</td>
</tr>
<tr>
<td>Clients who cannot afford live sex</td>
<td>11</td>
<td>29.7</td>
</tr>
<tr>
<td>Clients wish to use a condom</td>
<td>9</td>
<td>24.3</td>
</tr>
<tr>
<td>Prevent unwanted pregnancy</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>Other reasons</td>
<td>1</td>
<td>2.7</td>
</tr>
</tbody>
</table>

* Multiple responses were allowed

The major reasons why respondents (29.7%) sometimes use condom with clients were; to prevent acquiring STDs from clients and with clients who cannot afford unprotected sex respectively. One respondent reported that she uses condoms when clients don’t trust her HIV sero status.

The clients with whom respondents (32%, 37/114) don’t use condoms were reported to be:

- Clients who offer more money for unprotected sex by 63.9% (23/37) respondents
- Clients who insist on unprotected sex by 25% (10/37) respondents
- Regular clients by 11.1% (4/37) respondents

Though all FGDs reported to consistently use condoms with clients, some participants reported that they do not use condoms with regular clients and clients who insist on not using condoms.
"We don't use condoms with regular clients we have known for sometime. For clients who insist on unprotected sex and are aggressive we accept unprotected sex" (FGD participant, Makerere II parish)

6.2.2: Respondents who don't use condoms with clients

Four percent (4/114) of the respondents reported not to use condoms during sexual encounters with clients for the following reasons: condoms cause cancer (1 respondent), condoms are not used with some sex styles (1) and more monetary gains (2).

Most FGDs reported to know fellow sex workers who don't use condoms with clients citing reasons like;

Poverty among some CSWs and those with a positive HIV sero status.

"Some sex workers are already sick with HIV that is why they don't use condoms. A sex worker who is sick can say: I am already sick, let me make my money since live sex charges are higher. Few people know that with AIDS one should reduce the number of sexual partners" (FGD, Bwaise III parish)

6.2.3: Changing of condoms

Respondents who use condoms were asked how often they change condoms during sexual encounters with clients. Majority (95.5%,105/110) said that they use one condom for every sexual round with a client. Other practices were; Using one condom for 2 sexual rounds (3 respondents), a client can do whatever he wants after paying her money (2) respondents.
All FGDs reported that condoms are changed every after a sexual round with a client that is timed for 3-5 minutes.

"A short sexual act lasts five minutes and we always time them. In case a client has not finished (ejaculated) during this time we have to change the condom. He even has to pay more money for another short if he wants more time" (FGD, Bwaise III parish).

6.2.4: Who puts on the condom

Majority (88.2%, 97/110) of respondents said that clients put on the condoms themselves before the sexual act while only 27.3% (30/110) respondents said that they put on the condoms on clients themselves.

All FGDs reported that they put the male condom on the client’s penis themselves to ensure that the condom is inserted on the penis and that it is not torn.

"Clients sometimes deceive that they have worn the condom. They can also create holes in the condom. One time a man removed the tip of a condom which I noted just before sexual intercourse so I told him to put on two condoms. He never finished (ejaculation) because he got embarrassed. He even never came back to me but used one of my friends" (FGD, Bwaise II parish).
6.2.5: Problems experienced with condoms by respondents who use condoms.

These are presented in the figure below:

*Figure 3: Problems experienced with condom use by respondents*

<table>
<thead>
<tr>
<th>Problems</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burst</td>
<td>70</td>
</tr>
<tr>
<td>Retained</td>
<td>34</td>
</tr>
<tr>
<td>Dryness</td>
<td>34</td>
</tr>
<tr>
<td>Pain</td>
<td>30</td>
</tr>
<tr>
<td>None</td>
<td>24</td>
</tr>
<tr>
<td>Others</td>
<td>15</td>
</tr>
</tbody>
</table>

*Multiple responses were allowed*

Condom bursting was the commonest problem reported by majority (63.6%, 70/110) of the respondents. Other problems associated with condom use were; Client taking long to ejaculate (3/15 respondents), condoms cause itching (2/15), failure to enjoy sex by clients and CSWs (7/15), condoms have a bad smell (3/15)

Sixty seven percent (49/73) respondents who reported to consistently use condoms have ever experienced condom bursting while carrying out commercial sex work. Fifty six percent (21/37) respondents who reported to inconsistently use condoms have also ever experienced condom bursting. However, there was no significant statistical difference in the rate of condom bursting among those who consistently and those who inconsistently use condoms (OR; 1.56 95% CI; 0.64-3.8).
The FGD findings revealed that respondents experience dryness of the vagina when using condoms. This was attributed to lack of sexual arousal by a strange client and with clients who pay little money. Dryness of the vagina was reported to lead to condom bursting in addition to clients who use a lot of force.

“I don’t get aroused if a client pays little money. A fee of 3000/= is little, no vaginal fluids with this money leading to dry sex. I don’t even allow client to touch me except with more money. With little money, I always want to start with sex itself” (FGD, Bwaise II parish).

“A condom burst three days ago while having sex with a client. I removed it and put on a new condom in order to continue with what I was doing. But later I found a piece of condom in my underwear. I am worried that I might discover another piece of the condom” (FGD, Makerere II parish).
6.2.6: Socio-demographic variables, other variables of interest and condom use.

Results are presented in the table below.

### Table 4 Socio-demographic variables and condom use among respondents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Condom use (n=114)</th>
<th>Odds ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All (n=114)</td>
<td>2 &amp; 3</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>&lt;P7</td>
<td>16 (23)</td>
<td>17 (40)</td>
</tr>
<tr>
<td></td>
<td>&gt;P7</td>
<td>55 (77)</td>
<td>26 (60)</td>
</tr>
<tr>
<td><strong>Age(years)</strong></td>
<td>&lt;24</td>
<td>48 (66)</td>
<td>26 (63)</td>
</tr>
<tr>
<td></td>
<td>&gt;24</td>
<td>25 (34)</td>
<td>15 (37)</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td>Employed</td>
<td>51(70)</td>
<td>29(71)</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>22 (30)</td>
<td>12 (29)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td>Married</td>
<td>8 (11)</td>
<td>5 (22)</td>
</tr>
<tr>
<td></td>
<td>Single</td>
<td>66 (89)</td>
<td>35 (88)</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td>Catholic</td>
<td>22 (30)</td>
<td>14 (34)</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>51 (70)</td>
<td>27 (66)</td>
</tr>
<tr>
<td><strong>Years as CSW</strong></td>
<td>&lt;2</td>
<td>44 (60)</td>
<td>17 (41)</td>
</tr>
<tr>
<td></td>
<td>&gt;2</td>
<td>29 (40)</td>
<td>24 (59)</td>
</tr>
<tr>
<td><strong>Clients/day</strong></td>
<td>&lt;3</td>
<td>53 (73)</td>
<td>9 (22)</td>
</tr>
<tr>
<td></td>
<td>&gt;3</td>
<td>20 (27)</td>
<td>32 (88)</td>
</tr>
</tbody>
</table>

* An asterix indicates a significant statistical test.

All = Consistent condom use,  2 = Inconsistent condom use,  3 = No condom use.

There was a significant statistical difference between number of clients served per day and consistent condom use. Respondents who reported to receive three or less clients a day were more likely to consistently use condoms than those who reported to receive more than 3 clients per day (OR= 9.42, CL, 3.53<OR<25.85). Other socio-demographic variables presented in the table were not significantly associated with condom use.
• Have experience using the condom (3)
• Client put on the condom (3).
• Fear to use the female condom (1)
• She puts on the condom herself (1).

6.3.2: Condom brands used by respondents

The commonly used male condom brands are presented in the figure below.

![Figure 4: Condom brands used by respondents](image)

*Multiple responses were allowed

Majority (62.7%, 69/110) respondents reported to use Engabu condom brand for the following reasons; it is distributed free of charge (71%), strong and easy to use (8.7%), available (7.2%), smells good (5.8%), it is well lubricated (1), it feels good when using it (1).

Sixty percent of respondents reported to use life guard condom brand because; it is strong (63.6%), enjoyable (15.2%), clients preference (9.1%), well lubricated (7.6%), smooth...
6.3: ACCESS TO CONDOMS

Access to condoms was established by asking respondents who use condoms the type of condoms they use, brands, source and affordability of condoms. Reasons for choosing a particular type and brand of condoms were also established. Results are presented below.

6.3.1: Condom types used by respondents

All respondents who use condoms said they use male condoms during sexual encounters with clients. Only one respondent among these uses both the male and female condom. She uses the female condom when her clients demand unprotected sex or when she is on STD treatment. Reasons for choosing the male condom by respondents are presented in the table below.

<table>
<thead>
<tr>
<th>Table 5: Reasons for choosing the male condom by respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>Easy to use</td>
</tr>
<tr>
<td>Cheap</td>
</tr>
<tr>
<td>Available</td>
</tr>
<tr>
<td>Clients preference</td>
</tr>
<tr>
<td>No problem using it</td>
</tr>
<tr>
<td>Enjoyable</td>
</tr>
<tr>
<td>Durable</td>
</tr>
<tr>
<td>Comfortable</td>
</tr>
<tr>
<td>Others</td>
</tr>
</tbody>
</table>

*Multiple responses were allowed

Majority (46.4%) of respondents choose the male condom because it is easy to use. Other reasons for choosing the male condom were:

- No worry of condom getting stuck in the vagina (2 respondents)
(6.1%), cheap (4.5%). Other reasons given by 5 respondents were; lifeguard is available, smells good, romantic, name sounds good, it is soft.

Forty five percent respondents use protector condom because it is strong (48.2%), cheap (21.4%), enjoyable (10.7%), smooth (7.1%) romantic (5.4%) and other reasons were; protector is soft, its free of charge. Nine respondents use rough rider because it is strong (4), soft (2) and smells good (3). One respondent uses the romantic condom because it smells good.

6.3.2.1: The female condom

All FGDs had ever heard about the female condom but had never seen it. They made the following remarks about the female condom.

"The female condom is expensive yet male condoms are free, male clients don't like the female condom because it hides the labiae, clients also want labial sex that is done without a condom, the condom may go to the uterus if a man uses force, the ring presses when having sexual intercourse with a client, the condom is felt while the male one is not" (All FGDs, Kawempe division)

The KIs reported that MOH no longer supplies the female condoms and that the available stocks at all distribution points had expired. Key informants also cited other reasons for none use of the female condom by CSWs:

"Sex workers used to pick the female condoms but reported that men did not like them because they make a lot of noise and that women hold them while having sex. Sex workers also feared that the condom may disappear in the uterus of a woman. However,
was low sensitization of the female condoms unlike male condoms and they were also expensive” (KIs, AMREF and UDEL).

6.3.3: Sources of condoms by respondents

Majority (69.1%, 76/110) of respondents obtain their condoms from community condom distributors. These are community peer educators from Kawempe health centre adolescent clinic, AMREF and UDEL non government organizations that target young people. Other sources of condoms were drug shops (48.2%), private clinic (40%), pharmacy (27.3%), government health unit (3.6%), road side sellers (1.8%) and lodges (1.8%).

6.3.3.1: Clients as a source of condoms

Respondents were asked whether clients carry their own condoms during commercial sex work transactions. Reasons why clients carry or don’t carry condoms were also established.

Sixty six percent (75/114) of respondents reported that clients don’t carry condoms,

31.6% (36/114) said that clients sometimes carry condoms and only 2 respondents said that clients always carry condoms. Reasons why clients don’t carry condom were; knowing that CSWs carry condoms (83.3%), some clients come for unprotected sex(11.4%). Other reasons by 3 respondents were; clients fear their spouses to find them with condoms (2 respondents) and that it is the responsibility of a sex worker to have condoms.
6.4 KNOWLEDGE ON CONDOM USE BY RESPONDENTS

Knowledge on condom use was established by asking respondents about their source of knowledge on condoms, indications for condom use and steps of condom use. Results on source of knowledge on condom use are presented in the table below.

Table 6  Sources of knowledge about condoms by respondents.

<table>
<thead>
<tr>
<th>Source of knowledge</th>
<th>Frequency (n=114)</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>81</td>
<td>71.1</td>
</tr>
<tr>
<td>Health worker</td>
<td>80</td>
<td>70.1</td>
</tr>
<tr>
<td>Radio/TV</td>
<td>56</td>
<td>49.1</td>
</tr>
<tr>
<td>Community distributor</td>
<td>8</td>
<td>3.3</td>
</tr>
<tr>
<td>Relatives</td>
<td>7</td>
<td>7.0</td>
</tr>
<tr>
<td>Others</td>
<td>11</td>
<td>9.6</td>
</tr>
</tbody>
</table>

* Multiple responses were allowed.

Majority (71.1%) of respondents obtain information on condom use from friends. Other sources of information on condoms were; the internet, posters and video shows.

6.4.1 Indications for condom use

Only 64% (73/114) of the respondents mentioned the two indications for condoms as; to prevent STDs and unwanted pregnancies while other respondents mentioned one indication of condom use as either preventing unwanted pregnancies (15.7%, 18/114) or STDs (20.2%, 23/114). In total, 84.2% (97/114) of the respondents said that condoms are used to prevent STDs while 77.2% (88/114) said that condoms are used to prevent unwanted pregnancies. The other indication for condoms by one respondent was; condoms are used with clients who cannot afford higher charges for unprotected sex.
6.4.2: Knowledge on steps of condom use by respondents

Of the 114 respondents, 86% reported that the expiry date of the condom should be checked before using a condom, 21% said that tears or holes should be checked for while 7% said that pressure in a condom should be checked for.

The level of knowledge on steps of male condom use are presented in the table below.

Table 7: Level of knowledge on steps on male condom use by respondents

<table>
<thead>
<tr>
<th>Steps on condom use</th>
<th>Frequency (N=114)</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check for the expiry date</td>
<td>63</td>
<td>55.3</td>
</tr>
<tr>
<td>Check for air pressure inside the condom</td>
<td>43</td>
<td>37.7</td>
</tr>
<tr>
<td>Tear condom where indicated</td>
<td>30</td>
<td>26.3</td>
</tr>
<tr>
<td>Press tip of condom to leave space for semen</td>
<td>22</td>
<td>19.3</td>
</tr>
<tr>
<td>Put condom on an erect penis</td>
<td>81</td>
<td>71.0</td>
</tr>
<tr>
<td>Dispose condom after use</td>
<td>74</td>
<td>64.9</td>
</tr>
<tr>
<td>I cannot explain</td>
<td>19</td>
<td>16.7</td>
</tr>
</tbody>
</table>

* More than one response was allowed.

Putting the condom on a stiff penis was the commonest step on condom use that was mentioned by most (71%) of respondents. The latrine and rubbish pit were the commonest places of condom disposal by 48.2% and 11.4% respondents. Other places of condom disposal were; a trench (4 respondents), lodge (7), client goes with it (1), the roadside (1), bush (1) and burning (12).

The 3 steps on condom use that follow sexual intercourse and before condom disposal are;

- Withdrawing the penis from the vagina when it is still stiff
- Holding the base of the penis when withdrawing the it from the vagina
- Removing the condom carefully by rolling it down.

None of the respondents was able to mention all the steps on condom use. Therefore all respondents had inadequate knowledge on steps on condom use.

Respondents who were not able to name any steps on condom use were asked what correct condom use meant to them. Below were their responses;
Using a new condom for every sexual round (13/19 respondents), putting on a condom on an erect penis (8), removing a condom after ejaculation when penis is stiff (8) and disposing the condom properly after use (4).

6.4 ATTITUDE TOWARDS CONDOM USE
Attitude towards condom use was established by asking respondents if they considered condom use with every sexual encounter with a client important. Majority (92%, 105/114) of the respondents said that it is important to use a condom with every sexual encounter with a client in order to prevent STDs (76.2%, 80/105) and preventing unwanted pregnancies (52.4%, 55/105) respondents. These respondents therefore had a positive attitude towards condom use.

All FGDs also reported that it is important to use condoms with every sexual encounter with a client in order to prevent spread and acquiring STDs and unwanted pregnancies.

Nine respondents did not consider condom use with every sexual encounter with a client important for the following reasons Higher monetary gains from sex without a condom
(6 respondents), condoms don’t protect against STDs (1), she accepts clients demands for unprotected sex (2). These respondents were considered to have a negative attitude towards condom use.

6.4.1 Socio-demographic variables and attitude toward condom use

Table 8 Socio-demographic variables and attitude towards condom use by respondents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Attitude (N=114)</th>
<th>Odds ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(positive)</td>
<td>(negative)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>&lt;P7</td>
<td>27 (74)</td>
<td>6 (67)</td>
<td>5.78</td>
</tr>
<tr>
<td>P7</td>
<td>78 (26)</td>
<td>3 (33)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;24</td>
<td>67 (64)</td>
<td>6 (67)</td>
<td>1.13</td>
</tr>
<tr>
<td>&gt;24</td>
<td>38 (36)</td>
<td>3 (33)</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholics</td>
<td>32 (30)</td>
<td>4 (44)</td>
<td>1.83</td>
</tr>
<tr>
<td>Others</td>
<td>73 (70)</td>
<td>5 (56)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>96 (91)</td>
<td>5 (56)</td>
<td>8.53</td>
</tr>
<tr>
<td>Married</td>
<td>9 (9)</td>
<td>4 (44)</td>
<td></td>
</tr>
<tr>
<td>Years as CSW</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;2 years</td>
<td>58 (55)</td>
<td>4 (44)</td>
<td>1.54</td>
</tr>
<tr>
<td>&gt;2 years</td>
<td>47 (45)</td>
<td>5 (56)</td>
<td></td>
</tr>
<tr>
<td>Clients/day</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤3</td>
<td>57 (54)</td>
<td>5 (56)</td>
<td>1.05</td>
</tr>
<tr>
<td>&gt;3</td>
<td>48 (46)</td>
<td>4 (44)</td>
<td></td>
</tr>
</tbody>
</table>

* Asterisk indicates a significant statistical test.

There was a significant difference between level of education, marital status and attitude towards condom use. Respondents who had at least secondary education were more likely to say that condom use with every sexual encounter with a client is important than those who had primary and no education (OR=5.78, 95%CL;1.17<OR<31.74). Respondents who were single were more likely to have a positive attitude towards condom use (OR:8.53, 95% CL;1.56<OR<47.2).
6.5 OTHER FACTORS THAT INFLUENCE CONDOM USE

Other factors influencing condom use were established. These were; health risk perception, client violent acts such as rape and demand for unprotected sex and legalising commercial sex.

6.5.1: Health risk perception

Health risk perception was established by asking respondents if commercial sex might lead them to getting infected with STDs/ HIV and unwanted pregnancies. Preventive measures they have adopted were also established. The STD/HIV risk perception findings are presented in the figure below.

![Figure 5: Risk perception to acquiring STDs and HIV by respondents](image)

Majority (75%, 86/114) of respondents considered themselves at risk of acquiring STDs/HIV. Other respondents (3%) said they did not know (1) or did not care (2) whether they were at risk of acquiring STDs/HIV.
6.5.1.1 *Reasons why respondents considered themselves at risk of STDs/HIV*

These are presented in the table below.

**Table 9 Reasons why respondents are at risk of acquiring STDs/HIV**

<table>
<thead>
<tr>
<th>Reason at risk</th>
<th>Frequency (n=86)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms accidents</td>
<td>34</td>
<td>39.5</td>
</tr>
<tr>
<td>Sometimes I don’t use condoms</td>
<td>30</td>
<td>34.9</td>
</tr>
<tr>
<td>Some clients may have the HIV virus</td>
<td>21</td>
<td>24.4</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>4.7</td>
</tr>
</tbody>
</table>

*More than one response was allowed

Condom accidents like bursting (19/86) and retention in the vagina (15/86) were the major reasons why respondents considered themselves at risk of acquiring STDs/HIV. Other reasons were: history of an STD (1 respondent), friends (CSWs) who died of HIV (1), improper condom use by clients (1) and risky over night sex work (1).

All FGDs reported to be at risk of acquiring STDs/HIV as a result of sex work because: condoms burst, they have frequent sex, they have many sexual partners with whom they have dry sex, incidences of rape, men don’t know how to use condoms, men use a lot of force, clients refuse to use condoms and alcohol abuse.

"Some CSWs don’t use condoms when drunk and many of them have become sick. When someone drinks alcohol with a client until 3 o’clock, she may not remember to use a condom’ (FGD, Bwaise III parish).

"One time a soldier asked me to go to his home. He said he had condoms which he showed to me so I did not need to carry condoms. He looked a responsible man. At home he put on the condom and then pulled it off. As I complained he tried to strangulate me. I
could not shout but accepted to have unprotected sex otherwise he would kill me. Wasn’t this rape?" (FGD, Makerere III parish)

6.5.1.2 Preventive measures for STD and HIV adopted by respondents who considered themselves at risk of these diseases

These are presented in the table below.

Table 10 Preventive measures for STDs/HIV that were adopted by respondents

<table>
<thead>
<tr>
<th>Preventive measure</th>
<th>Frequency(n=86)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using condoms</td>
<td>58</td>
<td>67.4</td>
</tr>
<tr>
<td>Reduced the number of clients</td>
<td>12</td>
<td>14.0</td>
</tr>
<tr>
<td>Nothing</td>
<td>6</td>
<td>7.0</td>
</tr>
<tr>
<td>Looking for other work</td>
<td>4</td>
<td>4.7</td>
</tr>
<tr>
<td>Others</td>
<td>6</td>
<td>7.0</td>
</tr>
</tbody>
</table>

Majority (67.4%) of respondents at risk of STDs/HIV reported to use condoms as a preventive measure for STDs/HIV. Condom use was also the reason why some respondents (22%, 25/114) did not consider themselves at risk of acquiring STDs/HIV. Other preventive measures for STDs/HIV were; avoiding suspected HIV positive clients (1 respondent), having protected sex after the man washed his penis (1), going for voluntary HIV counseling and testing (1), I don’t know (1), No response (2).

All FGDs reported that they are using condom use to prevent STDs. However they said that the best perceived measure to prevent STDs/HIV was quitting commercial sex.

"Many CSWs are tired of sex work but because of poverty and responsibility we still practice it. A client may undress you, may inflict wound on your body, clients don’t want to use condoms, condoms burst and one has nothing to do. There is no good thing doing
this job. Overnight job with street recruitment of clients has a lot of problems” (FGD, Makerere II parish)

The KIs reported that they counsel CSWs to quit commercial sex for alternative employment. Vocational skills were also reported to be provided.

“Vocational skills in tailoring, catering, hair dressing, adult literacy and computer skills have been provided by AMREF and UDEL organisations. After acquiring vocational skills, some CSWs have quit commercial sex work. However some CSWs give reasons why they continue to practice commercial sex like; lack of formal education and therefore cannot compete for jobs, lack of job contacts, rude bosses, poor pay with alternative employment” (Key informant, UDEL).

The KIs also reported that they encourage CSWs to reduce the number of sexual partners (irregular and regular) and to use condoms with all their clients. However reducing the number of clients was reported to be difficult since more clients for CSWs mean more money. Condom use with regular clients was also reported to be limited.

6.5.1.3 Risk perception to getting an unwanted pregnancy

Out of 114 respondents, 54% (62/114) considered themselves at risk of an unwanted pregnancy as a result of commercial sex work. The preventive measures for unwanted pregnancy were; condom use (43/62) taking pills, (24), using injectable contraceptives (2/62) and abortion (5).
All FGDs reported to use condoms in order to prevent unwanted pregnancies and STDs. However one FGD reported condom failure to protect against an unwanted pregnancy.

“A client took me to a lodge. I remember I used a condom but I lost my menstrual periods for two months after that sexual encounter. I later discovered that I was pregnant. I wanted to abort but failed. I delivered a baby girl whose father is not known. I don’t know what happened but on finishing the condom was on the bed sheet. It seems the man removed the condom before sexual intercourse without my knowledge” (FGD, Bwaise III parish).

Findings from FGDs (2/6) reported to use contraceptives such as pills and injectaplan in addition to condoms in order to prevent unwanted pregnancies in case condoms burst, rape by a client and unprotected sex with their boyfriends and husbands.
6.5.1.4 Socio-demographic variables and health risk perception.

Results are presented in the table on the next page.

Table 11  Socio-demographic variables and STD/HIV risk perception among respondents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Health risk (n=111)</th>
<th>Odds ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (% )</td>
<td>No (% )</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;P7</td>
<td>23 (27)</td>
<td>7 (18)</td>
<td>1.07</td>
</tr>
<tr>
<td>&gt;P7</td>
<td>63 (73)</td>
<td>18 (72)</td>
<td></td>
</tr>
<tr>
<td>Age(years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;24</td>
<td>54 (64)</td>
<td>17 (68)</td>
<td></td>
</tr>
<tr>
<td>&gt;24</td>
<td>32 (36)</td>
<td>8 (32)</td>
<td>1.20</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>76 (88)</td>
<td>24 (96)</td>
<td>3.16</td>
</tr>
<tr>
<td>Married</td>
<td>10 (12)</td>
<td>1 (4)</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>28 (33)</td>
<td>7 (32)</td>
<td>1.42</td>
</tr>
<tr>
<td>Others</td>
<td>58 (67)</td>
<td>18 (68)</td>
<td></td>
</tr>
<tr>
<td>Clients/day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;3</td>
<td>40 (47)</td>
<td>20 (80)</td>
<td>4.60</td>
</tr>
<tr>
<td>&gt;3</td>
<td>46 (53)</td>
<td>5 (20)</td>
<td></td>
</tr>
<tr>
<td>Years as CSW</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;2</td>
<td>46 (53)</td>
<td>15 (60)</td>
<td>1.30</td>
</tr>
<tr>
<td>&gt;2</td>
<td>40 (47)</td>
<td>10 (40)</td>
<td></td>
</tr>
<tr>
<td>Condom use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All clients</td>
<td>50 (58)</td>
<td>23 (92)</td>
<td>8.28</td>
</tr>
<tr>
<td>Some&amp; none</td>
<td>36 (42)</td>
<td>2 (8)</td>
<td></td>
</tr>
</tbody>
</table>

* An asterix indicates a significant statistical test

There was a significant statistical association between number of clients received per day, condom use and risk perception to STDs/HIV. Respondents who reported to receive more than 3 clients per day were more likely to consider themselves at risk of acquiring STD/HIV than those who reported to get 3 or less clients per day (OR=4.6, 95%CL:1.45-15.5). Respondents who reported to inconsistently or not to use condoms were more likely to say they are at risk of acquiring STDs compared to respondents who reported to consistently use condoms (OR=8.28, 95%CL:1.72<OR<54.34).
6.5.2: Client factors that influence condom use

Client factors that influence condom use were established by asking respondents if clients demand for unprotected sex, reasons why clients demand for unprotected sex and what respondent does when a client asks for unprotected sex. Sexual violent act of rape by clients was also established.

6.5.2.1 Client’s demand for unprotected sex

Majority (68%, 77/114) of the respondents reported that clients demand for unprotected sex. Reasons why clients demand for unprotected sex are presented in the table below:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency (n=77)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live sex is more enjoyable</td>
<td>41</td>
<td>53.2</td>
</tr>
<tr>
<td>No clear reason given</td>
<td>10</td>
<td>13.0</td>
</tr>
<tr>
<td>Want value for their money</td>
<td>6</td>
<td>7.8</td>
</tr>
<tr>
<td>Feel great when ejaculating</td>
<td>4</td>
<td>5.2</td>
</tr>
<tr>
<td>Want labial sex done without a condom</td>
<td>3</td>
<td>3.9</td>
</tr>
<tr>
<td>Want to feel the respondent</td>
<td>4</td>
<td>5.2</td>
</tr>
<tr>
<td>Condom tightens penis</td>
<td>4</td>
<td>5.2</td>
</tr>
<tr>
<td>Other reasons</td>
<td>6</td>
<td>11.9</td>
</tr>
</tbody>
</table>

Majority (53.2%) of respondents said clients demand for unprotected sex because it is more enjoyable. Other reasons why clients ask for unprotected sex by respondents were: taking long to ejaculate with a condom (3), when clients want to impregnate a CSW (1), negative beliefs about safety of condoms (2), getting fed up with condoms, unknown HIV serostatus (1).
All FGDs reported that some clients demand for unprotected sex for reasons like; failure to reach orgasm with a condom, allergy to condoms, condoms are tight and decrease desire for sex, clients are not used to using condoms and condoms are not protective of HIV.

"Clients say that a condom has 3 holes that can only be detected by a microscope. Each hole allows passage of 10 microorganisms. So with a condom one gets infected with HIV.

If you smear pepper inside a condom and use it, you still feel the pepper in your private parts" (FGD, Bwaise III parish).

6.5.2.2: Action taken by respondents when clients ask for unprotected sex

Measures taken by respondent when a client asks for unprotected are presented in the table below.

Table 13: Measure taken by respondents when clients ask for unprotected sex

<table>
<thead>
<tr>
<th>Measure</th>
<th>Frequency (n=77)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refusing sex</td>
<td>32</td>
<td>41.5</td>
</tr>
<tr>
<td>Insisting on condom use</td>
<td>5</td>
<td>6.5</td>
</tr>
<tr>
<td>Charge highly for unprotected sex</td>
<td>26</td>
<td>35.1</td>
</tr>
<tr>
<td>Accept to have unprotected sex</td>
<td>12</td>
<td>15.6</td>
</tr>
<tr>
<td>Other reasons</td>
<td>2</td>
<td>2.6</td>
</tr>
</tbody>
</table>

More than one response was allowed

Majority (41.5%) of respondents reported to refuse clients demands for unprotected sex.

Other measure taken by respondents in case a client asks for unprotected sex were; avoiding clients who ask for unprotected sex.
All FGDs reported that they refuse client’s demands for unprotected sex even with higher monetary gains.

“Many CSWs work in the same room so one can make an alarm and other CSWs help you get rid of a client who insists on not putting on a condom. The money the client may have paid is refunded. However sex workers who are infected with HIV may accept the money” (FGD, Bwaise III parish).

6.5.2.2: Sexual violence by clients

Only 4.4% (5/114) respondents reported that clients have ever raped them. In response to the act of rape the respondents reported the following actions;

Crying (2), making an alarm (2) and receiving STD treatment (1).

One FGD participant reported a gang rape act by a client.

“A man picked me from the street to his fenced nice home. He said he did not have a wife at home. I found three men in that house who told me that if I refused sex with all of them they would kill me using a panga. I made an alarm, to no ones rescue. All the three men had sex with me. Only the man who picked me from the street used a condom”(FGD, Makerere III parish).
CHAPTER SEVEN:

7.0 DISCUSSION

The study aimed at generating information on the level of condom use and factors influencing condom use among sex workers in order for the DHT to develop interventions to make commercial sex safer from STDs and HIV.

7.1 Socio-demographic characteristics of respondents

Majority (63.7%) respondents were in the age range of 15-24 years of which 54% (39/72) were between 16-19 years. A survey on HIV/AIDS and STDs among CSWs in Kampala district also indicated 73% of CSWs to be in the range of 15-24 years (MOH 1998). This indicates that young women mainly dominate the commercial sex industry in Kampala district. Some of the respondents were adolescents. As adolescents, women are six times more likely to be HIV infected than men in the same group, commercial sex work being one of the contributing factors (UNAIDS global report 1999). Adolescent girls may also lack proper information on condom use and negotiation skills for their use.

Most (47.4%) of the respondents attained ordinary secondary school education. This indicates a high rate of school drop out of respondents before completing tertiary education. Lack of tertiary education, has contributed to some women to join the sex work industry and their involvement in the informal job sector as barmaids and food vendors. Over 56.2% respondents had an alternative source of income to sex work but this was not a predictor for consistent condom use among respondents (OR; 1.04, 95%CI; 0.42-2.62). Since respondents are employed in low paying jobs, they may be forced to
entertain as many clients including those who demand not to use a condom in order to earn a reasonable income.

Majority (64.9%) of respondents were single. Since most CSWs were between 15-24 years, they have probably not yet got husbands to marry them. However, the UDHS 2000/2001 indicated 18 years as the median age at first marriage of girls aged 20 to 24 years in Uganda’s central region (UBOS 2000/2001). Commercial sex work may also be providing economic, social and emotional security similar to marriage expectations such that most respondents don’t consider marriage a priority. Only (4.5%) of the respondents were married. This indicates that married women also need supplementary income for themselves and their families, therefore some of them join commercial sex work. Most (54.3%) respondents did not have children. This may be as a result of high contraceptive use such as consistent condom use, use of oral pills and abortion. Most respondents were muslims, Baganda because Kawempe division is mainly a muslim and Baganda community.

7.2: Level of condom use among sex workers

Ninety seven percent of the respondents reported to use condoms during sexual encounters with clients. This indicates a high level of condom use by respondents. A similar percentage was obtained in a KABP survey on HIV, AIDS and STDs where by 95% CSWs reported to have used a condom in the previous sexual encounter with a client (MOH 1998). However, for condoms to be effective, they must be used properly and consistently. Of the 97% respondents who reported to use condoms, 64% consistently
use them. This level of consistent condom use may have been as a result of continuous sensitization on importance of consistent condom use among CSWs with their clients by health workers. The perceived health risk to STDs, HIV and unwanted pregnancy as a result of commercial sex may also be contributing to consistent condom use. A survey in Nigeria which examined the relationship between several variables and consistent use of condoms among CSWs revealed that only 55% of CSWs had used condoms consistently in their previous five sex acts with clients (Muyiwa 2001). The differences between levels of condom use in the two studies may be explained by the higher levels of HIV/AIDS awareness in Uganda than Nigeria.

Some respondents reported to inconsistently (32%) or not to use condoms (4%) during sexual encounters with clients for more monetary gains from unprotected sex. A similar study on social determinants on condom use among CSWs in South Africa also indicated financial strain as the major obstacle to condom use among CSWs and their clients (Guardian 2002). Women join commercial sex in order to earn an income so some of them accept clients who demand for unprotected sex in order to earn maximally from their work. Respondents who reported to receive more than three clients a day were more likely to inconsistently or not use condoms (OR: 9.42, 95%CL: 3.53-25.9). Compared to those who consistently use condoms, respondents who accept unprotected sex may have more desire for more monetary gains obtained by entertaining as many clients than a healthy life, may be those who are HIV positive and see no need for protection.
People with secondary or higher education are able to better comprehend information about the role of condoms in STDs/HIV prevention and family planning and are able to take more precautions when indicated. In this study however, having at least secondary education was not a predictor for consistent condom use (OR:2.25, 95%CI; 0.91-5.58). Desire for more monetary gains from unprotected sex is the major obstacle for consistent condom use at all levels of education that was attained by the respondents. Many studies indicate secondary education as a predictor for condom use, an example is the UDHS 2000/2001 that showed 58% condom use among urban women with non cohabiting sexual partners, the women also had secondary education (UBOS 2000/2001). However no distinction was made between women who consistently or inconsistently use condoms during the UDHS.

7.3: Access to condoms

The female and male condoms are barrier methods to acquiring STD/HIV and unwanted pregnancies. Therefore condom social marketing programs should make condoms accessible to people who need them at affordable prices, through local outlets and in establishments where sex work takes place.

All respondents reported to use the male condom during their sexual encounters with clients citing reasons like; its easy to use, cheap, available. The male condom is inserted on the male penis, an external organ making it an easy barrier contraceptive to use. The male condoms (Engabu brand) is distributed free of charge by the MOH and to the community through community distributors and therefore many respondents reported to
use it. Other condom brands like life guard are sold in any retail shops, drug shops and clinics at prices that may be affordable to the respondents. The above findings therefore make the male condom accessible to the respondents.

The promotion and use of the female condom is another approach to empowering women in helping them negotiate for safer sex with their partners because it provides autonomy. Unfortunately, most respondents had never seen the female condom. This may be because the female condom is no longer supplied by MOH due to its low acceptability by the community. In Shanghai China however, acceptability of the female condom was reported to be high (90%) among 30 married couples, 87% of them felt it was a good contraceptive device, 80% found it easy to use (Xu-JX 1998). The difference between the rate of acceptability of the female condom in the two countries may be due to lower sensitization about the female condom in Uganda than China. Some respondents however, reported to insert the male condom on the client’s erect penis before sexual intercourse, a measure to ensure that the condom is used. This indicates that even in absence of a female condom, some CSWs can still demand and participate in ensuring safer sex with alternative methods like the male condom.

7.4: Knowledge on condom use

The commonest sources of information about condoms were; friends (71%) and health workers (70%). In Kawempe division, the DHT and other health workers provide static and outreach health activities among CSWs that include condom distribution and knowledge on their use. Friends to CSWs who provide information on condom use may
be fellow CSWs who are trained peer educators or ordinary friends. In general, people are more likely to alter their behavior if their peers are also changing theirs. This principle was applied in establishing community based peer education as part of a project aimed at increasing condom use among CSWs in a gold mining district near Johannesburg (Guardian 2002). Therefore training CSWs as peer educators is an important investment for behavior change among CSWs.

The indications for condom use by respondents were either to prevent STDs (84.2%) or unwanted pregnancy (77.2%) or both by 64% respondents. The UDHS indicated similar level of women’s knowledge on the role of condoms in STDs and HIV prevention in Uganda’s central region as 87.9% (UBOS 2000/2001). The high level of knowledge on the role of condoms in STDs and HIV prevention in the two studies may be as a result of the continuous national sensitization about condom use. Knowledge on indications of condoms is a motivator to adopting their use as was the case among respondents who reported to consistently use condoms with clients. However, only 64% of the respondents mentioned both indications for condom use. This therefore calls for continuous education on indications for condom use by health workers.

Respondents who inconsistently and those who don’t use condoms with clients were also knowledgeable about indications for condom use. A similar study on knowledge and condom use among STD patients in Mulago hospital also revealed that respondents had high knowledge (80%) on the role of condoms in STD and HIV prevention. However the high knowledge did not depict high condom use among STD patients. Only 30% of them had ever used condoms and only 0.5% used a condom always (Walker 1993).
conclusion from the two studies is that factors other than having knowledge on protective effect of condoms influenced condom use among the study participants.

None of the respondents mentioned all the steps on condom use. The percentage scores for most steps on condom use were also below 50%. This may have resulted from recall bias by respondents for the following reasons: In most sexual encounters, clients were reported to insert the condom on the penis rather than the respondent. Respondents who insert the male condom on the client's penis may not be following all the steps on condom use and therefore could not mention them. There is a need therefore for further education on steps of condom use among CSWs by health workers.

7.5: Attitude towards condom use

Ninety two percent (105/114) of the respondents considered condom use with every sexual encounter with a client important and were considered as those who had a positive attitude towards condom use. A person with a positive attitude towards a healthy behavior may or may not adopt that behavior when it is indicated. This was revealed in this study where some respondents who had a positive attitude towards condoms consistently used condoms while others inconsistently used them. A study on VCT services among pregnant mothers in Kawempe division, Kampala district revealed that most (73%) mothers had a positive attitude towards an HIV test but none had ever taken that test (Nampewo 2003). The above findings indicate a need to narrow the gap between positive attitude towards health interventions and their use among populations.
7.6: Health risk perception

Most (75%, 86/114) respondents considered themselves at risk of acquiring STDs/HIV because of condom accidents, inconsistent condom use and suspected client's HIV positive sero status. A similar study on risk perception and condom use among respondents in districts of Kampala, Lira and Kabale, Uganda showed that mistrust of partners and having many sexual partners as the main reasons why people considered themselves at risk of contracting HIV (Union for Africa Population studies 2003). In both studies, respondents labeled risky sexual behaviors, the first stage in initiating behavior change as illustrated by the AIDS risk reduction Model. Other stages of the AIDS risk reduction model are; commitment to change and taking action through enacting solutions like consistent condom use as was the case with some respondents. However condom accidents like bursting reduce the effectiveness of condoms therefore it was not surprising that respondents who had experienced condom bursting considered themselves at risk of STDs/HIV. With a high rate of sexual partner change as was the case among respondents (average 3.5 clients per day), the chance of getting a partner with an HIV positive sero status is higher. Therefore it was not surprising that respondents considered themselves at risk of STDs/HIV and especially those who inconsistently use condoms (OR; 8.28, 95%CI; 1.72-54.34).

Some of the preventive measures for those who reported to be at risk of STDs and HIV were; condom use by 67.4% (58/86) and reducing number of clients (12/86). These findings indicate that condom use is the major preventive measure against STDs and HIV among CSWs. Reducing the number of sexual partners however seems not to be a very
practical STD/HIV control measure among CSWs evidenced by few respondents who adopted it. Sex workers smoke tobacco and other herbs in a pipe locally called “Emindi” aimed at attracting many clients. This may further explain the impractical nature of this intervention.

Quitting commercial sex for other employment was considered the best solution to preventing STD/HIV by FGD participants. However this may also be impractical for the following reasons: Respondents who were given vocational skills training by stakeholders have returned to the commercial sex industry again. Most respondents had other forms of employment to commercial sex and but were still practicing commercial sex.

7.7: Clients demand for unprotected sex

Sixty eight percent (77/114) of the respondents reported clients who demand for unprotected sex for reasons like; unprotected sex is more enjoyable. A condom interferes with the traditional meaning of sexual intercourse because it blocks skin contact. This may lead to less sexual enjoyment though this is subjective. A similar study among female sex workers and pimps in Indonesia revealed that perceived less pleasure due to the condom and lack of need for protection with clients who were acquainted to the CSWs as obstacles to condom use by clients (Endang 2002). The two studies indicate perceived loss of sexual pleasure with a condom which may be a true finding.

Most respondents whose clients demand for unprotected sex reported to either refuse clients demands (32/77) and some insist on condom use (5/77). This indicates that CSWs
have the ability to negotiate for condom use despite perceived disparity of gender power relations in favour of men. A similar study on consistent condom use among CSWs in Nigeria indicated that CSWs who asked clients to use condoms were 39 times more likely to consistently use condoms than those who did not ask clients to use condoms (Muyiwa 2001). Therefore self efficacy is a women empowerment life skill to safer sex. Some respondents reported to accept clients demands for unprotected sex. Therefore condom promotion programmes that target clients to CSWs can lead to increase in consistent condom use by respondents.

Only 4.4% (51/114) of the respondents reported to have ever been raped by a client. When compared to the total number of study participants, this number of rape cases is low. The lodges where majority of commercial sexual services take place, may be safe places where acts of rape are not very likely to occur. Rape is sex without consent of a partner and in such instances a condom is not likely to be used.

7.8: Study limitation

Respondents who participated in this study may be those utilise health services that target CSWs in Kawempe division and therefore may not be representative of CSWs who are not reached by these health services.
CHAPTER EIGHT:
CONCLUSIONS

• The level of condom use among respondents and their clients was high. However only 64% of these respondents consistently use condoms.

• Respondents consistently use condoms to prevent STDs and unwanted pregnancies. However condom accidents like bursting limit the protective effect of condoms.

• Knowledge on indications for condom use was high. However knowledge on steps of condom use was inadequate.

• Most respondents perceived themselves at risk of acquiring STDs/ HIV and had a positive attitude towards condom use. However desire for higher monetary gains from unprotected sex was the major obstacle to condom use.

• The male condom is the major barrier method against STDs/HIV and unwanted pregnancy that is used by most respondents. Other STD/HIV control measures like reducing the number of sexual partners were poorly adopted.

• Quitting commercial sex work was the best perceived preventive measure against STDs/ HIV by respondents. However practical issues like better economic benefits, lack of alternative well paying jobs hinder CSWs from quitting commercial sex work.
CHAPTER NINE:

RECOMMENDATIONS

- The DHT and other stakeholders need to provide more knowledge on indications and steps on proper condom use to CSWs. Importance of consistent condom use during sex work transactions between CSWs and their clients should also be more emphasised. Peer educators who are CSWs should be more involved in promoting condom use among CSWs and their clients.

- The DHT and other stakeholders should encourage CSWs to create more alternative income generating activities to supplement commercial sex work. Improving the income of CSWs may lead to more negotiation for safer sex and therefore increase consistent condom use with clients.

- A multi-sectoral team involving religious leaders, social workers and counselors should continuously encourage more CSWs to quit commercial sex for other forms of employment. This will eliminate health risks resulting from practice of commercial sex work.

- Contentment even in scarcity of money, a virtue in life and a sense of self worth should be emphasized among CSWs by the DHT. When this information is continuously disseminated, fewer CSWs will engage in unprotected sex for more monetary gains.

- The DHT should carry out a study on health risk perception to STDs/HIV among clients to CSWs.
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APPENDIX ONE:

CONSENT FORM FOR QUESTIONNAIRE INTERVIEW

Good morning/afternoon madam

My name is ................. from the office of the District Director of Health Services, Kampala district. I am conducting a study on condom use among commercial sex workers in Kawempe division, Kampala district.

The purpose of this study is gather information that will assist the District Health Team of Kampala district and other stakeholders to plan appropriate interventions that will promote safer sex among commercial sex workers.

This study carries minimum risks. The information obtained will be kept confidential and will be used for purposes of this study only. Your participation in this study is entirely voluntary and you are free to withdraw from this study at any time without penalty. You are also free to ask questions about this study. Your name will not be required when answering questions.

Please sign this form if you have accepted to participate in this study.

Thank you for your valuable time

Signature/thumb print of the interviewer..........................................................

Signature of the witness..........................................................

Date..........................................................
CONDOM USE AMONG SEX WORKERS IN KAWEMPE DIVISION, KAMPALA DISTRICT

Questionnaire no: ........................................
Date of the interview ........................................
Area of residence ...........................................
Interviewers name ...........................................

SOCIO-DEMOGRAPHIC CHARACTERISTICS
1. How old are you?(Years)
2. What is your religion?
   i) Catholic
   ii) Protestant
   iii) Moslem
   iv) Adventist
   v) Others(specify).
3. What is your tribe?
   i) Muganda
   ii) Musoga
   iii) Munyankole
   vi) Others(specify)
4. What is your highest level of education
5. What is your occupation?
   i) Student
   ii) Unemployed
   ii) Bar maid
   iii) Hair dresser
   iv) Food vender
   v) Shop attendant
   vi) Commercial sex worker
6. What is your marital status?
   i) Single
   ii) Married
   iii) Separated
   iv) Divorced
   v) Widow

7. Do you have children?  i) Yes  ii) No

8. If Qn 7= yes, how many children do you have?

**Nature of sex work**

9. For how long have you been involved in commercial sex work?

10) Where do you serve your sex clients from?
    i) Lodge
    ii) my home
    iii) Bar
    iv) Street
    v) Others (specify).

11) Which type of sex clients utilise your services(More than one response is expected)
    i) Single men
    ii) Married men
    iii) Other(specify)

12) On average, how many sex clients do you get in a day?
LEVEL OF CONDOM USE AMONG SEX WORKERS

Do you use condoms during your sexual encounters with clients?

i) Yes
ii) No
iii) Others (Specify)

13) During your sexual encounters with your sex clients, do you use condoms with?
   i) All your clients
   ii) Some of your clients
   iii) None of your clients (go to question 25)

14) For respondents who use condoms (Qn 13=i&ii), why do you use condoms with your clients?

..........................................................................................................................
..........................................................................................................................

15) For respondents who use condoms (qn 13=i&ii), how often do you change condoms during your sexual contact with a client?
   i) Every sexual round with a client
   ii) I use one condom for all sex rounds with a client
   iii) Others (specify)

16) If qn 15 = (ii), what are the reasons for using one condom for all sex rounds with a client?

..........................................................................................................................
..........................................................................................................................

17) For respondents who use condoms (qn13=i&ii). What problems do you experience when using a condom?

[ ] Condom got stuck in the vagina

[ ] Condom burst

[ ] Condom causes pain

[ ] Condom causes dryness

[ ] Other (specify)
18) For respondents who use condoms (qn 13=i &ii). Who puts on the condom during sex with a client

<table>
<thead>
<tr>
<th></th>
<th>Male condom</th>
<th>Female condom</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Myself</td>
<td>............</td>
<td>............</td>
</tr>
<tr>
<td>ii) The client</td>
<td>............</td>
<td>............</td>
</tr>
</tbody>
</table>

19) For respondents who sometimes use condoms (Qn 13=ii), why don’t you use condoms with some of your clients? (Go to question 20)

............................................................................................................

20) For respondents who sometimes use condoms with clients (Qn 13=ii), with which clients don’t you use condoms?

i) Clients who offer more money
ii) Steady clients
iii) Any client(s) when clients are scarce
iv) Others (specify)

21) For respondents who don’t use condoms with clients (Qn13=iii), what are the reasons why you don’t use condoms with all your sex clients?

............................................................................................................

ACCESS TO CONDOMS (For respondents who use condoms with clients(responses to question 13 = i &ii))

22). Which type of condom(s) do you usually use with your clients?

   i) Female condom
   ii) Male condom

23) Why do you choose to use that/those type(s) of condoms

Male condom.................................................................

.................................................................

Female condom.................................................................
24) Which brands of condoms do you use/usually use with your clients?
   i) Engabu
   ii) Protector
   iii) Life guard
   iv) Rough rider
   v) I don’t know
   vi) Others (specify)

25) Why do you choose that/those brands of condoms? (Give reasons for each brand that is chosen)

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<th>Brand</th>
<th>Reason</th>
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26) Where do you usually get your condoms from?
   i) Government health facility
   ii) Drug shop
   iii) Private clinic
   iv) Pharmacy
   v) Community distributors
   vi) Other (Specify)

27) {All respondents}. Do your clients carry condoms during sex work transactions?
   i) Always
   ii) Sometimes
   iii) No (For answers ii & iii go to Qn 28)

28) For Qn 27= (ii & iii), what are the reasons why clients don’t come with condoms
   i) Clients say they cannot afford condoms
   ii) Clients know that we carry our condoms
   iii) Other (Specify)
KNOWLEDGE REGARDING CONDOM USE

29) What is your common source of information on condoms (>one response is possible)
   i) Parents/guardians
   ii) Relatives
   iii) Friends
   iv) Radio/TV
   v) Health worker
   vi) Others(specify)

30) For what reasons do people use condoms?

........................................................................................................................................
........................................................................................................................................

31) What should a person check for before using a condom?
   i) Check for expiry date
   ii) Check for tears, holes
   iii) Other(specify)

32) Can you describe how a male and female condom is used? Also include mode of condom disposal
   Male condom......................................................................................................................
........................................................................................................................................
........................................................................................................................................

   ii) Female condom..............................................................................................................
........................................................................................................................................
........................................................................................................................................

33) What does “correct condom use” mean to you?(More than one response is possible)
   i) Using a new condom per sex round
   ii) Putting on a condom on an erect male penis
   iii) Removing the condom after ejaculation when penis is still stiff
   iv) Disposing condoms properly after use
   v) Others(specify)
ATTITUDE TOWARDS CONDOM USE (ALL RESPONDENTS)

34) Do you think it is important to use condoms with every sexual encounter with a client?
   i) Yes (Go to qn 35)  ii) No (Go to qn 36)

35) If answer to qn 34 = yes, why is it important to use a condom with every sexual encounter with a client?

36) If answer to question 34 = No, why isn’t important to use a condom with every sexual encounter with a client?

OTHER FACTORS THAT INFLUENCE CONDOM USE

37) Do you think commercial sex might lead you to getting infected with STDs and HIV?
   i) Yes
   ii) No
   iii) Others (specify)

38) If answer to question 37 = yes, why do you think so?

39) If answer to question 37 = No, why don’t you think so?

40) If qn 37 = yes, what measures have you taken to ensure that you don’t acquire STDs and HIV/AIDS?
   i) Reducing the number of sex partners
   ii) Using a condom with all my clients
   iii) Others (specify)

41) What other health problems is commercial sex work exposing you to?
   1. .................................................................
   2. .................................................................
42) What measures have you taken to avoid the above health problems?

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<tr>
<th>Problem</th>
<th>Measure(s)</th>
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43) Have any of your clients ever asked for sex without a condom?
   i) Yes  
   ii) No

44) If Qn 43 = Yes, what are some of the reasons given by clients for not wanting to use condoms?

45) If Qn 43 = Yes, what do you do when a client asks for sex without a condom?

46) Has a client ever attempted to rape you or raped you?
   i) A client attempted rape to rape me
   ii) A client raped me

47) If Qn 46 = ii), what did you do or usually do when a client rapes you?

48) Do you have any suggestions or concerns about improving commercial sex work?

Thank you very much for answering our questions.
The interviewer should ensure that all questions have been answered
APPENDIX 11
CONSENT FORM FOR FOCUS GROUP DISCUSSION

You are welcome to this focus group discussion. We are a team of health workers from the office of the District Director of Health Services, Kampala district. We are conducting a study on condom use among sex workers in Kawempe division.

The purpose of this study is to gather information that will enable the District Health Team and other stake holders to plan for appropriate interventions that will promote safer commercial sex.

This study has minimum risks. The Information collected will be kept confidential and will be used for purposes of this study only. Your name will not be required when participating in this discussion. Your participation in this study is entirely voluntary and you are free to withdraw from the study any time without penalty. We will be taking notes during the interview and we request for your permission to tape record your comments so that your opinion is correctly noted.

Please sign this form if you have accepted to participate in this study.

Signature(or thumb print) of respondents

1) ................................................. 4) .................................................
2) ................................................. 5) .................................................
3) ................................................. 6) .................................................
FOCUS GROUP DISCUSSION GUIDE

Condom use among commercial sex workers

Modulator: The principal investigator
Number of participants per focus group = 8

Instructions
- Please give your answers for questions below. There are no right or wrong answers, we are interested in getting opinion of different people
- Speak only when it is your time and be audible
- Avoid holding discussions with other people
- Please respect each other's opinion

Theme 1. Nature of commercial sex
i) What are the various forms commercial sex work in Kawempe division?
ii) Is there any form of organisation of commercial sex work in Kawempe division?
iii) What is the nature of your clients?

Theme 2: Level of condom use among CSWs in Kawempe division.
i) Do you use condoms with your clients and reasons why you use/don't use condoms
ii) What types and brands of condoms do you commonly use
iii) Why do you prefer certain types and brands of condoms to others
iv) Who puts on the condom and why?

Theme 3: Access to condoms among CSWs.
i) Where do you usually get your condoms from?
ii) On average, how much do you pay for the condoms
iii) In your opinion, are these condoms affordable
iv) What brand(s) do you want to be distributed?
iv) What problems do you find when using condoms with clients
Theme 4: Other factors that influence condom use by CSWs

Clients and condom use
i) Have your sex clients ever asked for sex without a condom?
ii) What reasons do your clients give for not wanting to use condoms?
iii) What do you do in case a client refuses to use a condom?

Risk perception about HIV/AIDS
i) Do you consider yourself at risk of acquiring STDs and HIV from clients? Yes/No Give reasons for each answer.
ii) Do you consider yourself at risk of spreading STDs to your clients, husband or boyfriend? Give reasons for your answer.
iii) What have you done to prevent acquiring or spreading STDs and HIV?
iv) What is your best perceived measure to reduce your risk of acquiring STDs including HIV?
v) Has any of your clients ever raped or attempted to rape you? What did you do when this happened?

Are there any other issues/concerns you want to be addressed by the local leaders and the District Health Team?

Thank you for your responses
APPENDIX III

CONSENT FORM FOR KEY INFORMANT GUIDE

Good morning /afternoon sir/madam,

I am called ....................... from the office of the District Director of Health Services, Kampala district. I am conducting a study on condom use among commercial sex workers in Kawempe division. The purpose of this study ids to collect information that will be used by the district health team and other stakeholders to plan for appropriate interventions that will promote safer commercial sex.

This study carries minimum risks. The Information collected will be treated confidentially and will be used for purposes of this study only. You name will not be required when answering questions. Your participation in this study is entirely voluntary and you are free to withdraw from this study at any time.

Please sign this form if you have accepted to participate in this study.

Signature of key informant  .....................

Signature of interviewer .................. Date ..................

Thank you for your valuable time
KEY INFORMANT GUIDE

1) How is commercial sex work organised in Kawempe division?
   ii) What HIV risk reduction measures have sex workers been informed about?

2) Do you think CSWs have adopted some of the HIV prevention behavior measures?

3) Do you supply free condoms to sex workers?
   i) Who supplies these condoms
   ii) What types and brands do you usually supply?
   iii) What types and brands of condoms do sex workers desire?
   iv) What is the mode of distribution of condoms to sex workers
   v) Where do you get condom supplies from?

4) The number of commercial sex workers in Kampala district is increasing. What are your current and future policy plans regarding commercial sex work?

5) What is your opinion on the debate of legalising prostitution in Uganda? Do you think legalising commercial sex work will increase access of CSWs for HIV prevention activities?