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Peers reaching peers: a case study on expanding contraceptive access for female sex workers in Uganda

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ABSTRACT

Background. Female sex workers (FSWs) face disproportionately high rates of unintended pregnancy and unmet family planning needs. Peer-led interventions offer a promising strategy to expand access to contraceptives for populations such as FSWs that are routinely stigmatized or otherwise left behind by traditional healthcare facilities. **Methods.** We trained 50 peer educators across four divisions of Nansana Municipality in Uganda to deliver contraceptive education and provide free short-acting contraceptives directly to FSWs. Peer educators also facilitated referrals as needed to a stigma-free clinic offering long-term contraceptives, and comprehensive sexual and reproductive health services. Peer educators were trained in destigmatizing sexual and reproductive health service provision for FSWs specifically. Providing these services at a designated clinic minimized structural barriers, such as stock-outs and disrespectful provider attitudes, enabling effective referrals and service uptake. **Results.** Over 12 months, 787 FSWs received contraceptive education: 5420 male and 510 female condoms were distributed, 232 FSWs accepted oral contraceptives, and 179 were referred for and received long-acting methods, with 74 receiving injectables and 105 implants or intrauterine devices. **Conclusions.** Peer-led models can expand contraceptive access among FSWs in designated stigma-free facilities with reliable supply chains. To achieve sustainable contraceptive access among FSWs more broadly, this approach should be integrated into government sexual and reproductive health systems.

Keywords: attitudes, barriers, contraceptives, female sex workers, peer educators, pregnancy, sexual and reproductive health, stigma, Uganda.

Introduction

Female sex workers (FSWs) in sub-Saharan Africa (SSA) face a disproportionate burden of health risks.[1] Globally, 38% of FSWs report at least one induced abortion, and 22% report multiple induced abortions.[2] In SSA, rates of unintended pregnancy remain high; between 62% and 66% of all pregnancies among FSWs in countries such as Cameroon and Zambia are unintended.[3,4] In Uganda, up to 89% of FSWs have been pregnant at least once; of whom 37.4% have terminated one or more pregnancies and 29.9% have had at least one miscarriage,[5] with 37% of FSWs living with HIV accounting for 18% of new infections.[6] Many women in SSA experience unmet contraceptive need; they wish to avoid or delay pregnancy, but are not using an effective method, often because of limited access rather than choice.[7] For example, in Cameroon, only 33% of FSWs used condoms, 26% used a non-barrier method and just 6% relied on a long-acting reversible method.[8] In Uganda, 33.8% of FSWs reported no family planning use, and just over half (52.7%) relied on moderately effective methods, most commonly injectables and condoms, leaving them at risk of unintended pregnancy.[5]

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FSWs in SSA face numerous, multi-level barriers that limit their access to and uptake of contraceptive methods.[3,5,7–9] At the structural level, criminalization of sex work and punitive policing practices in countries such as Uganda intensify barriers to contraceptive access by making women fear arrest and forced disclosure.[8,10] Restrictive abortion laws further complicate their situation by denying safe options for terminating unintended pregnancies.[11] At the system-level, siloed HIV and sexual and reproductive health (SRH) services preclude FSWs receiving STI testing or treatment from accessing family planning services in the same visit.[5] At the community and clinic levels, stigma and discrimination, breaches of confidentiality, and judgmental provider attitudes deter many women from seeking care, because they fear mistreatment.[9] Moreover, long waiting times in public health facilities also discourage them from using available services.[9] In addition to these structural-, system-, community- and facility-level barriers to contraceptive access and uptake, limited knowledge about the full range of contraceptive methods, including injectables and implants, and how to combine methods with condoms for dual protection against HIV, STIs and unintended pregnancies may hinder uptake.[3,5,7–9,12] Evidence shows that integrated, non-stigmatizing platforms may reduce barriers to access and increase contraceptive uptake. In Uganda, women who accessed stigma-free STI services, delivered respectfully and without discrimination, used moderately effective contraceptives more often than those who did not.[5]

To address these well-documented barriers to contraceptive access and uptake among FSWs in Uganda, where most SRH services remain facility-based and provider-initiated, we designed and implemented a peer-led contraception program. We recruited FSW community members and trained them as peer educators to deliver SRH information, dispel myths, and distribute barrier methods and oral contraceptives within their networks. This program reduced reliance on facility-based services, which many women perceive as stigmatizing or inaccessible. For long-acting methods that required trained providers, such as injectables, implants and intrauterine devices (IUDs), peer educators referred clients to FSW-friendly facilities where sensitized staff provided confidential and stigma-free care.

Methods

Study setting

This program was implemented in Nansana Municipality, Uganda, an area with persistently high fertility,[13] early sexual debut among adolescents and low contraceptive uptake.[13] Nansana is a municipality in Wakiso district located 10 km from Kampala, Uganda's capital. It is a peri-urban area, and many of its occupants deal in local businesses. It is also a high-density working-class district and a hub for FSWs. This program was implemented by the Inclusive Health Bureau, a non-governmental organization based in Kampala. The Bureau trained the FSW peer educators and provided free SRH services at its clinic in Nansana. The clinic was staffed by a team of three medical doctors, two clinical officers and three midwives.

Study population/target group

The implementation program targeted FSWs, one of the most marginalized and discriminated key populations in Uganda.[14] Sex work as an occupation places FSWs at high risk of unintended pregnancy, unsafe abortion, HIV and other STIs. FSWs were prioritized for this implementation program because of their high unmet need for contraception and disproportionate burden of adverse SRH outcomes.

Recruitment strategy

Peer educators who were current FSWs were purposively recruited from FSW networks across the four administrative divisions of Nansana Municipality. This ensured broad geographic representation, including among those working in peri-urban suburbs with particularly limited access to SRH services. We recruited FSW peer educators who were trusted within their networks, willing to serve as role models and able to share SRH information in an approachable, non-judgmental way. These criteria drew on formative discussions with FSWs and implementing partners, who stressed that trusted peers would be more readily accepted and effective at program implementation. This recruitment approach deliberately leveraged the strong social cohesion within the FSW community to maximize trust, reach and acceptance.

Program activities

The program's core activities centered on empowering peer educators to serve as focal persons within their communities. Training was conducted by three of the organization's own medical doctors and two midwives through three full-day sessions (8 h from 8 am to 5 pm) that used a workshop format with hands-on practical activities, using standardized materials based on the Uganda Ministry of Health family planning guidelines and the World Health Organization manual, 'A Guide to Family Planning for Community Health Workers and Their Clients'.[15] Each of the trainers had been working in reproductive health for at least 4 years. The training equipped peer educators with knowledge on contraceptive methods, communication skills, stigma reduction and referral protocols.

To foster confidence and minimize stigma, we held peer educator trainings in a private setting. Training sessions used interactive 'stigma-bursting' activities, including open discussions, role-plays, and reflections to help peers recognize and challenge stigmatizing beliefs and language. Peer recruits

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completed a 1-week course covering contraceptive methods, safe service delivery, referral mechanisms and approaches to stigma reduction within their communities.

After completing the training, peer educators could distribute male and female condoms and combined oral contraceptives directly within their communities, based on client preferences and the information shared during peer interactions. Peer educators also provided health education to fellow FSWs, focusing on dispelling myths, promoting dual protection (condoms plus another contraceptive method) and raising awareness of the full range of available contraceptive options. To support their work and retention in the program, peer educators received a modest stipend and supplies; attrition over the program period was low.

For distribution of provider-dependent contraceptive methods, such as injectables, implants and IUDs, peer educators referred clients to the organization's designated medical facility using simple referral notes. At this stigma-free facility, skilled midwives and medical doctors delivered client-preferred contraceptive methods in a confidential and respectful manner. Midwives and medical doctors routinely received refresher training led by a obstetrician and gynecologist on method administration, client monitoring, and the management of any serious adverse events. Training was conducted using the World Health Organization's Handbook, 'Family Planning: A Global Handbook For Providers'.[16]

Measures

We tracked program outputs through weekly reports submitted by peer educators from which monthly reports on the number of condoms and oral contraceptives distributed and referrals made were derived, which ensured systematic monitoring and documentation of outcomes. We also tracked the routine records kept at the clinic. Peer educators logged the women they reached, and the condoms and oral contraceptives they distributed. The clinic recorded referrals received and methods provided on site. We collected these data throughout the 1-year period. We did not collect baseline measures before the program began, and we did not follow individual women over time to confirm continued use.

Ethics approval

The data reported here come from routine, de-identified program and clinic records that were collected for service delivery and monitoring. No individually identifiable information was collected or analyzed, and no research procedures were performed on clients. Ethics approval is not applicable for this research.

Outcomes

Outcomes of the program are reported using the first three constructs of the RE-AIM Framework.[17] We applied the first three RE-AIM constructs. Reach captured the number and characteristics of FSWs contacted through peer networks. Effectiveness captured the uptake of condoms and contraceptive methods. Adoption captured the willingness of peer educators and the clinic to take on their roles.

Results

Reach

Over a 1-year implementation period, we recruited and trained 50 FSW peer educators across the four administrative divisions of the municipality. Through their networks, these peers reached 787 FSWs with information on contraceptive options and their safe use (Table 1). We did not record the number of times each woman was contacted, as the focus was on ensuring that all women in the networks received at least one introduction to contraceptive services.

Effectiveness

The peer educators distributed 5420 male condoms and 510 female condoms to the FSWs. Some of the FSWs took more than one service, with some who accepted oral contraceptives also taking barrier methods, such as condoms. Distribution was done repetitively, with peers supplying condoms directly and placing condoms at strategic locations where the FSWs could easily access them. In addition to condoms, the program distributed oral contraceptives to 232 FSWs. For those who preferred longer-term methods, 179 FSWs were referred to a designated medical facility, where 74 received injectables and 105 received other methods, such as implants and IUDs (Table 1).

Table 1. Findings tabulated according to the RE-AIM framework.

RE-AIM domain	Program findings
Reach	• 50 peer educators recruited and trained across four divisions. • 787 FSWs reached with contraceptive education through peer networks.
Effectiveness	• 5420 male condoms and 510 female condoms distributed. • 232 FSWs accepted oral contraceptives. • 179 FSWs referred to long-term methods: 74 received injectables and 105 adopted implants or IUDs.
Adoption	• Program implemented across all four administrative divisions. • Peer educators drawn from trusted FSW networks. • Referrals were successfully received at the organization's designated stigma-free clinic.

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Adoption

The program was implemented in four administrative divisions of Nansana Municipality. The peer educators were recruited from the FSWs in the municipality and were trusted role models within their communities. Referrals generated by peer educators were successfully received and acted upon at the organization's designated stigma-free clinic.

Discussion

Our implementation program demonstrated that a peer-led model can improve contraceptive access among FSWs, a key population that continues to experience disproportionately high rates of unintended pregnancy, induced abortion and unmet contraception needs.[18] Training 50 peer educators across four divisions of Nansana Municipality enabled the program to reach 787 FSWs with contraceptive education. These results are consistent with previous evidence demonstrating the effectiveness of peer educators in improving health outcomes among FSWs.[9,19,20] Peer educators leverage their unique position as trusted individuals with shared lived experiences, and being embedded in sex work networks allows peer educators to reach FSWs even in highly stigmatized or criminalized environments.[21,22] Importantly, across many settings, the use of FSWs as peer educators has also been shown to expand access to health services compared with facility-only approaches.[9,23,24]

The program achieved the distribution of 5420 male condoms and 510 female condoms, and distributed oral contraceptives to 232 women. An additional 179 women were referred for long-term methods, with 74 receiving injectables and 105 receiving implants or IUDs. Condom distribution was substantially higher than uptake of other methods, which reflects both demand and the fact that condoms are more frequently accessed and used in parallel with other contraceptives. This pattern suggests that peer educators were effective in promoting multimodal prevention, combining condoms for protection against HIV and STIs with other contraceptive methods to prevent unintended pregnancy. High condom uptake reflects broader evidence that condoms remain the most used and familiar method among FSWs.[23,25]

It should be noted that reliance on condoms alone is not ideal, as FSWs often face challenges in using them consistently,[19] leaving them at continued risk of unintended pregnancy. The relatively low uptake of long-acting contraception methods may have been driven by myths, fears of side-effects and provider-related barriers, as documented in other settings.[8,9] However, our study did not collect data on specific reasons for choosing one method of contraception over another or reasons for choosing only condoms rather than multimodal protection methods. Although some peer-led interventions have been associated with the spread of misinformation,[20] we sought to mitigate this risk by providing structured training to peer educators before implementation. The training emphasized accurate contraceptive information and reliable commodity distribution. Although we did not directly assess misinformation during the program, lessons from Uganda's peer-delivered HIV self-testing interventions suggest that peer models function more effectively when educators are well-equipped with correct knowledge and supplies.[20,26]

Similar to findings from a study in Kenya, the success of our program was likely enhanced by access to a stigma-free clinic that provided free services to FSWs referred by peers and offered drop-in visits.[19] A dedicated, safe clinic reduced barriers for FSWs to receive care, including stigma, unfriendly health workers and stock-outs, challenges that have been well documented across settings. Our client-friendly clinic aligns with evidence from Zambia and Mozambique, where consistent commodity availability and respectful, 'friendly' service delivery points improved contraceptive uptake compared with public facilities often characterized by stock-outs and disrespectful treatment.[3,23,24]

Our approach differs from existing services, which have mostly used peers to promote condoms and refer clients elsewhere for other contraceptive methods. A recent scoping review of peer-education programs for FSWs found that interventions concentrate on HIV and STI prevention and condom use, with little direct provision of a broader method mix by the peers themselves.[27] Our peers carried contraceptive pills and condoms, and distributed them during routine contact. They also linked women to a known clinic for injectables, implants and other methods that require provider administration. Placing the peers and the clinic within the same trusted network minimized the number of steps a woman had to take to access contraceptives, and kept her in contact with people who understood her circumstances. However, sustaining this approach will depend on integration into government SRH structures, as well as explicit financing commitments from the government.

Limitations to our approach include, first, its implementation as a stand-alone intervention without integration into government SRH systems. Although the non-governmental organization-led setting allowed greater control over stock-outs and reduced stigma, scaling this model within public-sector facilities would require addressing systemic challenges, such as stigma and discrimination, breaches of confidentiality, judgmental provider attitudes, and long waiting times, all of which often hinder uptake.[9,23] Second, unlike in implementation studies, we lacked systematic follow-up data, which limited our ability to assess continuation of contraception. We could not determine whether women who received a method continued, switched or stopped using it, so our results reflect uptake at the point of distribution rather than sustained use. Third, reliance on self-reported data introduced potential bias. Additionally, our evaluation focused on implementation effectiveness, such as uptake and referral patterns, rather than clinical outcomes, such as unintended pregnancies or HIV incidence. We also lacked data on continuation, dual-method

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use, refusal to take condoms and downstream SRH outcomes, which limited the strength of our assessment. Finally, we maintained the clinic's stigma-free environment through staff sensitization, informal feedback from FSWs and a suggestion box that invited comments on the services. A formal assessment of observed stigma within the clinic, or input from a community advisory board, would further strengthen confidence regarding clinic status. Future programs should build in structured client feedback and independent assessment of service quality.

For better service delivery to FSWs, we recommend adoption and institutionalizing peer-led models within national SRH and HIV programs in Uganda by embedding peer educators into government structures with standardized training, stipends and supervision to ensure sustainability. We further recommend expanding structural enablers, such as stigma-free clinics, extended service hours and confidential services within public health systems, to replicate the successes observed in dedicated facilities. Additionally, the Ministry of Health, district health authorities and health centers should ensure consistent availability of contraceptives, as these institutions are directly responsible for supply chain management and service delivery.

Conclusion

Peer-led education improved access to contraceptives among FSWs with high condom uptake, oral contraception uptake, and referrals and uptake for long-term methods. This success was complemented by the presence of a stigma-free clinic that provided free service. Future programs should extend follow up and pursue integration into national public SRH systems to enhance long-term sustainability and effectiveness.

References

1 Schwartz SR, Papworth E, Ky-Zerbo O, Sithole B, Anato S, Grosso A, Ouedraogo HG, Tchalla J, Ntshangase C, Ketende S, Baral S. Reproductive health needs of female sex workers and opportunities for enhanced prevention of mother-to-child transmission efforts in sub-Saharan Africa. *J Family Planning Reprod Health Care* 2017; 43(1): 50–59. doi:10.1136/jfprhc-2014-100968

2 Khezri M, Tavakoli F, Schwartz S, Karamouzian M, Sharifi H, McKnight CA, Jarlais DD, Baral S, Shokoohi M. Global epidemiology of abortion among female sex workers: a systematic review, meta-analysis, and meta-regression. *Annals Epidemiol* 2023; 85; 13–37. doi:10.1016/j.annepidem.2023.06.022

3 Chanda MM, Ortblad KF, Mwale M, Chongo S, Kanchele C, Kamungoma N, Barresi LG, Harling G, Bärnighausen T, Oldenburg CE. Contraceptive use and unplanned pregnancy among female sex workers in Zambia. *Contraception* 2017; 96(3): 196–202. doi:10.1016/j.contraception.2017.07.003

4 Noah J-PYA, Ndié J, Muluh C, Dongmo RK, Ndongo FA, Tabala FN, De Dieu Anoubissi J, Tedongmo MG, Wepnyu YN, Bonyohe MA, Metambou J, Heuya YN, Akiy ZZ, Ebongue IK, Angumua C, Meka AZ, Keugoung B, Fokam J, Ateudjieu J, Bissek ACZ-K. Prevalence of pregnancy, unintended pregnancy, poor pregnancy outcome and its associated factors among female sex workers in Cameroon. *BMC Public Health* 2025; 25(1): 2564. doi:10.1186/s12889-025-23736-7

5 Hakim AJ, Ogwal M, Doshi RH, Kiyingi H, Sande E, Serwadda D, Musinguzi G, Standish J, Hladik W. At the intersection of sexual and reproductive health and HIV services: use of moderately effective family planning among female sex workers in Kampala, Uganda. *BMC Pregnancy Childbirth* 2022; 22(1): 646. doi:10.1186/s12884-022-04977-5

6 Uganda AIDS Commission. 2024 Uganda HIV and AIDS factsheet. Uganda AIDS Commission; 2024. Available at https://uac.go.ug/index.php?option=com_sppagebuilder&view=page&id=24&Ite

7 Twizelimana D, Muula AS. Unmet contraceptive needs among female sex workers (FSWs) in semi urban Blantyre, Malawi. *Reprod Health* 2021; 18(1): 11. doi:10.1186/s12978-020-01064-w

8 Bowring AL, Schwartz S, Lyons C, Rao A, Olawore O, Njindam IM, Nzau J, Fouda G, Fako GH, Turpin G, Levitt D, Georges S, Tamoufe U, Billong SC, Njoya O, Zoung-Kanyi A-C, Baral S. Unmet need for family planning and experience of unintended pregnancy among female sex workers in urban Cameroon: results from a national cross-sectional study. *Global Health: Sci Practice* 2020; 8(1): 82–99. doi:10.9745/GHSP-D-19-00330

9 Ochako R, Okal J, Kimetu S, Askew I, Temmerman M. Female sex workers experiences of using contraceptive methods: a qualitative study in Kenya. *BMC Women's Health* 2018; 18(1): 105. doi:10.1186/s12905-018-0601-5

10 Joint United Nations Programme on HIV/AIDS (UNAIDS). UNAIDS guidance note on HIV and sex work. Joint United Nations Programme on HIV/AIDS (UNAIDS); 2012, p. 56. Available at https://www.unaids.org/en/resources/documents/2012/20120402_UNAIDS-guidance-note-HIV-sex-work

11 Guttmacher Institute. From unsafe to safe abortion in sub-Saharan Africa: slow but steady progress; 2020. Available at https://www.guttmacher.org/report/from-unsafe-to-safe-abortion-in-subsaharan-africa

12 Donkoh IE, Okyere J, Seidu A-A, Ahinkorah BO, Aboagye RG, Yaya S. Association between knowledge and use of contraceptive among women of reproductive age in sub-Saharan Africa. *Health Sci Rep* 2024; 7(5): e2028. doi:10.1002/hsr2.2028

13 Muldoon KA. A systematic review of the clinical and social epidemiological research among sex workers in Uganda. *BMC Public Health* 2015; 15(1): 1226. doi:10.1186/s12889-015-2553-0

14 Arinaitwe B, Ariho P, Naturinda CH, Byoleko B, Base A, Atwijukiire H, Matavu H, Kabami J, Obua C, Wakida EK, Otwine A. Enrollment and retention of female sex workers in HIV care in health facilities in Mbarara city. *Front Reprod Health* 2023; 4, 1089663. doi:10.3389/frph.2022.1089663

15 World Health Organization. A guide to family planning for community health workers and their clients; 2012, p. 50. Available at https://iris.who.int/handle/10665/44882

16 World Health Organization. Family Planning A Global Handbook for Provider. Department of Reproductive Health and Research; 2018. Available at https://www.who.int/publications/i/item/9780999203705

17 RE-AIM. What is RE-AIM? 2025. Available at: https://re-aim.org/learn/what-is-re-aim/ [Retrieved 1 September 2025]

18 Bukenya JN, Wanyenze RK, Barrett G, Hall J, Makumbi F, Guwatudde D. Contraceptive use, prevalence and predictors of pregnancy planning among female sex workers in Uganda: a cross sectional study. *BMC Pregnancy Childbirth* 2019; 19: 121. doi:10.1186/s12884-019-2260-4

19 Dulli L, Field S, Masaba R, Ndiritu J. Addressing broader reproductive health needs of female sex workers through integrated family planning/HIV prevention services: a non-randomized trial of a health-services intervention designed to improve uptake of family planning services in Kenya. *PLoS ONE* 2019; 14(7): e0219813. doi:10.1371/journal.pone.0219813

20 McGowan M, Roche SD, Nakitende A, Wachinger J, Nanyiri E, Amongin J, Nakabuye A, Musoke DK, McMahon SA, B rnighausen T, Ortblad KF. Understanding how social support influences peer-delivered HIV prevention interventions among Ugandan female sex workers: a case study from HIV self-testing. *BMC Public Health* 2022; 22(1): 427. doi:10.1186/s12889-022-12836-3

21 Krishnamurthy P, Hui SK, Shivkumar N, Gowda C, Pushpalatha R. Assessing the impact of peer educator outreach on the likelihood and acceleration of clinic utilization among sex workers. *PLoS ONE* 2016; 11(7): e0159656. doi:10.1371/journal.pone.0159656

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22 Prahlada G, Dawleshwar CU. Role of peer support networks on the health outcomes of female sex workers: a social work study. *Educat Admin: Theory Pract* 2024; 30(7): 1239–1249. doi:10.53555/kuey.v30i7.9083

23 Lafort Y, Lessitala F, Ismael de Melo MS, Griffin S, Chersich M, Delva W. Impact of a "Diagonal" intervention on uptake of sexual and reproductive health services by female sex workers in mozambique: a mixed-methods implementation study. *Front Public Health* 2018; 6: 109. doi:10.3389/fpubh.2018.00109

24 Lafort Y, Greener R, Roy A, Greener L, Ombidi W, Lessitala F, Haghparast-Bidgoli H, Beksinska M, Gichangi P, Reza-Paul S, Smit JA, Chersich M, Delva W. HIV prevention and care-seeking behaviour among female sex workers in four cities in India, Kenya, Mozambique and South Africa. *Trop Med Internat Health* 2016; 21(10): 1293–1303. doi:10.1111/tmi.12761

25 Beckham SW, Stockton M, Galai N, Davis W, Mwambo J, Likindikoki S, Kerrigan D. Family planning use and correlates among female sex workers in a community empowerment HIV prevention intervention in Iringa, Tanzania: a case for tailored programming. *BMC Public Health* 2021; 21(1): 1377. doi:10.1186/s12889-021-11426-z

26 Ortblad K, Musoke DK, Ngabirano T, Nakitende A, Magoola J, Kayiira P, Taasi G, Barresi LG, Haberer JE, McConnell MA, Oldenburg CE, Bärnighausen T. Direct provision versus facility collection of HIV self-tests among female sex workers in Uganda: a cluster-randomized controlled health systems trial. *PLOS Med* 2017; 14(11): e1002458. doi:10.1371/journal.pmed.1002458

27 Navidi I, Shakibazadeh E, Akbarpour S, Raisi F. Peer-education strategies for enhancing sexual health services among female sex workers: a scoping review. *BMC Women's Health* 2026; 26(1): 40. doi:10.1186/s12905-025-04208-x

Ethics approval. The program described here was a service delivery activity, and the results reported come from routine, de-identified program and clinic records. Ethics approval is not applicable for this research.

Data availability. The data that support these findings are not publicly available. De-identified aggregate data can be obtained from the corresponding author on reasonable request.

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