TECHNICAL REPORT

UNESO

Baseline Assessment on HIV and SRHR Service Needs of Adolescent girls and young women engaged in Sex Work in Uganda

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Executive Summary

This baseline assessment examined the HIV and Sexual and Reproductive Health and Rights (SRHR) service needs of adolescent girls and young women (AGYW) aged 15–24 engaged in sex work in Uganda, a highly vulnerable and underserved population. The study aimed to generate evidence to inform targeted programming, strengthen service delivery models, and guide advocacy for equitable resource allocation. A mixed-methods approach was used, including a desk review, secondary analysis of national key population data, and interviews with AGYW and key stakeholders across seven districts representing diverse regional contexts

Findings reveal that AGYW constitute a substantial proportion of Uganda's sex work population, particularly in regions such as Ankole and Bunyoro. Most are single, socially and economically vulnerable, and often enter sex work due to poverty, orphanhood, school dropout, early pregnancy, and violence or instability within the household. Peer networks play a major role in introducing AGYW into sex work, with many relying on peers for emotional and material support

Although HIV positivity is lower in younger sex workers compared to older age groups, the prevalence of HPV is notably high, indicating elevated vulnerability and limited access to vaccination, screening, and preventive services. Uptake of HIV Testing Services is relatively strong; however, significant linkage gaps persist, with 43% of viremic AGYW unaware of their status and 16% aware but not receiving treatment. Only a small proportion access STI screening, treatment, and comprehensive family planning beyond condom use, and few receive education or support related to sexual and gender-based violence. These gaps are driven by limited youth-friendly service environments, weak service integration, stigma and discrimination, high mobility among AGYW, and fragmented coordination among providers

The findings indicate an urgent need to: (1) strengthen HIV case-finding and linkage to ART through peer-led and community-based outreach models, (2) expand integrated HIV/SRHR services that are confidential, flexible, and youth-friendly, (3) improve STI and HPV screening and treatment access, (4) broaden access to diverse contraceptive options, and (5) address structural drivers through targeted social protection, livelihood initiatives, education retention, and GBV prevention and response frameworks

In conclusion, AGYW engaged in sex work face layered risks and service access barriers that demand a coordinated, youth-responsive, and rights-based approach. Strengthening health systems, community support structures, and socio-economic empowerment pathways is essential to improving health outcomes and reducing vulnerability among this population.

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Abbreviations/Acronyms

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
AIC	AIDS Information Centre
AWAC	Allied Women Advocates for Change
CSO	Civil Society Organization
FP	Family Planning
FSW	Female Sex Worker
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HRAPF	Human Rights Awareness and Promotion Forum
HTS	HIV Testing Services
MARPI	Most At Risk Populations Initiative
MoH	Ministry of Health
NGO	Non-Governmental Organization
PAC	Post-Abortion Care
PEP	Post-Exposure Prophylaxis
PNFP	Private Not-for-Profit
PrEP	Pre-Exposure Prophylaxis
RAHU	Reach a Hand Uganda
RHU	Reproductive Health Uganda
SBVG	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TASO	The AIDS Support Organization
UBOS	Uganda Bureau of Statistics
UNESO	Uganda Network of Sex Worker-led Organizations
UHRN	Uganda Harm Reduction Network
UYAFPAH	Uganda Youth and Adolescents Health Forum
VMMC	Voluntary Medical Male Circumcision
WONETHA	Women's Organization Network for Human Rights Advocacy

1. Introduction

Adolescents and young people in Uganda face significant challenges in accessing comprehensive sexual and reproductive health (SRH) and HIV services. These challenges are particularly acute for adolescent and young girls engaged in sex work, one of the most marginalized and underserved groups in national health efforts. Their heightened vulnerability arises from the intersection of age, gender, poverty, social exclusion, and the criminalization of sex work, all of which limit their access to essential health services and protection mechanisms. Reproductive health outcomes and HIV prevalence among adolescent and young sex workers remain alarmingly high. Many face overlapping risks, including unintended pregnancies, unsafe abortions, sexually transmitted infections (STIs), and maternal health complications. Widespread physical and sexual violence, often unreported, further compounds their vulnerability. Family planning needs remain largely unmet, while access to safe, confidential, and adolescent-friendly services is frequently undermined by stigma, provider bias, and restrictive legal frameworks.

Recent national data underscore the urgency of addressing these gaps. Adolescent girls and young women (AGYW) aged 15–24 account for a disproportionate share of new HIV infections, with a prevalence of 4.2% and contributing to more than two-thirds of new HIV cases in Uganda. Among sex workers, HIV prevalence is estimated at 31.3%, likely even higher among adolescents, though age-specific data are limited. This lack of disaggregated evidence obscures the distinct needs of adolescent sex workers and hampers the development of targeted, youth-responsive interventions. Despite longstanding national and global commitments to advancing the SRHR and HIV agenda for key populations, adolescent sex workers continue to be left behind due to stigma, criminalization, and inadequate access to appropriate services and information.

To address this gap, a baseline assessment of the HIV and SRHR service needs of adolescent and young sex workers was undertaken to generate age- and context-specific evidence. The findings are intended to inform rights-based, youth-responsive interventions and guide equitable resource allocation. This assessment aims to provide the foundation for inclusive, evidence-based policies and programs that protect their health, safeguard rights of adolescent and young sex workers, and ensure that no one is left behind.

1.1. Objective of the assessment

The general objective of the baseline assessment was to generate evidence on the HIV and SRHR service needs of adolescent girls and young women (15–24 years) engaged in sex work in Uganda, in order to inform advocacy efforts and guide the development of targeted, evidence-based programs that enhance their access to and utilization of essential services

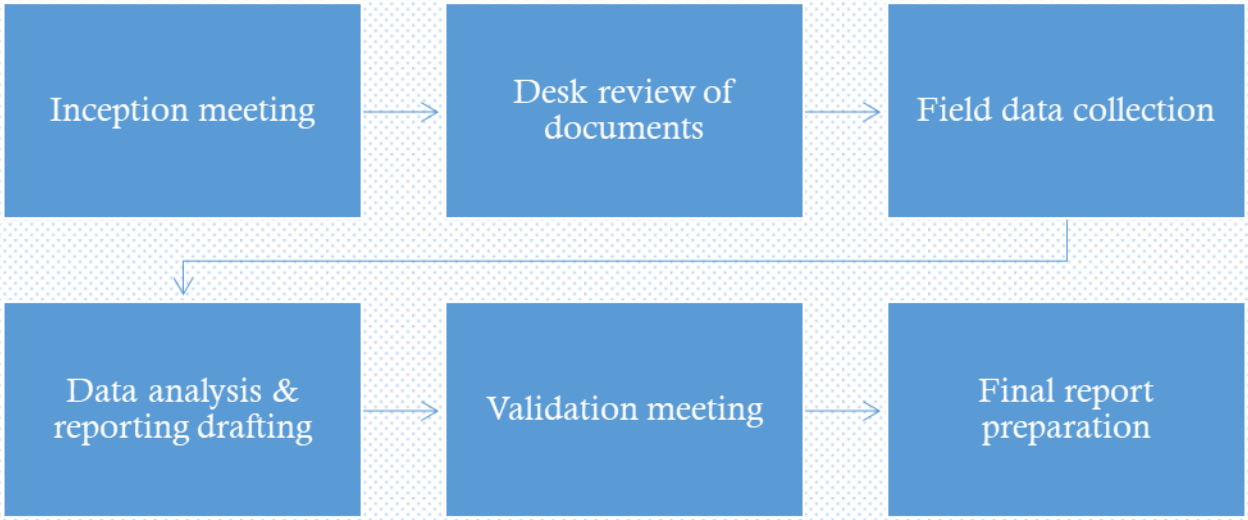
Specifically, the assessment sought to:

1) Evaluate the existing HIV and SRHR services and identify existing gaps in service provision for AGYW sex workers in Uganda.
2) To identify and document the existing landscape of services and relevant stakeholders currently providing HIV and SRHR services to young and adolescent sex workers in Uganda
3) Investigate the underlying root causes and key drivers contributing to young girls joining sex work in Uganda.
4) Identify the key barriers and facilitators that influence the access to and utilization of HIV and SRHR services by young and adolescent sex workers.
5) Generate actionable, and evidence-based recommendations for improving the accessibility, quality, and responsiveness of HIV and SRHR services tailored to the specific needs of young and adolescent sex workers.

2. Methodology

The baseline assessment employed a mixed-methods approach combining a structured desk review, secondary data analysis, and primary data collection through interviews. The desk review examined existing evidence on HIV and SRHR service needs among adolescent and young sex workers in Uganda, as well as the barriers limiting access to targeted interventions. Relevant documents were systematically identified and analyzed to provide comprehensive and context-specific insights. In parallel, a secondary analysis of national key population data was conducted to identify gaps in service uptake and coverage, forming a robust evidence base to inform recommendations [1]. To enrich these findings, key informant interviews with stakeholders and structured interviews with AGYW in sex work were undertaken, offering practical insights into implementation experiences, context-specific challenges, and successful strategies. These perspectives enhanced the interpretation of evidence and guided the development of targeted, evidence-based recommendations for AGYW sex workers

Figure 1: Summary of the methodological approach



2.1. Study setting

Data collection was conducted at both national and sub-national levels, targeting key stakeholders (state and non-state actors), adolescent and young sex workers, and their group leaders. The assessment focused on seven districts strategically selected to represent diverse regional contexts: Kampala, Wakiso, Mbale, Gulu, Arua, Mbarara, and Kasese.

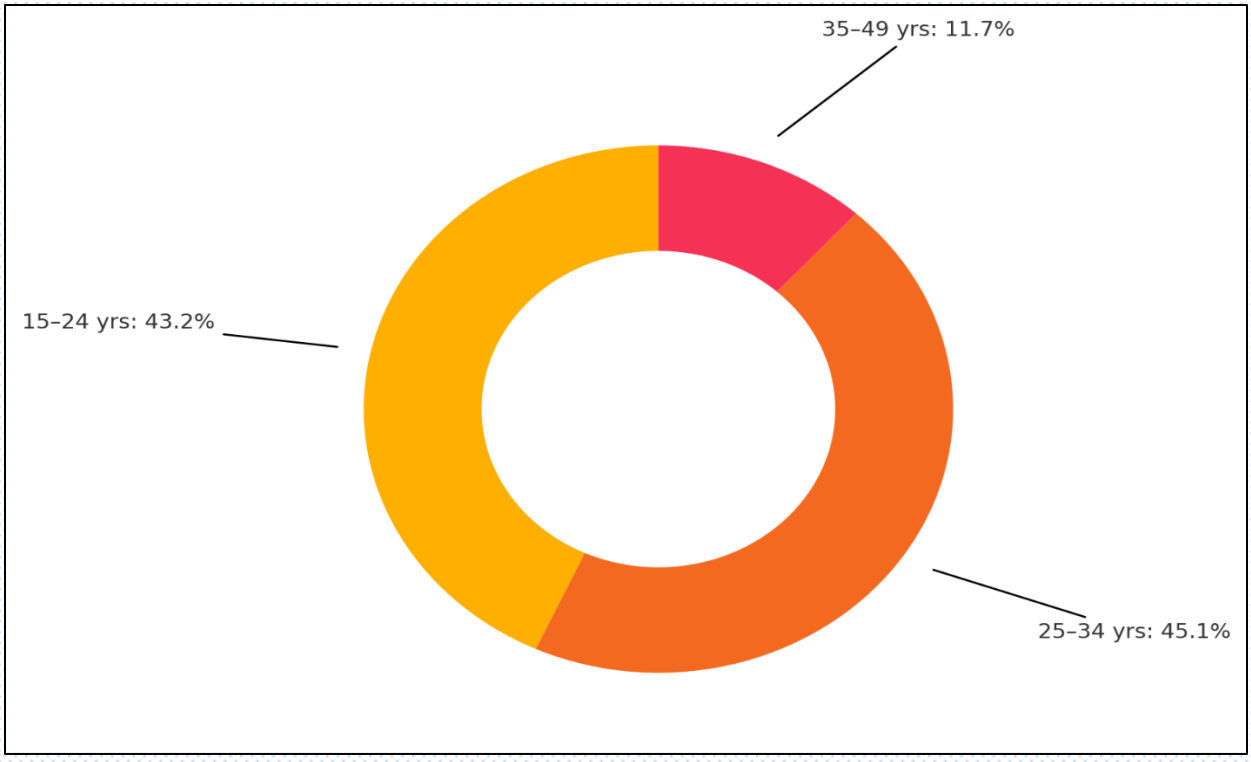
[1] METS (2024). HIV prevention combination tracker https//prev.mets.or.ug

3. Findings

3.1. Demographic profile of AGYW engaged in sex work

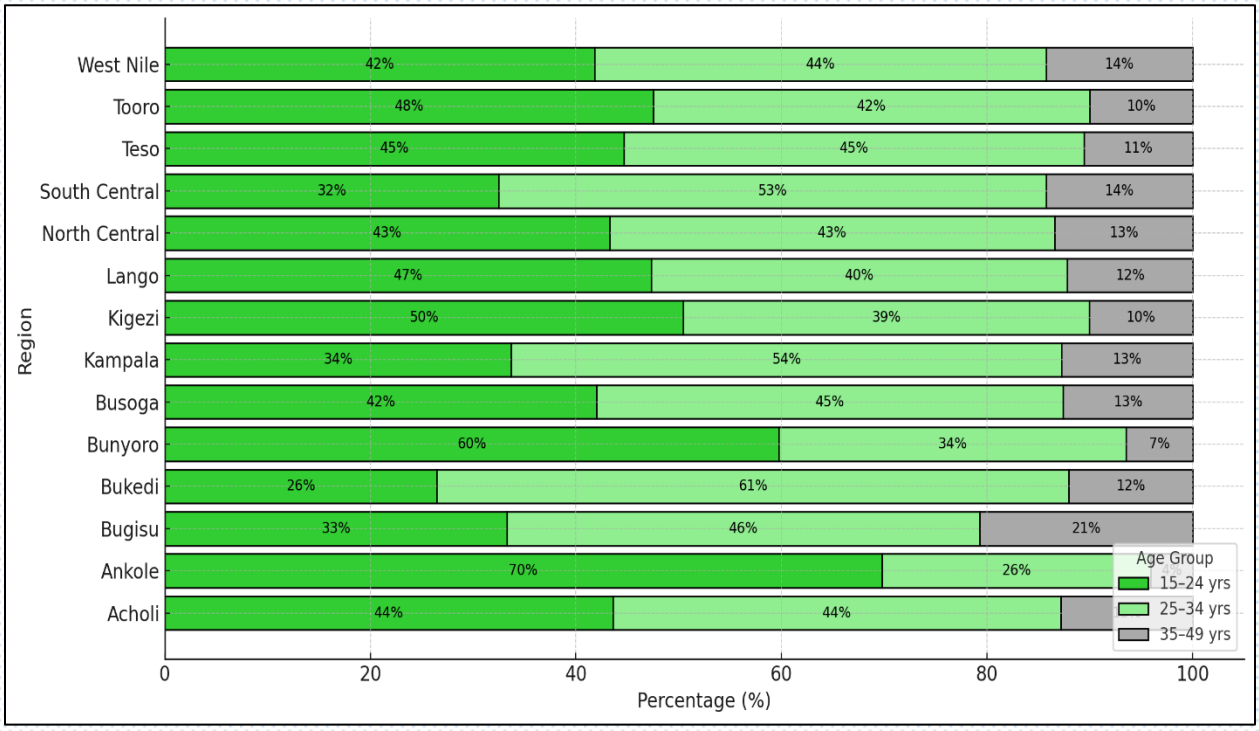
(Figure 1). This underscores the urgent need for targeted, youth-friendly SRH/HIV and harm reduction services to address their heightened vulnerabilities. Figure 2 presents a more detailed age distribution of sex workers, comparing 15–24-year-olds with those aged 25 years and above across regions. More analysis shows notable geographical variations in the proportion 15–24-year-old sex workers with the highest proportions observed in Ankole (70%), Bunyoro (60%), Kigezi (50%), Tooro (48%), and Lango (47%). Moderate representation is seen in regions like Teso, Acholi, North Central, and Busoga (42–45%), while the lowest proportions are recorded in Bukedi (26%), South Central (32%), Bugisu (33%), and Kampala (34%). These disparities highlight the need for region-specific, youth-focused interventions, particularly in high-prevalence areas like Ankole and Bunyoro.

Figure 2: Age distribution of female sex workers in Uganda



Source: METS (2024). HIV prevention combination tracker https//prev.mets.or.ug

Figure 3: Age distribution FSW by region

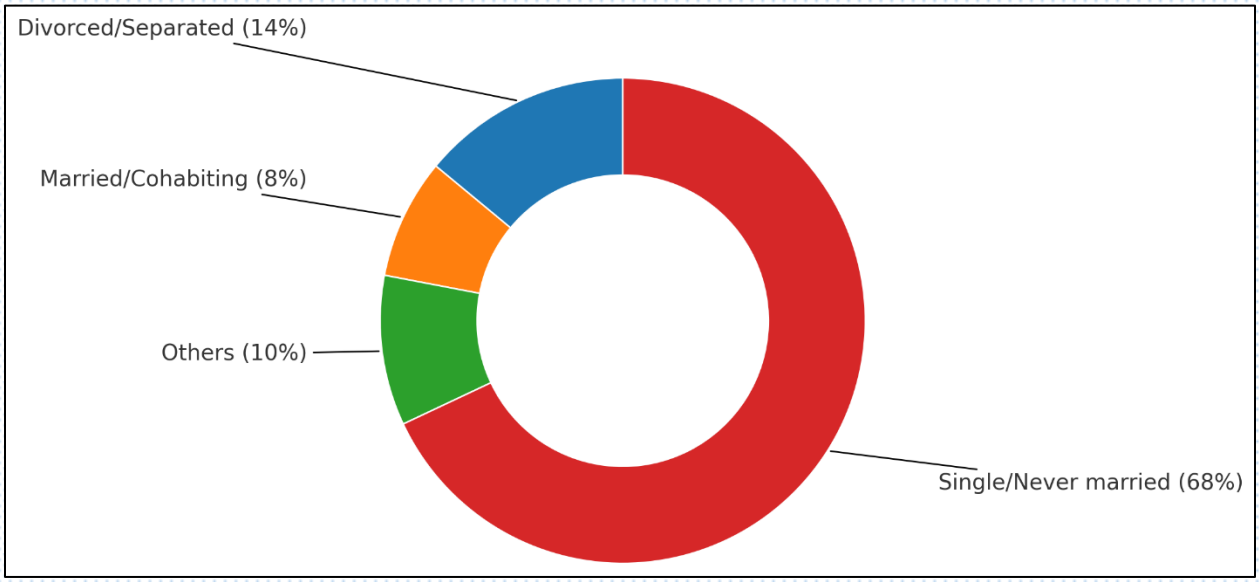


Source: METS (2024). HIV prevention combination tracker https//prev.mets.or.ug

3.1.1 Marital/living arrangements by AGYW engaged in sex work

Figure 3 illustrates that the overwhelming majority of AGYW sex workers are single/never married (68%), highlighting how entry into sex work largely occurs before or outside of formal unions. A smaller proportion are divorced or separated (14%), suggesting that relationship breakdowns may push some young women into sex work as a coping mechanism for economic survival. Those in the "others" category (10%) reflect non-traditional or unclassified living arrangements such as casual or transactional partnerships, further emphasizing instability in intimate relationships. Only 8% are married or cohabiting, showing that very few AGYW enter or remain in sex work while in stable unions. Overall, the distribution underscores how lack of marital stability and formal family support structures may increase vulnerability to sex work, with single and socially disconnected young women being most at risk.

Figure 4: Marital status distribution of AGWY sex workers in Uganda



3.2. The burden of HIV and poor RH outcomes

3.2.1. HIV positivity among AGYW engaged in sex work

HIV positivity rates among sex workers aged 15–24 years are consistently lower across all regions compared to those aged 25 and above, reflecting shorter cumulative exposure to HIV risk. For instance, in Bunyoro, the positivity rate is 2.4% among younger sex workers versus 3.3% among their older counterparts, while in Bugisu it is 0.4% compared to 0.7%. The differences are supported by narrow and distinct 95% confidence intervals. These findings highlight a critical opportunity for targeted HIV prevention among younger sex workers through youth-responsive interventions, including PrEP, condom use and behavior change communication, to sustain low infection rates and prevent future transmissions.

Table 1: HIV positivity among sex workers by region

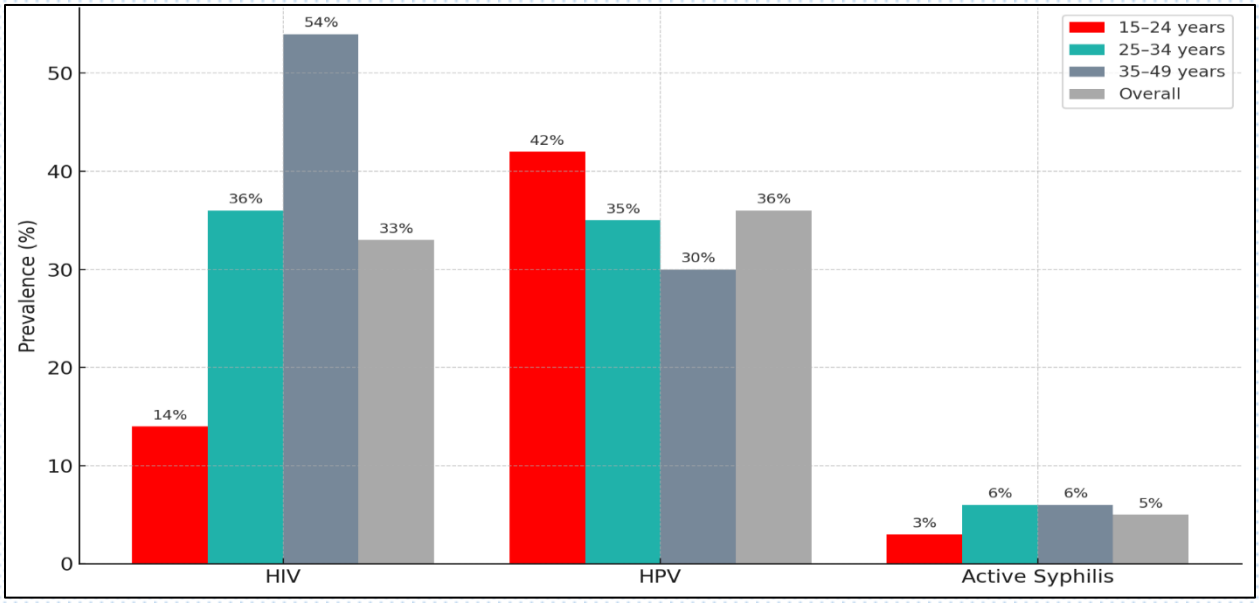
Region	HIV positivity rate among FSW (95% CI)	
	15-24 years	25+ years
Acholi	0.9 (0.7-1.4)	0.9 (0.7-1.3)
Ankole	1.2 (1.0-1.4)	2.0 (1.7-2.4)
Bugisu	0.4 (0.2-0.8)	0.7 (0.5-1.0)
Bukedi	0.9 (0.6-1.2)	1.0 (0.8-1.2)
Bunyoro	2.4 (2.1-2.7)	3.3 (2.9-3.8)
Busoga	0.3 (0.2-0.5)	0.6 (0.4-0.7)
Kampala	0.7 (0.6-0.9)	1.0 (0.9-1.1)
Kigezi	1.2 (0.9-1.6)	1.5 (1.2-2.0)
Lango	1.5 (1.2-1.9)	3.4 (2.9-3.9)
North Central	1.3 (1.1-1.4)	2.3 (2.1-2.5)
South Central	2.1 (1.8-2.3)	2.0 (1.8-2.2)
Teso	0.4 (0.2-0.8)	1.1 (0.8-1.7)
Tooro	0.5 (0.4-0.7)	0.8 (0.6-0.9)
West Nile	0.4 (0.3-0.6)	0.5 (0.4-0.7)

Source: METS (2024). HIV prevention combination tracker https//prev.mets.or.ug

3.2.2. Prevalence of HIV, HPV and active syphilis among female sex workers

The prevalence of HPV is alarmingly high at 42% in female sex workers (FSWs) aged 15–24 years, surpassing that of older age groups, despite lower rates of HIV (14%) and active syphilis (3%) compared to FSWs aged 25–34 years (36% HIV) and 35–49 years (54% HIV). This pattern highlights a significant burden of HPV among younger FSWs and points to an urgent need for age-specific prevention and early intervention strategies. The elevated HPV prevalence may be driven by both biological and behavioral vulnerabilities. Younger women are biologically more susceptible due to cervical immaturity and increased cervical ectopy, which heighten their risk of acquiring HPV. Behaviorally, early initiation into sex work, inconsistent condom use (reported at 29%), and limited access to screening services (only 22% screened for STIs) increase exposure. Furthermore, low HPV vaccination coverage and limited negotiating power expose this group to coercive and unprotected sex.

Figure 5: Prevalence of HIV, HPV and Active Syphilis among sex workers by age groups



Summary of SRH/HIV service gaps and needs for AGYW engaged in sex work

- A substantial share of female sex workers (43%) are adolescents and young women, underscoring the need for tailored SRH/HIV services that address their unique vulnerabilities.
- AGYW in sex work (15–24 years) have lower HIV positivity rates than older peers, pointing to the need for early, targeted SRH/HIV prevention and testing services before cumulative risk increases
- AGYW in sex work face an elevated HPV burden due to biological susceptibility and behavioral vulnerabilities, underscoring the need for targeted and scaled up HPV prevention, vaccination, and screening services.
- Many AGYW sex workers decline HIV testing services due to stigma, fear, and low risk perception, reflecting the need for youth-friendly, stigma-free SRH/HIV services
- A critical treatment gap of 5% remains, highlighting persistent challenges in achieving universal ART coverage among adolescent and young sex workers
- There are significant linkage gaps among viremic AGYW engaged in sex work: 43% are unaware of their HIV status, highlighting major deficiencies in HIV testing and case identification, while 16% know their status but are not on treatment.
- A small proportion of AGYW engaged in sex work undergo STI screening, and among those screened, very few receive treatment, indicating limited access to services and weak follow-up mechanisms.

3.3. Existing HIV and SRHR services targeting AGYW engaged in sex work

3.3.1. The core package of interventions for AGYW including sex workers

Through stakeholder consultations and a review of relevant documents specific HIV prevention packages for AGYW including sex workers were identified. These interventions are categorized into biomedical, behavioral, and structural approaches, delivered across both health facility and community settings. Implementation is guided by a multi-sectoral approach, with support from development partners, implementing agencies, civil society organizations (CSOs), and private sector actors, under the stewardship of the Government of Uganda. AGYW, including those engaged in sex work, are identified and prioritized for targeted HIV prevention interventions, as outlined in Table 2.

Table 2: The current AGYW service package provided in Uganda

Intervention	Package offered	Intended impact/outcomes
Biomedical interventions	○ HIV testing services ○ Condom promotion, demand creation, provision ○ Pre-exposure prophylaxis (PrEP) ○ Linkage to post violence care, including PEP ○ STI screening and testing ○ Provided with selected SRH Services including family planning ○ Provision of sterile needles & syringes ○ Linkage to medication-assisted therapy	**Impact** Reduction in HIV new infections among AGYW **Primary outcomes** ○ Consistent and correct condom use during high-risk sex ○ Consistent use of PrEP ○ Use of PEP when needed ○ Reduced prevalence of STI ○ Increased VMMC prevalence
Behavioral interventions	○ Risk assessment and reduction counseling ○ Prevention communication, information, and demand creation ○ Provided with comprehensive sexuality education	**Contributing outcomes** ○ Improved knowledge about HIV, risk behaviors & prevention options ○ Reduction in HIV risk behavior (less transactional sex)
Structural interventions	○ Community empowerment ○ Prevention and care for violence ○ Interventions addressing stigma & discrimination	○ Reduction in structural risk factors (e.g., stigma & discrimination) ○ Secondary school completion

Intervention	Package offered	Intended impact/outcomes
	○ Education subsidy ○ Financial literacy and skilling ○ Economic strengthening	○ AGYW with sufficient financial resources ○ Reduction in GBV prevalence among AGYW

3.3.2. The existing SRH/HIV services and providers targeting AGYW in sex work

A wide range of public, private not-for-profit health facilities, and community-based organizations deliver comprehensive HIV and SRHR services tailored to the needs of adolescent girls and young women (AGYW) engaged in sex work. HIV prevention interventions, including facility-based and outreach HIV testing services, PrEP, PEP, and peer-led self-testing are provided by public health facilities, alongside implementing partners such as MARPI, AIC, TASO, AWAC, and RAHU. These services are often integrated with SRHR interventions such as contraception, post-abortion care, and emergency contraception, STI screening and management delivered through both static health facilities and Drop-in Centres, as well as outreach efforts by providers including Marie Stopes, RHU, and UYAFPAH. In addition, AGYW benefit from complementary services such as mental health care, GBV response, and legal protection offered by partners like AWAC, Butabika Hospital, UNESO, HRAPF, and MIFUMI, ensuring access to holistic, rights-based care across multiple service delivery points.

Table 3: SRH/HIV services by providers

Service Area	Organization	Services/Intervention
1. HIV services (HTS, ART, PrEP, PEP)	Public & PNFP health facilities	Facility-based & outreach HTS, PrEP, PEP and ART
	MARPI	Facility and outreach HTS for key populations
	AIC	Youth-friendly HTS, peer counseling
	TASO	Integrated community/youth HTS
	CQUIN & AWAC	Drop-in-centers offering PrEP, PEP, emergency contraception, testing, linkage
	WOPEIN	Operates DIC that offers free HTS
	FEYODI	Community mobilization and referral for PEP
	Empowered at Dusk	HIV/AIDS services and rights advocacy
	Peer-Educator HIV Self-Testing Programs	Peer distribution of HIV self-test kits

Service Area	Organization	Services/Intervention
	Kaseses Women Health Support Initiative	HTS and community follow-up of lost clients for HIV care and treatment
	ACIHEWE (Action for Improved Health and Wealth) Mbarara	○ Distribution of self-test kits distribution ○ Condom promotion and distribution ○ PreP education and referrals ○ GBV Screening and management ○ Skilling
	Reach a Hand, Uganda (RAHU)	Community HTS during youth outreach in urban setting
2. Family Planning	RHU	Contraception, PAC, facility & outreach services
	Marie Stopes	Contraception, PAC, clinic and outreach
	UYAFPAH	Distribution of FP commodities
	SLUM (CDC funded)	○ Operates a DIC that provides health education, FP commodities such as condoms ○ Has a toll-free helpline
	VOICE –Gulu	Community mobilization and referral for family planning and other SRHR services
	MWAPA Mbale	Condoms promotion and distribution, and referrals for others SRHR services
	WOPEIN	Condom promotion and distribution at DIC for AGYW engaged in SW
	ACIHEWE	Offers family planning (Sayana press)
3. STI Management	AIC	STI screening and treatment
	Public & PNFP facilities	STI testing and treatment
	WOPEIN	Operates DIC for STI diagnosis and treatment
	SLUM (CDC funded)	Operate a clinic every Wednesday and Friday that provides STIs screening and treatment and cervical cancer screening
	Marie Stopes	STI treatment at clinics
	AWAC	Linkage to STI services
	Community harm reduction container	On-site STI screening/support in high-risk areas
Post Abortion Care (PAC)	WOPEIN	Operates DIC where referral for PAC is done
	AWAC	Referral for PAC
	WWM	Referral for post abortion care services

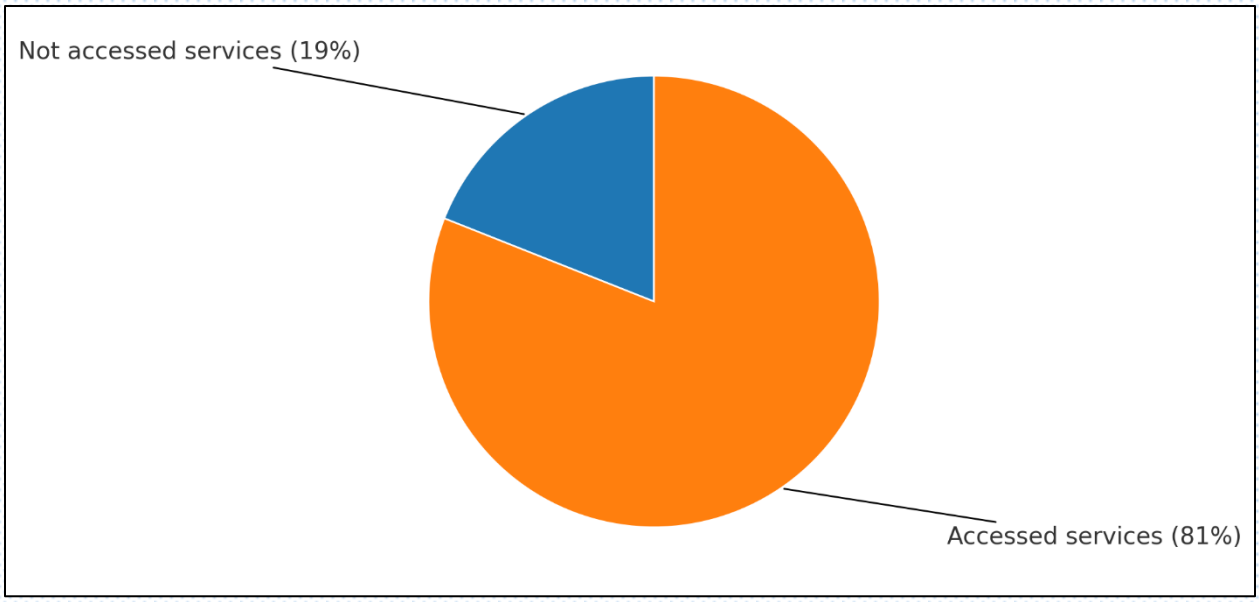
Service Area	Organization	Services/Intervention
4. Human Rights & Legal Aid	UNESO	Legal rights education, referrals, advocacy
	AWAC	Empowerment, legal referrals, law enforcement engagement
	WONETHA	Documentation & legal support on violations
	WWM	Direct case handling (Mbale)
	Action Aid	Human rights training
	HRAPF	Legal aid, advocacy, legal reform research
5. Mental Health Services	Butabika Hospital	Specialized rehab plans
	Mental Health Uganda	Support for individuals and caregivers
	OGERA	Mental Health Wellness Centre
	Lady Mermaid (LMEC)	Operates a mental wellness Centre for SWs
	UHRN	One-stop Drop-in Centre for mental health
	Golden Centre for Women's Rights (GCWR)	○ Mental health services ○ Run a crisis help line for SWs
	AWAC	Mental Health Wellness Centre
6. GBV Response	Spotlight/UNFPA	SGBV prevention and response
	ACIHEWE	GBV Screening and management
	RHU	Community empowerment for GBV reporting
	MIFUMI	Grassroots GBV survivor support
7. Economic empowerment	WOPEIN	○ Supports Community Saving Group for AGYW in sex work (Basoka Kwavula) ○ Offers financial literacy
	OGERA	○ Support economic empowerment through establishment of internal saving and lending groups
	Lady Mermaid (LMEC)	○ Has a registered SACCO for SWs ○ Has a vocational Centre for SWs
	HOPE Mbale	○ Skills training
	Alliance for Youth and Children Ibanda	○ Skilling of AGYW including those engaged in sex work

3.3.3. Uptake of SRH/HIV Services among sex workers (15-24 years)

A survey of AGYW engaged in sex work shows that 8 in 10 accessed at least one HIV, SRHR, or legal service in the past 12 months. This reflects encouraging levels of service uptake and some responsiveness of the health system to their needs. Nonetheless, 19%

did not access any such services, highlighting persistent gaps in coverage and barriers to utilization. These barriers may include stigma, discrimination, fear of disclosure, limited awareness, and lack of youth-friendly service delivery. While the high level of engagement is promising, targeted interventions remain essential to reach the nearly one in five AGYW who are excluded, ensuring equitable access to critical health and legal services.

Figure 6: Proportion of AGYW engaged in sex who accessed SRH/HIV services in the past 12 months



a) HIV testing services among AGYW engaged in sex work

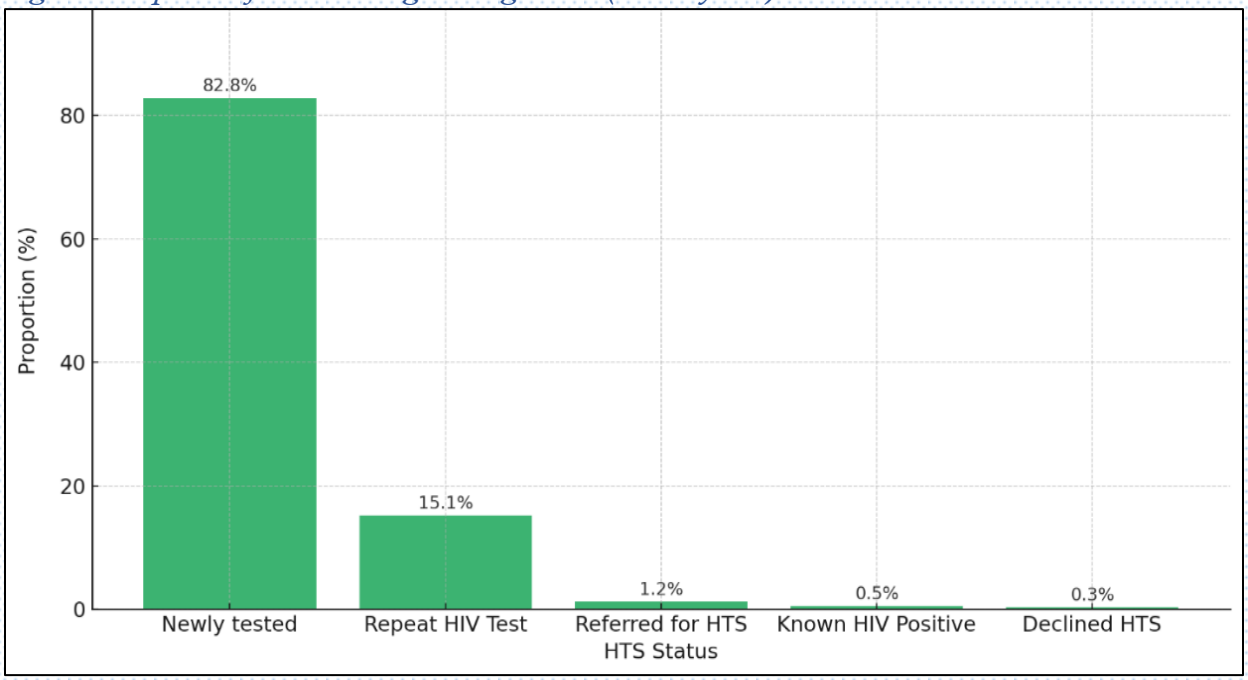
More detailed analysis of nationwide 2024 health facility data shows that 82% of female sex workers aged 15–20 years who accessed HIV Testing Services (HTS) were newly tested, while 15.1% received a repeat test, indicating high uptake among both first-time and returning clients. Only 0.3% declined testing despite the opportunity. While these findings reflect strong overall acceptance of HTS in this age group, the small proportion that declined services suggests potential barriers such as stigma, fear, or low risk perception. Addressing these challenges through targeted counseling and youth-friendly approaches is essential to close the remaining gap in service uptake.

b) Uptake of ART services among AGYW engaged in sex work

Although 95% of female sex workers aged 15–24 years who tested HIV positive are initiated on antiretroviral therapy (ART), a critical treatment gap of 5% remains. This gap is equally observed among those aged 25 years and above, highlighting persistent challenges in achieving universal ART coverage among sex workers. Early initiation of ART among young sex workers is vital for improving individual health outcomes

and reducing the risk of HIV transmission to their sexual partners. It also supports mental well-being through timely access to counseling and helps prevent drug resistance by suppressing viral replication. As a high-risk group, early ART initiation among young sex workers contributes significantly to achieving public health goals, including the UNAIDS 95-95-95 targets. The missed opportunity for timely initiation may be attributed to factors such as fear of stigma, lack of psychosocial support, or structural barriers within health facilities. Closing this gap requires intensified follow-up, enhanced linkage to care mechanisms, and tailored interventions that address the unique needs and vulnerabilities of sex workers.

Figure 7: Uptake of HIV testing among FSW (15-24 years)

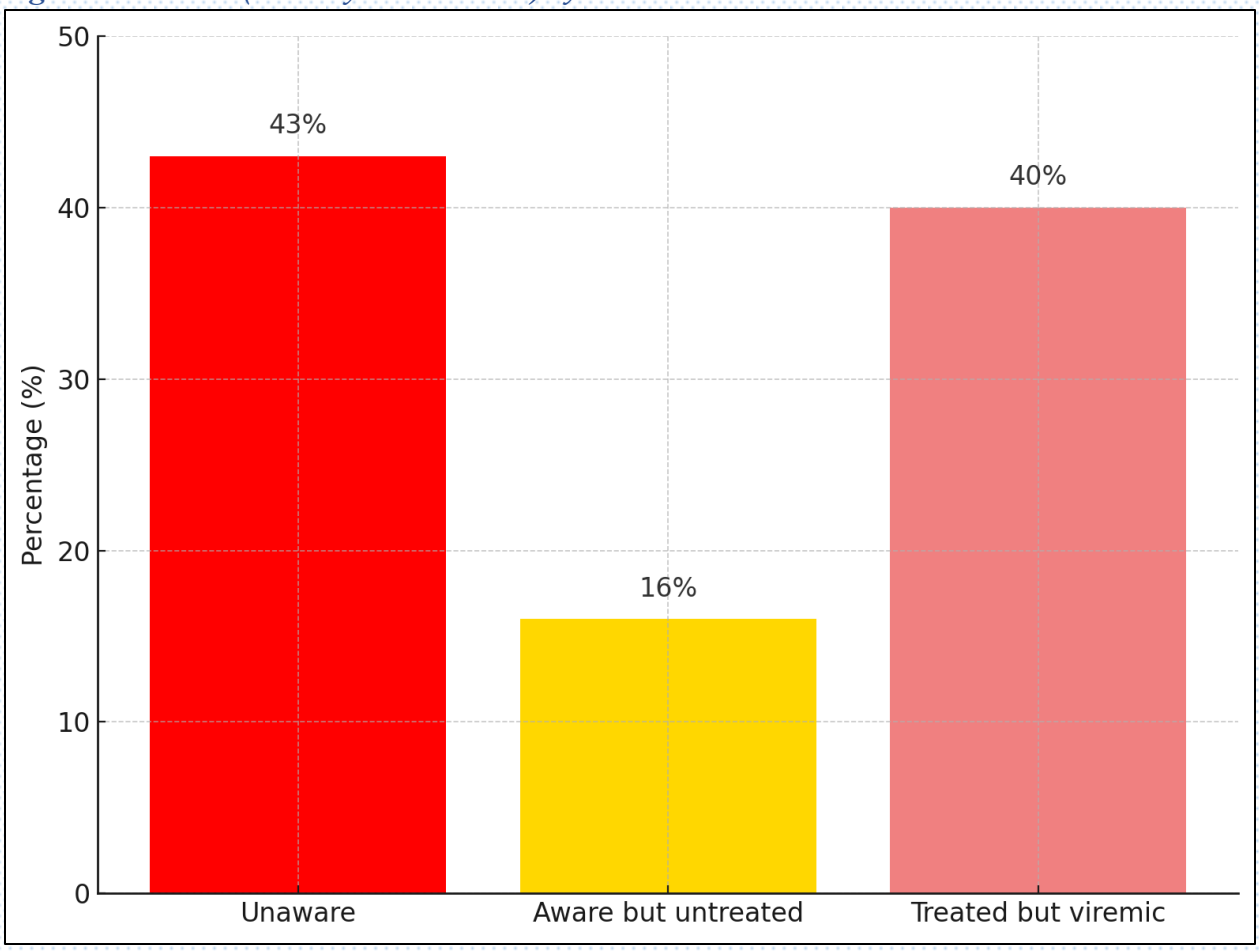


c) Linkage gaps among viremic AGYW engaged in sex work

Figure 7 illustrates significant linkage gaps among viremic AGYW engaged in sex work. *Viremic* refers to individuals living with HIV who have detectable levels of the virus in their blood, indicating they are not virally suppressed and remain at risk of transmitting the virus. Notably, 43% of AGYW engaged in sex work are unaware of their HIV status, underscoring major shortcomings in HIV testing and case identification. More so 16% are aware of their status but are not on treatment, reflecting weak linkage-to-care systems and barriers to ART initiation, such as stigma or lack of youth-friendly services. Furthermore, 40% are on treatment but remain viremic, suggesting poor adherence, delayed viral suppression, or treatment failure. Collectively, these figures highlight critical gaps in the HIV prevention and care

continuum, from diagnosis to effective viral suppression, which requires strengthened case finding, linkage, and retention strategies tailored to this vulnerable group.

Figure 8: Viremic (15–24-year-old FSW) by awareness and treatment status



d) Gaps in coverage of SRHR among AGYW engaged in sex work

The analysis of nation-wide health facility data reveals significant gaps in the continuum of HIV and sexual and reproductive health (SRH) services among adolescent girls and young women engaged in sex work. While 95% of those who test HIV positive are initiated on ART indicating strong linkage to HIV treatment, uptake of other essential SRH services remains low. Only 22% are screened for sexually transmitted infections (STIs), and just 21% of those screened receive treatment, suggesting limited access or weak follow-up mechanisms. Family planning uptake is also suboptimal, with only 31% using any method and 29% reporting condom use, despite high exposure to HIV and unintended pregnancy risks. Furthermore, just 19% are reached with sexual and gender-based violence (SGBV) education, underscoring missed opportunities for empowerment and protection. These gaps highlight the need

for more integrated, accessible, and youth-responsive services to improve health outcomes among this vulnerable population.

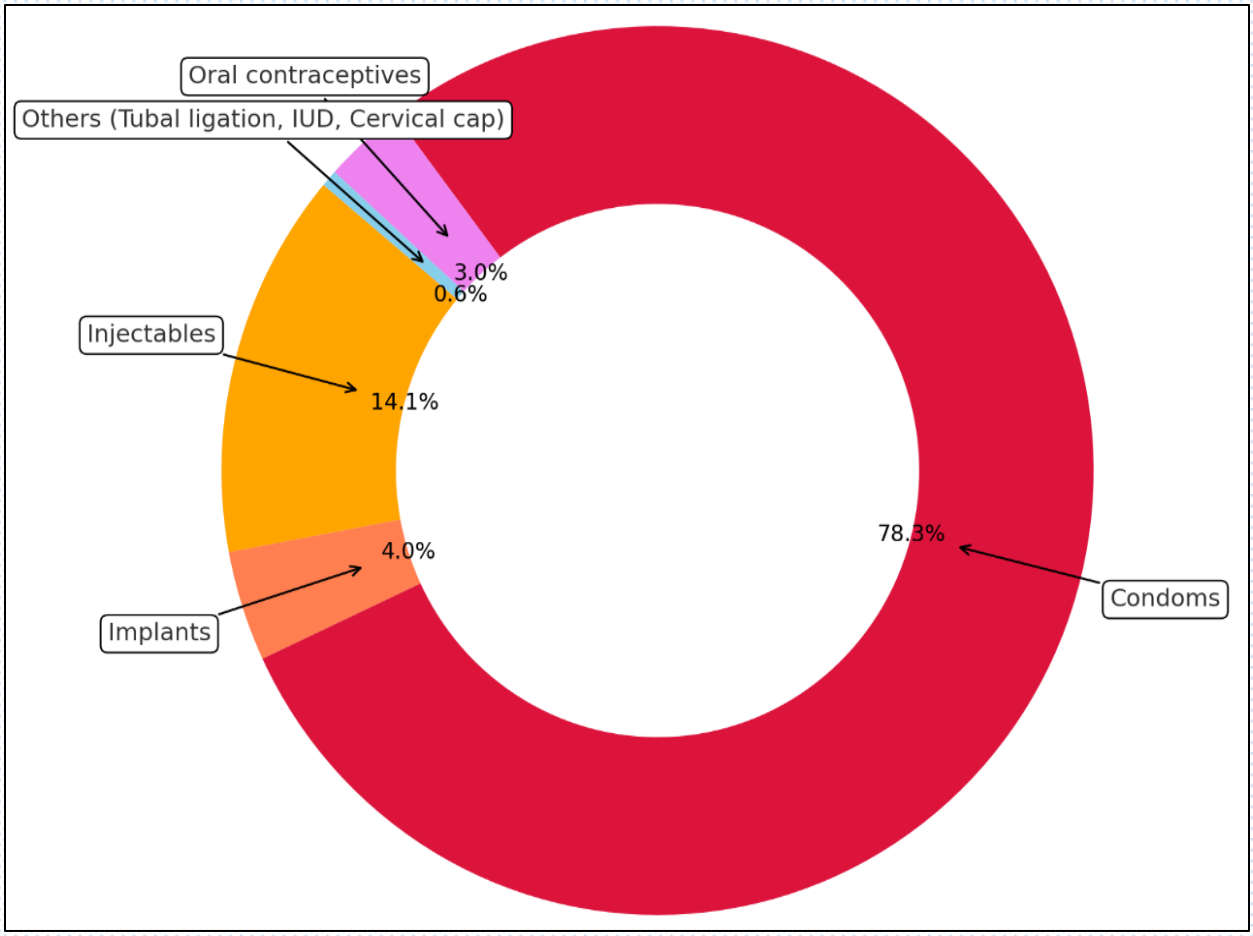
Table 4: Service coverage/uptake by female sex workers (15-24 years)

Indicator	Percentage (%)
1) FSWs (15–24 years) who tested HIV positive and were initiated on ART	95%
2) FSWs (15–24 years) screened for STIs	22%
3) FSWs (15–24 years) screened for STIs who received treatment	21%
4) FSWs (15–24 years) using any family planning method	31%
5) FSWs (15–24 years) using condoms	29%
6) FSWs (15–24 years) reached with SGBV education	19%

e) Uptake of family planning method mix by female sex workers (15-24 years)

Figure 5 shows that among female sex workers aged 15–24 years, uptake of family planning (FP) methods is dominated by condoms, which account for 78% of the reported method mix. However, this does not necessarily translate to consistent condom use, as only 29% of this group reported actual use. The high preference for condoms may be attributed to their accessibility and dual protection benefits against both HIV and unintended pregnancy. Injectables (14%) and implants (4%) are the most commonly used non-barrier modern methods, indicating a moderate uptake of hormonal and long-acting options. Oral contraceptives account for 3% of use, while less than 1% rely on methods such as intrauterine devices, cervical caps, and sterilization, grouped under "Others." This trend reflects a dominance of short-term, user-controlled methods and underscores the need to increase access to and demand for long-acting reversible contraceptives (LARCs) to enhance contraceptive choice and support more sustained protection for this high-risk population.

Figure 9: Family planning method mix by female sex workers (15-24 years)



3.4. Summary of gaps in coverage and uptake of SRH/HIV services

Service area	Coverage/uptake gaps (among 15–24-year-old sex workers)
HIV Testing Services (HTS)	○ Although uptake is high (97.1%), 0.3% decline HIV testing, indicating persistent barriers: stigma, fear of results, and low risk perception deter testing ○ A high proportion of viremic AGYW sex workers (43%) are unaware of their status ○ Limited targeted counseling and youth-friendly services
ART Initiation	○ 5% gap in ART initiation among HIV-positive AGYW engaged in sex work due to fear of stigma, lack of psychosocial support, and structural barriers in care systems ○ 16% viremic AGYW sex workers are aware of their status but untreated, which is the highest among all age groups, suggesting major testing and linkage gaps among young people. ○ Inadequate follow-up and weak linkage-to-care mechanisms post-HIV diagnosis
STI Services	○ Only 2 in 10 AGYW engaged in sex work are screened for STIs despite being engaged in high-risk sexual behavior ○ Of those screened, only 21% receive treatment, pointing to weak follow-up or service linkages.
Family Planning	○ A small proportion of AGYW (31%) use any family planning method ○ Despite high condom preference in the method mix (78%), actual reported use is low at 29%, indicating inconsistency. ○ Low uptake of LARCs (implants 4%, injectables 14%)
SGBV Education	○ A small proportion (19%) is reached with SGBV prevention education, reflecting limited empowerment and protection outreach.
Cross-Cutting	○ Low integration of HIV and SRHR services, reducing convenience and continuity of care. ○ Services often lack adolescent-friendly design and do not sufficiently address the specific needs of young sex workers ○ Limited health literacy and awareness on broader SRHR and GBV services.

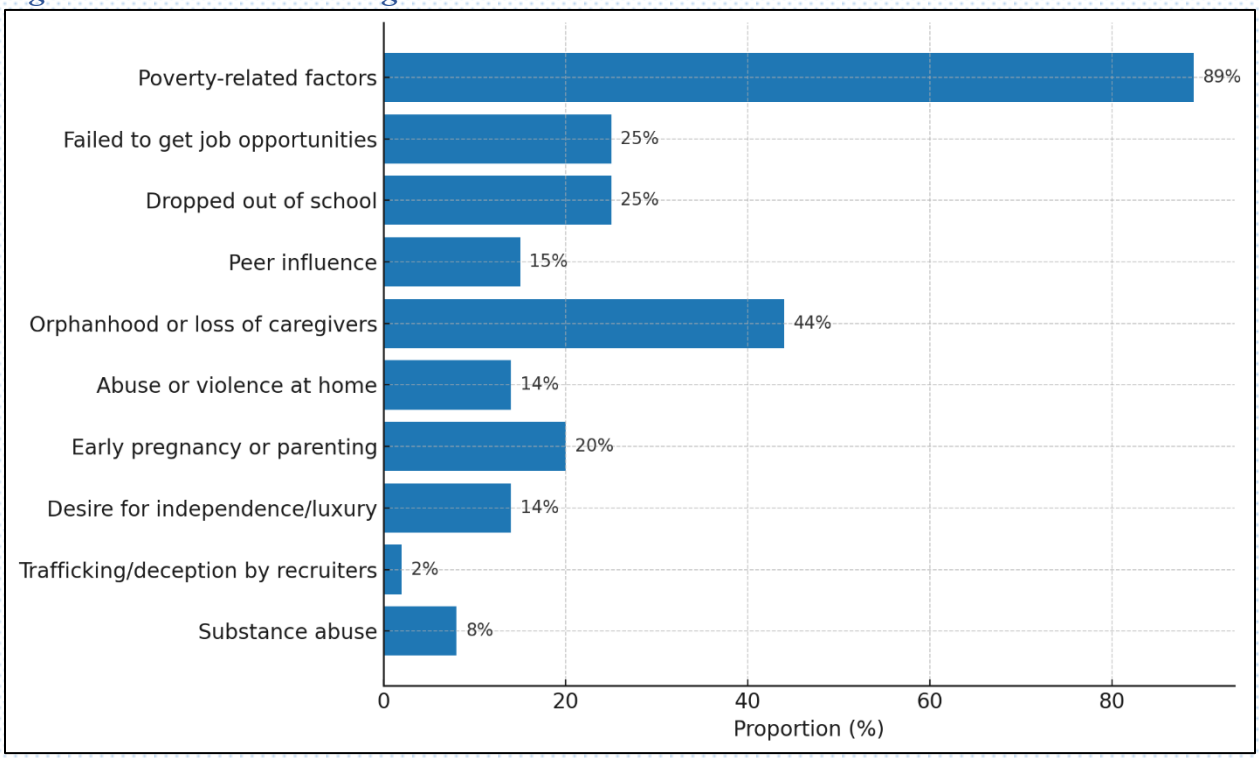
Table 5: Summary of quality issues

Key issue	Description
1. Funding and resource constraints	○ There is a shrinking funding space with donor restrictions on certain services, coupled with inadequate supplies of essential commodities and limited financing for AGYW-specific programs
2. Program design and service delivery limitations	○ Limited creativity and innovation in program design, making services less attractive to young people. ○ Inconvenient service hours that do not align with the needs of AGYW in sex work. ○ Inadequate strategies to reach sex workers outside established hotspots. ○ Lack of differentiated or youth-friendly approaches that consider privacy, confidentiality, and stigma concerns
3. Access and follow-up challenges	○ The high mobility of AGYW in sex work complicates referrals, tracking, and follow-up, often leading to loss to care. ○ Lack of permanent addresses and frequently changing phone contacts disrupt continuity of care and hinder effective follow-up. ○ Restrictions imposed by gate keepers such as bar managers limit AGYW's freedom of movement, preventing timely access to health and social services. ○ Poor adherence to ART among some AGYW further undermines treatment outcomes and increases vulnerability to adverse health effects. ○ Difficulty reaching hidden or hard-to-reach populations outside known hotspots.
4. Perceptions, stigma, and stakeholder dynamics	○ Perceptions that some providers promote sex work or homosexuality foster isolation and undermine their capacity to deliver services effectively ○ Stigma and discrimination against sex workers continue to undermine service uptake and trust ○ Some AGYW engaged in sex work have unrealistic expectations that organizations should meet all their medical expenses, which fosters dependency and at times creates tension when such support cannot be provided ○ Limited support from law enforcement or local authorities reduces safety and confidence in accessing services. ○ Negative attitudes from community members or other stakeholders that limit access to services by AGYW in sex work.

3.5. Factors that drive young girls into sex work

Interactions with AGYW through interviews revealed multiple interrelated factors that influence their entry into sex work (Table 5). At the forefront are poverty-related challenges, which emerge as the primary structural drivers. These include financial hardship, marked by lack of money for survival and inability to afford school fees or basic scholastic materials, all of which contribute to heightened vulnerability. Compounding this are family and social insecurities, such as orphanhood or loss of caregivers and experiences of abuse or violence at home, intensify household instability and expose girls to further risks. Lack of access to education and employment add another layer, with school dropout and inability to access gainful employment serving as strong pathways into sex work. Beyond these structural and family-related pressures, peer and social influences also play a role, as girls are drawn in through peer networks or motivated by a desire for independence and a more luxurious lifestyle. These factors are examined in greater detail in the subsequent sections.

Figure 10: Factors that drive girls into sex work



Poverty and economic hardship

Poverty-related factors emerged as the most significant drivers of AGYW's entry into sex work, reported by 89% of respondents (Figure 7). These include the lack of money for basic survival, persistent financial hardship, and the inability to afford school fees, which collectively create a cycle of vulnerability and exclusion. As a result, without access to education or stable income, many girls are left with few viable options for

sustaining themselves, making them highly susceptible to exploitation. This demonstrates that economic vulnerability is not merely a background condition but the primary structural force compelling AGYW into sex work. As such, there is an urgent need for social protection measures, educational support, and livelihood opportunities to break this cycle of dependency. Recent evidence from the Uganda National Household Survey (2023/24) reinforces this finding, showing that 1 in 6 people lives in absolute poverty, with young women disproportionately affected due to their limited access to education and formal employment. The situation is even more pronounced in urban slums and border towns, where alternative income-generating opportunities are scarce. Furthermore, limited vocational skills and restricted access to financial resources deepen this vulnerability, entrenching reliance on sex work as a survival strategy.

Early pregnancy/motherhood

The burden of early pregnancy or parenting, reported by 20% of respondents in Figure 7, further compound the vulnerabilities faced by AGYW and create environments of instability that push many into sex work as a means of survival. Girls who become pregnant at a young age often drop out of school due to stigma, lack of support, or the inability to balance childcare with education. This significantly reduces their future employment prospects. The responsibilities of parenting, coupled with limited access to childcare, financial support, and social safety nets, place immense pressure on young mothers to find immediate income. It was noted that in many cases, families withdraw support or subject girls to discrimination, leaving them isolated and burdened with the dual challenge of providing for themselves and their children. With restricted access to formal employment and vocational opportunities, sex work often emerges as one of the few available options to meet daily needs. This highlights how early pregnancy not only reflects underlying gaps in sexual and reproductive health services, including limited access to contraception and comprehensive sexuality education, but also serves as a structural driver of long-term vulnerability and intergenerational cycles of poverty and exploitation.

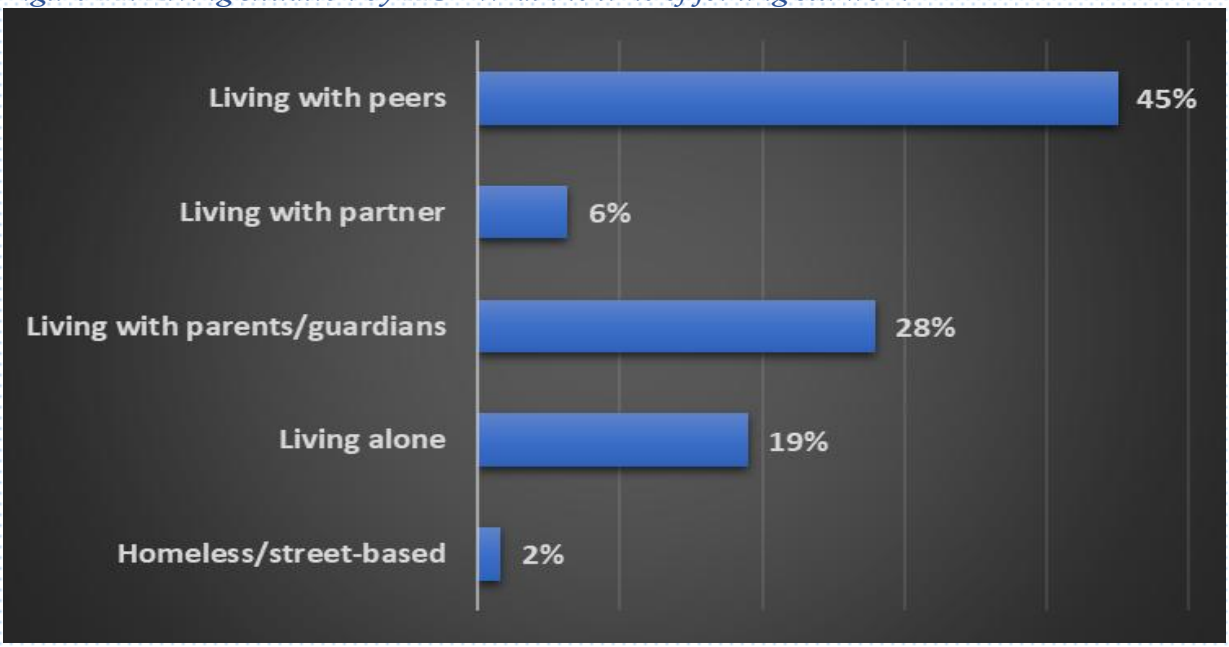
Lack of family support, often resulting from orphanhood or absence of caregivers

Orphanhood or loss of caregivers, reported by 44% of respondents, was the second most common driver of AGYW's entry into sex work, underscoring how the absence of family support significantly heightens vulnerability. The loss of parents or primary caregivers often leaves girls without essential financial, emotional, and social protection, forcing them to fend for themselves at a young age. Without this safety net, many struggle to meet basic needs such as food, shelter, education, and healthcare, increasing their susceptibility to exploitation. In such contexts, sex work may appear as one of the few available survival strategies. The situation is further compounded by stigma, discrimination, and lack of community support for orphans, particularly in settings where extended family structures are overstretched or unable to provide adequate care. These dynamic highlights how structural weaknesses in social safety

nets and child protection systems exacerbate the risks faced by orphaned girls, pushing them into precarious livelihoods such as sex work.

Figure 8 shows that at the time of joining sex work, the majority of AGYW (45%) were living with peers, indicating reliance on peer networks rather than family structures for support, an arrangement that may also reinforce pathways into sex work. About 28% lived with parents or guardians, demonstrating that a considerable proportion entered sex work despite being in family settings, likely due to inadequate parental support, strained relationships, or unmet financial and emotional needs. Nearly one in five (19%) were living alone, reflecting isolation and the absence of protective family structures, while 6% resided with partners, potentially exposing them to dependency or exploitation. A small minority (2%) were homeless or street-based, representing the most extreme form of social and economic marginalization. Collectively, these findings underscore that weak or absent family support and protection is a key driver of AGYW's entry into sex work, leaving many to depend on peers or unstable arrangements that heighten vulnerability and risk.

Figure 11: Living situation by AGYW at the time of joining sex work



Abuse or violence at home

Abuse or violence at home was reported by 14% of respondents. Household instability and entrenched gender-related vulnerabilities are reported to contribute to driving AGYW into sex work. Exposure to physical, emotional, or sexual violence within the home not only creates unsafe living environments but also erodes self-esteem and trust, pushing girls to seek escape or alternative sources of support. In many cases, such abuse is compounded by neglect or the absence of protection from caregivers, leaving girls with few avenues for safety or recourse. Consequently, leaving home often becomes the only viable option; however, without social or financial support, many

are left highly vulnerable to exploitation, with sex work emerging as a survival strategy. This dynamic demonstrates how gender-based violence within households is not merely a personal tragedy but also a structural driver of vulnerability, underscoring the urgent need for stronger child protection systems, community safety nets, and interventions that address the intersection of domestic violence, poverty, and exploitation. Moreover, many girls experience sexual abuse, physical violence, or coercion within their homes or communities, often compelling them to flee in search of safety or independence. Evidence from the 2022 Uganda Violence Against Children Survey (VACS) indicates that one in three girls experiences sexual violence during childhood, and over 50% do not receive any form of support [2]. Orphaned or neglected girls, particularly those affected by HIV, face heightened vulnerability due to the absence of family protection or economic support. Lacking safe housing, education, and livelihood options, some girls resort to survival sex or are exploited by traffickers and older partners [3].

High dropout rates among girls at both primary and lower secondary school levels

School dropout and low educational attainment are major drivers of sex work among adolescent girls and young women (AGYW) in Uganda. According to the Uganda Bureau of Statistics, approximately 46% and 66% of girls drop out of primary and lower secondary school respectively, with key contributing factors including poverty, early pregnancy, lack of school fees, and limited access to sanitary products. This aligns with the survey findings, which show that fewer than half (47%) of AGYW engaged in sex work have completed primary school. Girls who leave school early often face limited employment opportunities and lack the vocational skills necessary for formal or self-employment, pushing many into informal and risky survival strategies such as sex work. The absence of education also weakens their ability to make informed decisions about their sexual and reproductive health, increases susceptibility to exploitation, and reduces access to protective support systems. As a result, school dropout not only exposes girls to economic vulnerability but also diminishes their agency, making sex work a perceived or actual necessity for survival.

Peer influence and social pressures

This plays a pivotal role in driving girls into sex work through both normalization and active recruitment. Many AGYW are introduced to sex work by friends or acquaintances already engaged in the trade, who often present it as a viable means of survival or a quick source of income in contexts of limited economic opportunity. In this study, 85% of AGYW reported being introduced into sex work by someone, with two-thirds of these introductions (60%) made by a close friend (Figure 7). This aligns with findings from a study commissioned by Uganda AIDS Commission (2021),

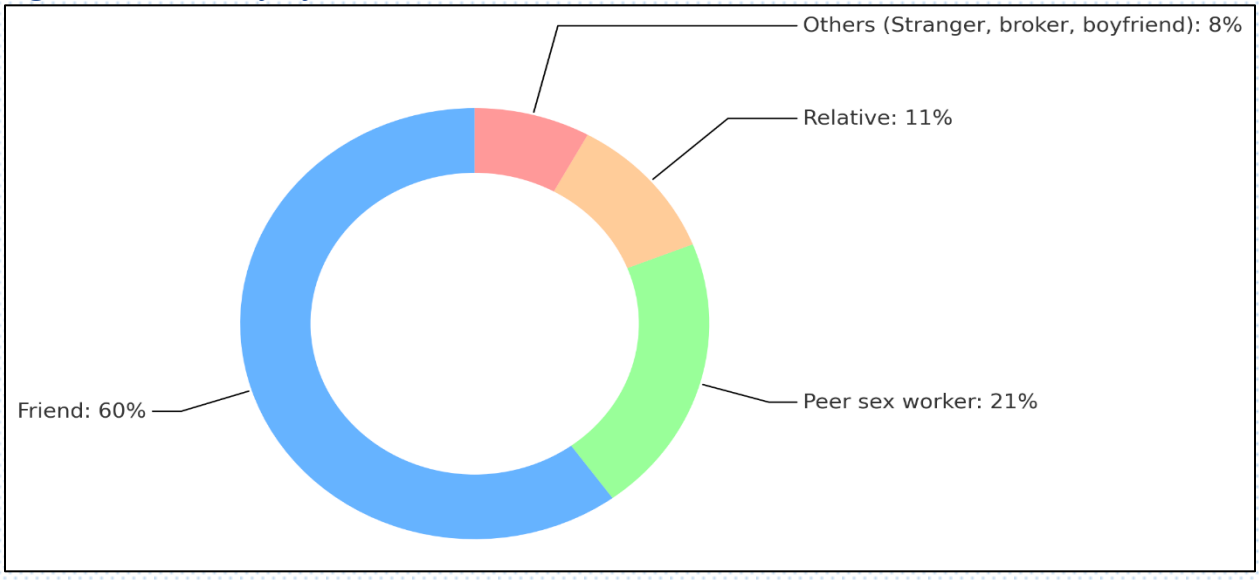
[2] Ministry of Gender, Labour and Social Development (MoGLSD), Uganda Bureau of Statistics (UBOS), & U.S. Centers for Disease Control and Prevention (CDC). (2022). Violence Against Children Survey: Uganda 2022 Findings Report. Kampala, Uganda.

[3] UNICEF. (2023). *Adolescent Girls in Crisis: Voices from Uganda on the Impact of Violence and Poverty*. New York: United Nations Children's Fund.

which reported that 47% of AGYW entered sex work through a peer or close friend, often linked to shared experiences of economic hardship or homelessness [4]. Peer networks not only facilitate initial entry but also influence perceptions of sex work, framing it as socially acceptable or even empowering in some urban contexts where transactional sex is normalized. This influence is increasingly amplified through social media and mobile platforms, which serve as key channels for recruitment, networking, and client engagement among young sex workers [5]. These dynamics underscore the need for peer-led prevention and empowerment programs that provide safe alternatives and challenge harmful norms.

Closely linked to peer influence is the desire for independence or a more luxurious lifestyle, reported by 14% of respondents. Beyond meeting basic survival needs, some AGYW are motivated by aspirations for autonomy, social mobility, and material gains. For many, sex work is viewed as a pathway to financial independence, enabling them to afford personal necessities, fashionable items, or a lifestyle otherwise unattainable due to poverty and limited opportunities. These aspirations are often reinforced by peer comparisons, societal expectations, and the influence of urban environments, particularly through social media, where consumerism and status symbols are highly valued. Within this context, sex work may be perceived not only as a coping mechanism but also as a strategy for empowerment, providing a sense of agency and control over their lives. However, while these motivations reflect ambition and resilience, they also expose the deeper structural inequalities that continue to deny young women safe and sustainable pathways to achieve true independence.

Figure 12: Source of influence into sex work



[4] Uganda AIDS Commission (2021). *Situational Analysis of Adolescent Girls and Young Women at Risk of HIV in Uganda*. Kampala: UAC.

[5] Ahaibwe, G., Mbowa, S., & Kasirye, I. (2020). *Digital economies and sex work among young women in urban Uganda*. Economic Policy Research Centre

The post-conflict effect

In the post-conflict Northern Uganda, AGYW who were children during the war are now transitioning to adolescence and adulthood in challenging environments. Studies have shown that the war effects on traditional livelihoods and social structures and limited access to employment and education opportunities create financial pressures that force AGYW into sex work and other forms of exploitation [6,7,8]. This is exacerbated by stigma against those who endured war-related sexual violence, including forced marriage and motherhood in the bush. The conflict left many parents disabled or dead living behind orphaned children without parental care. Due to lack of family support or social connections, these orphans have been forced to move to urban areas in search of opportunities, where they face considerable vulnerabilities including sexual exploitation and being employed in harmful jobs (such as working as bar attendants, housemaids, karaoke dancers and masseurs among others). Furthermore, despite reconstruction efforts for critical infrastructure such as health facilities and roads, physical access to healthcare (including HIV and SRH services) in post-conflict northern Uganda still remains a challenge due to the scattered and distant health facilities [9]. Moreso, the post-conflict region continues to be a hard-to-reach area with health workforce challenges including shortage of health and poor skills mix, which limits delivery of health services.

Substance (alcohol & drug) abuse

Substance abuse is both a driver and consequence of engagement in sex work among adolescent girls and young women in Uganda. For many young girls, the pathway into sex work is shaped by a combination of social isolation, limited educational or employment opportunities, and financial hardship; conditions that also increase vulnerability to substance use. In some cases, drug or alcohol dependence precedes and propels entry into sex work, as AGYW seek ways to finance their addiction or are exploited in drug-fueled environments. On the other hand, others turn to substance use as a coping mechanism to manage the emotional and psychological toll of sex work, including experiences of violence, stigma, and exploitation. This bi-directional relationship creates a reinforcing cycle where substance abuse exacerbates risky sexual behaviors, impairs judgment, and reduces the ability to negotiate condom use, thereby heightening vulnerability to HIV and other adverse health outcomes. Furthermore, substance dependence often leads to poor mental health, social withdrawal, and disengagement from education or productive employment, further entrenching AGYW in precarious survival strategies such as sex work.

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4. Conclusions and recommendations

A. Addressing gaps in the existing HIV and SRHR services targeting AGYW sex workers

The baseline assessment highlighted significant gaps in service delivery targeting AGYW engaged in sex work. Uptake of STI screening remains low, and even among those screened, few receive treatment, reflecting limited access and weak follow-up mechanisms. ART linkage is also inadequate, with almost a half of the target population unaware of their HIV status and 16% aware but not on treatment. These challenges are compounded by poor integration of HIV and SRHR services, insufficient youth-friendly approaches, and persistent stigma from providers. In view of these findings, we recommend the following action points:

1) Strengthen HIV case-finding and linkage to care. To effectively reach hidden and highly mobile AGYW sex workers, HIV testing should be scaled up through peer-led strategies, mobile outreach, and hotspot mapping. This should be complemented by the expansion of HIV self-testing kits, accompanied by clear referral pathways for confirmatory testing and timely treatment initiation. Once identified, robust linkage-to-care mechanisms, such as peer navigators and digital tracking tools, are essential to facilitate same-day ART initiation, ensure continuity of care, and improve viral suppression outcomes. In addition, integrating psychosocial support and adherence counseling will help reduce stigma, build trust, and foster long-term treatment retention.

***2) Expand and improve STI screening and treatment*.** To address the low uptake of STI services among AGYW in sex work, STI screening and treatment should be seamlessly integrated into existing HIV/SRH programs to create one-stop, comprehensive service delivery points. This integration will not only enhance convenience but also reduce missed opportunities for care. In addition, increasing the availability of STI diagnostics and treatment commodities at drop-in centers and youth-friendly clinics will ensure timely access to essential services. Lastly, strengthening follow-up mechanisms, such as short-message reminders and peer outreach can ensure that individuals who are screened also complete treatment, thereby improving health outcomes.

3) Enhance service integration and delivery models. Building on current health sector campaigns on integration of health services, efforts should focus on scaling up comprehensive, client-centered services for AGYW sex workers, including HIV

testing, ART, STI management, family planning, and HPV vaccination at both facility and community levels. Flexible and mobile service delivery points can reach highly mobile populations, while differentiated models, such as: community ART refills and multi-month dispensing can enhance retention and treatment adherence. Together, these strategies promote a more accessible, responsive, and sustainable service system.

4) **Enhance youth-friendly SRH/HIV services for AGYW engaged in sex work.** The low uptake of SRH/HIV services among AGYW sex workers is largely due to unfriendly service environments, characterized by judgmental or discriminatory attitudes, lack of privacy and confidentiality, and limited youth-friendly service hours that hinder access. As such, youth-friendly services could be enhanced through the following strategies:

- Strengthen service provider capacity through on-site mentorship and coaching to deliver adolescent-centered, confidential, and non-judgmental care tailored to the needs of young sex workers
- Scale up youth-friendly service delivery models to reduce access barriers, including confidential drop-in centers and flexible clinic hours and outreach schedules to match the availability of AGYW engaged in sex work.
- Scale-up peer-led programs to build trust, disseminate accurate health information, and actively link young sex workers to appropriate services.
- Implement robust client feedback mechanisms such as community scorecards and anonymous hotlines to continuously improve service quality
- Engage local leaders, bar managers, and other gatekeepers in advocacy, awareness campaigns, and sensitization sessions to minimize community-level barriers and support safe access to services.

B. Strategies for enhancing partner coordination

SRH/HIV services targeting AGYW engaged in sex work are available through public, PNFP, and CSO providers; however, service delivery is fragmented, coordination across providers is weak, and geographic and population coverage remains uneven. Addressing these challenges requires strengthened coordination and harmonization of services through:

1) ***Enhance formal referral pathways.*** Develop formal referral networks linking public, PNFP, and CSO providers serving AGYW engaged in sex work to ensure seamless access to comprehensive SRH/HIV services.

2) ***Coordination platforms.*** Establish mechanisms such as quarterly district-level planning meetings to align service delivery, share best practices, and reduce duplication among partners.

3) ***Standardize service packages.*** Harmonize SRH/HIV service packages across all providers to guarantee consistent quality, equitable coverage, and compliance with national guidelines for AGYW-focused interventions.

C. Addressing the factors influencing AGYW entry into sex work

Adolescent and young women enter sex work due to multiple, interconnected factors. Key drivers include poverty, family and social insecurities, such as orphanhood, caregiver loss, and domestic abuse, as well as, limited access to education and employment opportunities. Peer and social influences, including networks and aspirations for independence or an improved lifestyle, further contribute to their engagement in sex work. The following interventions are recommended to address this challenge:

1) ***Expand targeted social protection and livelihood interventions for AGYW at risk.*** Targeted social protection and livelihood programs for AGYW at risk should be scaled up to address economic vulnerability and reduce engagement in high-risk behaviors. Evidence-based interventions, such as: cash transfers, vocational and skills training, and participation in savings and microfinance groups should be prioritized. A standardized vulnerability assessment tool should be developed to guide identification of AGYW most in need, ensuring that interventions are tailored to their specific circumstances. These initiatives will promote financial independence, strengthen resilience, and provide sustainable alternatives to risky livelihoods, thereby contributing to improved SRH and overall well-being.

2) Integrate education retention and re-entry initiatives. Implement targeted education retention and re-entry initiatives that provide holistic support to AGYW. This includes scholarships to reduce financial barriers, provision of sanitary products to promote menstrual hygiene and consistent school attendance, and childcare support for young mothers to enable their continued participation in education. These measures foster equitable access to education, improve retention rates, and empower AGYW to pursue long-term personal and professional development.

3) Strengthen the prevention and response to gender-based violence (GBV). GBV prevention and response services should be strengthened across schools, communities, and health facilities. In schools, efforts should build on the existing Reporting, Tracking, Referral, and Response (RTRR) Guidelines on Violence against Children. Key priorities include implementing comprehensive GBV awareness and prevention programs, establishing safe and accessible reporting and referral mechanisms, building the capacity of educators and frontline workers, and ensuring timely, survivor-centered care and support services.

4) Implement peer-led mentorship and empowerment programs. Implement peer-led mentorship and empowerment programs to offer safe, supportive alternatives for young girls, while addressing negative peer influences and socio-economic pressures that contribute to early entry into sex work. These programs targeting girls at high risk, should build skills, foster resilience, and strengthen social support networks to reduce vulnerability and promote positive life choices.