The Primary Livelihood Activity in Dei Fihing Village


Rapid Assessment Study in Dei Fishing Village, 2003

A PATH WORTH WALKING!

LAKESHORE AIDS INITIATIVE PROJECT (LAIP)

ANNUAL INTERNAL REVIEW REPORT


Training of Peer Educators-cum-Counselors, 2004

Print Media integrated with interpersonal Communication


Periodic Review for Learning, Accountability and Planning

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EXECUTIVE SUMMARY

Introduction
The Agency for Accelerated Regional Development (AFARD) has completed the first phase of the implementation of the two-year Lakeshore AIDS Initiative Project (LAIP). This project target fisher communities on Lake Albert in Nebbi district and its major focus is on: (i) Sensitizing the community on HIV/AIDS prevention; (ii) Building initiatives for home based community care and support.; (iii) Supporting local capacity building for service delivery and long term responses; and (iv) Strengthening AFARD's project management capacity.

This report presents an annual internal review of LAIP's 'performance' in order to recast its next phase of implementation. The annual review of LAIP aims to: (i) Assess LAIP implementation performance after one year; and (ii) Draw lessons of what worked (and what failed) in order to inform the implementation of the remaining one-year. Herein, performance measure is based on an assessment of relevance; effectives; efficiency; sustainability; and impacts for which specific indicators were developed. Lesson learning therefore constituted an in-depth understanding of the processes/strategies employed in LAIP implementation.

The review process and methodology

The review process started with a desk review of LAIP operations, which was followed by an internal reflection by AFARD members on the findings. Secondary resource materials including the initial research report, LAIP project document, planning meeting minutes, progress reports, and district monitoring report were reviewed. A rapid individual knowledge, attitude, and practice survey was conducted in LAIP and Singla (as a control) area among 151 randomly selected people (34% females) aged 14 years and above. Nine focus group discussions were held with *lithers*, unmarried youths, *cwarangutha*, married couples, elders/community leaders, peer educators-cum-counselors, traditional birth attendants, drama groups, and members of post test clubs. Key informant interviews were conducted among 20 purposely sampled people comprising of landing site masters, resident police officers and religious leaders, bar owners, LC officials, health unit staffs, World Vision staff, and head-teachers. These mixed approach to data collection aimed at triangulating the findings.

Summary of findings

a) *Relevance*

From the literatures reviewed it was evident that LAIP relevance fits within MACA developed by Uganda AIDS Commission and AFARD's vision. Implementation design responded to community needs and also integrates best practices upheld in community intervention. Established local change agents have reinforced community participation and appreciation of the project.

b) *Effectiveness*

LAIP is being effectively implemented. All planned activities were accomplished, timely, and all targets surpassed. Only reading materials in the form of leaflets and brochures and individual pre-test and post test counseling have slackened. These were attributed to pricing variation and inadequacy of VCT services.

c) *Efficiency*

With an approved budget of UGX 191,868,933 (approximately € 100,000 then), LAIP is functionally efficient. Its gross efficiency and operational efficiency during the project design was 31.7% and 19.7% respectively. During the implementation of year-one activities a 42.1% and 22.7% gross and operational efficiency were attained respectively which once compared to the plan indicate a considerable level of resource utilization efficiency. More utilization efficiency was attained in sensitization on HIV/AIDS and community home based care and support, video and drama shows, peer education, and training of condom distributors.

d) *Sustainability*

Attempts have been made to establish adequate and relevant local structures. Basic functional skills were provided to them. These institutions are optimally functional. They are operating with minimal supervision and financial support. And, they have set their own local leadership structures. Yet, they are committed and continue to deliver services to Dei community. However, being young and exposed to such an initiative for the first time ever their organizational capacity is weak.

e) *Most significant impacts*

From both the survey and the interviews it became pertinent that LAIP caused the following changes in the lives of the people of Dei fishing village:

(i) Knowledge about HIV/AIDS

Although all the survey respondents had heard of HIV/AIDS, mainly through the radio, PECs/VHWs, and the print media; LAIP area has 100% comprehensive knowledge about AIDS compared to non-LAIP area with only 40%. This has created a 'hunger for HIV/AIDS information' in the neighborhood of Dei. However, while some myths still persist, core areas of inadequate knowledge in the project site includes the malingering incorrect information in modes of prevention such as cleaning oneself soon after sexual intercourse and not sharing latrine; and information regarding support services such as the prevention of mother-to-child, life skills and OVC children's rights. This gaps added to the persisting factors for predispositions to infection increases the risk to infection.

(ii) Attitudes towards HIV/AIDS

While 99.3% acknowledge that AIDS exists, only 91.9% accept that it is very risky to have unprotected sex with multiple partners and only 83.2% accept that it is right to abstain and or be faithful to one's partner. Strikingly, as low as 42.3% (52.1% in LAIP area and 32.9%) recognize that they would avoid infecting other people when they know they are infected with HIV/AIDS. However, in LAIP area, this present a big leap from the pre-intervention period when AIDS was considered a dirty disease and many shunned it. Majority now recognize its presence amidst the community and are willing to fight it, religious leaders inclusive.

(iii) Positive practices to prevent and mitigate HIV/AIDS

The changes noted in (i) and (ii) above triggered positive practices that catalyze reduction of exposure to infections, stigmatization, and increases social safety nets for mitigating the effects of HIV/AIDS. AIDS is perceived to be reducing in LAIP area than in the non-project area. Some of the reported changes in LAIP area are as hereunder:

- Open discussions about HIV/AIDS. HIV/AIDS is no longer a secret. The silence is now broken.
- Changing sexual and social behaviors although multiple sexual partners, intergenerational sex and transactional sex exist. It was noted that demand for condoms and marital fidelity has increased

- The community is also shunning away from certain cultural practices that promote HIV/AIDS spread e.g., wife inheritance, sharing of sharps objects, witchcrafts as AIDS cure, and taking care of the sick without protection.
- Traditional healers have also adopted proper practices that prevent predisposition to HIV/AIDS infection and are referring some clients for counseling.
- Trained TBAs are practicing safe maternal delivery techniques and are referring mothers for health unit based post-natal services. As well, pregnant mothers are responding to safe delivery demand and going to health units for post-natal services.
- People have a high willingness to test and declare one's status. To date 458 people have tested (with >65% positively among VCT attendants in Dei and >85% in Singla).
- PLWA are shunning stigmatization as they are able to openly declare their status and associate with the wider community. A Post Test Club is established to that effect.
- Increased collective community responses to fight against HIV/AIDS by supporting people affected and infected by HIV/AIDS. Orphans and vulnerable children and persons living with AIDS are the prime beneficiaries here.

f) Community assessment of LAIP

LAIP is considered by respondents in Dei (the project area) to have impacted greatly in the areas of increasing AIDS awareness, marital fidelity, and reduction of sexual intercourse that used to be rampant, rotational, and unprotected. With the people supported to access VCT services, it is also pointed that it made people know their HIV-status which compounded by the starting up of the PTC promoted positive living among PLWAs. However, LAIP suffers mainly from lack of direct support to PLWAs; specific focus on HIV/AIDS; and failing to supply condoms.

g) Resource leverage

LAIP's progress has been registered in part due to support from (i) DDHS office and Pakwach and Angal health units; (ii) the activeness of PLWAs from the Nebbi Role Model; (iii) OVC support by Canada Fund for Local Initiative for OVC support in Dei; Global Fund for social marketing of condoms; and UNICEF for OVC support in Erussi and Wadelai. These factors intertwined to facilitate positive behavior change in Dei community.

h) LAIPS challenges

The implementation of LAIP is also faced with a number of challenges such as the biting poverty in the community; gender issues; isolation of HIV/AIDS as only a medical issue; limited access to ARV, VCT, and condoms; and bi-seasonal outbreak of cholera.

i) Lessons learnt

In this one year, we have been able to learn that:

- Behaviour change communication needs a coordinated complementary multi-channel approach. Verbal (interpersonal) communication alone is not adequate.
- Social categorization is a basis for effective communication for social change as it allows on learning.
- A coordinated multi-actor approach enhances quality assurance, resource efficiency, and accountability.
- Effective community empowerment occurs when they are involved in the entire project cycle so that they are able to own the entire project as theirs.
- Local capacity building is a basis for sustainability.
- HIV/AIDS is broader than a sectoral [often health] focus.
- Participatory monitoring integrates beneficiaries knowledge and practices with the ex ante project logframe designed and thus mainstream knowledge creation and accountability.

- Change as a process takes time. It takes time for people to openly declare their sero-status. Testing services alone is not enough but regular rapport building with the community increases the chance of trust upon which individual-to-individual counseling starts hence public and self confidence to declare one's sero-status and support initiatives to prevent farther spread.
- Transparent project accountability to beneficiaries promotes local actors energies to work for their destiny.

j) Recommendations

In this regard, given the challenges and lessons learnt, it is important that at LAIP (the project) level:

- LAIP continue with the BCC strategy and focus on strategic information packaging.
- The PTC needs strengthening in its leadership, operation, and its activities widened.
- OVC project scope be increased. Fishing alone cannot generate adequate income.
- Livelihood security in the community be built by promoting livelihood diversification.
- The concept of safe health need to be broadened into building a Healthy Dei Community beyond HIV/AIDS safety.
- Local institutions and structures especially of PTC and drama groups are strengthened so that they grow into sustainable groups.
- The magnitude of the problem in the neighboring Singla is a manifestation of the bigger and pending AIDS scourge in the fisher communities as is called for by the LC III Chairman. AFARD need to explore opportunities for upscalling.

ACRONYMS

AFARD	=	Agency For Accelerated Regional Development
AIDS	=	Acquired Immune Deficiency Syndrome
CF	=	Community Facilitators
CHBC	=	Community Home Based Care
DCI	=	Development Cooperation Ireland
DDHS	=	District Director of Health Services
FGD	=	Focus Group Discussion
HC	=	Health Centre
HIV	=	Human Immune Virus
KAP	=	Knowledge Attitude and Practice
LAIP	=	Lakeshore AIDS Initiative Project
LC	=	Local Council
NGO	=	Non Governmental Organizations
OVC	=	Orphans and Vulnerable Children
PEC	=	Peer Educator-cum-Counselors
PLWA	=	Persons Living with AIDS
PMTCT	=	Prevention of Mother-to-Child Transmission
PTC	=	Post Test Club
TBA	=	Traditional Birth Attendant
UGX	=	Ugandan shillings
VCT	=	Voluntary Counseling and Testing
VHW	=	Village Health Workers

Table of Contents

LIST OF TABLES AND FIGURES

1.0 INTRODUCTION

The Agency for Accelerated Regional Development (AFARD) has completed the first phase of the implementation of the two-year Lakeshore AIDS Initiative Project (LAIP). This project focuses at fisher communities on Lake Albert in Nebbi district. It is implemented in Dei fishing village composed of five villages – Dei A, Dei B, Dei C, Central, Dei village.

As a management function, after this phase, it was felt desirous to understand the projects' 'performance' in order to recast its next phase of implementation. Such a feeling also aroused from the increasing need to upscale the project basing on the calls AFARD is receiving and the expressed HIV/AIDS danger the wider fisher communities are living in.

This internal review report is, therefore, primarily concerned with what has transpired during the implementation of LAIP internally within AFARD and among its beneficiary community. The report is divided into seven parts. It starts with an overview of LAIP's origin and delves into the objectives and processes of the review. Performance measure using selected indicators are presented in part three. Part four places the impacts created by LAIP within a wider context appreciating the inter-linkages the project had with other institutions. The challenges affecting progress stride is presented in part five; which is followed in part six with lessons learnt this far. In the last part, recommendations are provided.

2.0 ABOUT LAIP: ITS ORIGIN AND FOCUS

In 2003 the AFARD pioneered the NGO representative position on the rejuvenated District HIV/AIDS Committee (DHAC). This was at a time when USAID HIV/AID funded AIM Programme was intervening in Nebbi district. Following two meetings to vet community based project proposal, DHAC realized that no community responses were coming from Lake Albert and the Albert Nile. Such a gap raised the concern as to whether HIV/AIDS problem did not either exist in these areas or rather there were no local institutions to champion such a need.

As a response, AFARD conducted a rapid assessment study on the Knowledge, Attitude and Practices (KAP) concerning HIV/AIDS behaviors in Dei Fishing Village, Nyakagei parish, Panyimur sub county, Nebbi district.[1] From the study, it was found that comprehensive knowledge was marred by social myths which in the height of predisposing factors increases susceptibility to (re)infection; and local capacity to intervene was lacking. Consequently, from such a need a 3-year intervention to reduce the spread of HIV/AIDS and mitigate it effects was formulated. The intervention was named, *'Lakeshore AIDS Initiative Project'* (LAIP). [2] LAIP proposal was discussed and negotiated with Development Cooperation Ireland (DCI), adjusted to 2 years from the initial 3 years, and was later approved after a year.

LAIP major focus is on:

(i) Sensitizing the community on HIV/AIDS prevention.

(ii) Building initiatives for home based community care and support.

(iii) Supporting local capacity building for service delivery and long term responses.

[1] See S. O. Orach, A. Lakwo and W. Cwinyaai (May 2003). *Study Report on Knowledge, Attitude and Practice Concerning HIV/AIDS in Dei Fishing Village, Panyimur Sub county, Nebbi District. A Rapid Assessment of Need for Intervention*. AFARD.

[2] See AFARD (January 2004). *Lakeshore AIDS Initiative Project (LAIP)*. A Project Proposal for the Prevention and Control of HIV/AIDS in Dei Fishing Village, Panyimur Sub county, Nebbi District, Uganda 2004-05.

(iv) Strengthening AFARD's project management capacity.

The Project Memorandum of Understanding (MoU) was signed in Kampala on the 28th May 2004 by Ms. Liz Higgins, Head of Development, Embassy of Ireland and Rev. Fr. Geoffrey Ocamgiu, the Chairperson Board of Director of AFARD. Immediately, LAIP implementation started. The project was operationalized into quarterly plans with detailed activity budgets. A monitoring framework and reporting formats were developed. Key stakeholders such as the Chairman District Council and his Executive Secretary for Health, Resident District Commissioner (RDC), the Chief Administrative Officer (CAO), The District Director of Health Services (DDHS), the District HIV/AIDS Focal Point Officer (DFPO), in-charge health services Jonam health sub district, and Panyimur sub county leadership and the people of Dei were also informed.

From left to right, Rev. Fr. G. Ocamgiu, Ms. L. Higgin, and Ms. M. Oduka (File Photo).

Two Community Facilitators (CFs - 1 man and 1 woman) were identified. Through the CFs and local councils (LCs) series of community meetings were held to popularize the project and to identify key actors: Peer Educators/Counselors (PECs), Traditional Birth Attendants (TBAs), and influential community leaders.

Finally, the project was officially launched by the DDHS in July 2004. Members of Board of Directors of AFARD, the LC III Panyimur Sub County and local dignitaries attended the function. The local people contributed materially and financially towards the cost of the launch. For instance, the landing center provided fish, while the PECs, TBAs, and community leaders contributed Ushs 2000 each.

3.0 THE DRIVE FOR AND PROCESS OF THE REVIEW

3.1 The driving force

After 1 year of implementation, especially after a year of negotiation, a number of operational issues surround the project context and its achievement. AFARD, therefore, needed to ascertain how the project is progressing. There is also need to learn from the various strategies and outcomes so as to improve on implementation in the remaining one year. Finally, given that over the project implementation period no such similar intervention has arisen to the benefits of fisher communities, such an evaluation is also expected to cast insight for up-scaling both within the current project area and to other fishing communities.

3.2 The objectives

The annual review of LAIP aims to:

1. Assess LAIP implementation performance after one year.

2. Draw lessons of what worked (and what failed) in order to inform the implementation of the remaining one-year and/or up-scaling.

3.3 The scope of review

In conducting the internal annual review, the agreed upon primary focus and scope of the work is summarized in table 1 hereunder.

Table 1: Scope of work for internal annual review

Project relevance	• *Project rationale and context right from its inception in view of beneficiary, national, district, and sub county needs; donor priorities.* • *Changes in the project context during implementation.* • *Relevance of project intervention strategies with due attention to beneficiary participation in intervention planning, implementation and M&E and beneficiary satisfaction with intervention strategies and results.*
Project efficiency	• *Cost and utilization of resources vide budget and plan.* • *Time management in project progress.*
Project effectiveness	• *Project progress and realization of set objectives in view of planned activities for the period*
Project sustainability	• *The extent to which the project is/will become sustainable.*
Project impact	• *The foreseen and unforeseen changes in the lives of project beneficiaries.* • *Factor and processes affecting project objectives, impact and sustainability.*
Lessons learnt	• *Operational lessons related to the project itself.* • *Developmental lessons related to societal consequences of the project.*

Finally, it is expected that such an assessment should state the project contextual and operational challenges and recommendations. This should be documented in a report that details all the above stated scope.

3.4 The review focus

In order to assess performance it is important to clarify what performance measure is in this case. Performance herein is taken to refer to the extent to which LAIP's implementation is fulfilling its objectives. Five facets (as summarized in table 2 below) were critically looked at to assess the objective realization and meet the scope of work indicated under 2.3 above, namely:

- *Relevance:* Measured the ability of the project to fit within broader needs of its stakeholders. [3] This included stakeholders' needs, satisfaction, participation, and support.
- *Effectiveness:* Focused on the extent to which the project is fulfilling its objective. This aspect anchored on project results as shown by achievement of targets vis-à-vis planned activities and outputs.
- *Efficiency:* Measured resource utilization prudence and cost minimization. Its focus was on direct project versus management cost; activity budget management prudence; and the ratio of outputs to inputs to ascertain whether LAIP is ensuring maximum outputs at minimum cost possible.
- *Sustainability:* Explored how the project and the local structures established would ably continue to impact on the community on their own.
- *Impact:* Explored beneficiary reactions to project outputs as evidenced by observable changes in their KAP (well aware of the contributions of external factors).

[3] Stakeholders herein include beneficiaries, funders, peer organisations engaged in similar activity, local government with supervisory functions, and management team whose interests and expectations all differ.

Finally, lesson learning was based on an understanding of the processes/strategies employed in LAIP implementation. Using plausible attribution scenario, from both the direct beneficiaries and the implementers, it became clear as to why certain changes occurred and what good practices are a must.

Table 2: Key performance measure questions and indicators

Performance focus	Key questions	Indicators
Relevance	• *Does the project fit within the entire stakeholders' diverse needs?* • *What is the stakeholder perception of the project?*	• Project juxtafitting within stakeholders' needs and strategies. • Stakeholder satisfaction
Effectiveness	• *Is the project meeting its set down targets?*	• Number of clients targeted vis-à-vis reached
Efficiency	• *Are financial resources used optimally in favor of beneficiaries?* • *What is the comparative ratio of costs and outputs?* • *Are services provided in time both in terms of project execution?*	• Size of development verses recurrent budget • Cost per client served • Project activity completion rates
Sustainability	• *Are the locally established structures able to operate on their own in the short, medium and long run?*	• Organizational and financial viability of local structures especially PECs, TBAs, drama groups and PTC
Impact	• *What are the observable changes in the beneficiaries KAP regarding HIV/AIDS related behaviors?*	• Changes in KAP of beneficiaries

3.5 The review process and methodology

This internal annual review was completed after a number of processes. It started with a desk review of LAIP operations. This was followed by an internal reflection by AFARD members on the findings. Finally, the need to broadly evaluate, internally, the project emerged and instrument designs, data collection within Dei (and the neighboring Singla) fishing villages, and report generation and dissemination followed.

To generate data requisite to meeting the above objectives a number of data collection methods were used, namely:

- *Literature review*: Secondary resource materials including the initial research report, LAIP project document, planning meeting minutes, progress reports, and district monitoring report were studied to synchronize the past and present situations in Dei. In this way, changes observed over the project period were identified and classified, and challenges outlined and reviewed vis-à-vis implementation responses to some of those challenges that were identified in earlier project periods.

- *A rapid KAP assessment survey:* This survey was an expanded version of the 2003 research study. It covered both Dei and Singla fishing villages with the latter providing a basis for a better comparison of with and without project situation in individual KAP. It used

individual questionnaire approach that covered both the demographic and individual KAP of HIV/AIDS behavior of respondents.

- *Focus group discussions (FGDs)*: FGDs were held with 7-10 people separately for different social categories – the *lithers*, unmarried youths, *cwarangutha*, married couples, elders/community leaders, peer educators-cum-counselors, traditional birth attendants, drama groups, and members of post test clubs. From these discussions, stakeholder views were sought regarding the project, its impact, and its sustainability.

- *Key informants interviews (KIIs)*: KIIs were conducted with 20 people comprising of landing site masters, resident police officers and religious leaders, bar owners, LC officials, health unit staffs, World Vision staff, and head-teachers. From these interviews, views on change in the community were also gathered just as the vitality of the project.

3.6 Sample selection

Two sampling methods were used in undertaking this review process. Random sampling technique was used to identify individuals for the rapid KAP assessment survey. Attention was not paid as to whether one had participated or not in LAIP activities so as to get a balanced view of the situation as it is in the areas. In this way, a pseudo-control sample was established by also selecting Singla fishing village, in the neighbouring Ganda parish, where LAIP has had no intervention.

And, purposive sampling was used to identify respondents for FGDs and KIIs because these instruments targeted those who are involved in the project implementation. These are respondents who were either directly involved in the execution of LAIP (and had views of the project and it results as an 'outsider observation') and those who were the primary project beneficiaries (with 'insider views' on what they are gaining and/or loosing from the project).

4.0 PERFORMANCE MEASURE

4.1 LAIP relevance

From the literatures reviewed it was evident that LAIP relevance fits within a broader HIV/AIDS implementation. Foremost, LAIP approach fits within one of AFARD's vision component of 'an informed, *healthy*, and prosperous West Nile society'. As such, unlike other NGOs without operational focus but rather jump-hooking any funding opportunity, the implementation of LAIP is testimony of AFARD's commitment to its vision and mission.

Secondly, the project design responded greatly to the felt community needs identified during the research and the ideas suggested by Dei community as what should be done for them. For instance, an elder lamented, '*please hurry with any intervention before we all die of AIDS*'. The need for people's awareness was called for to raise knowledge on 'the what and how of HIV/AIDS'. This can be seen from table 3 below adapted from the initial project research document.

Table 3: Summary of HIV/AIDS KAP and needs in Dei village

Community knowledge	Community attitude	Community practice	Community needs
• While almost all heard of AIDS, only 90.5% knew sex as the mode of transmission • 7.3% had bad myths on transmission and 2.4% on prevention • Comprehensive knowledge stood at only 55.7%	• Religious leaders shun down AIDS • Elders advocated for unsafe sex • Women encouraged unsafe deliveries	• 37.8% of respondents confessed to unsafe sex • Quick paid for sex with many and rotational partners was common • Women are asked for sex in order to buy fish • Marital promiscuity was rampant among both wives and husbands	• Blood testing be done • Awareness be created • Counselors be trained and counseling done • Promote condoms • Encourage responsible parenting and stable marriages • Ensure home based care and support

Third, the implementation strategy of LAIP has a balanced approach. It integrated community felt needs with best practices upheld in community intervention. As such by linking with relevant institutions, the project ensured quality assurance by not delving into what it could not do. For instance, clinical support and care were left to be addressed by the rightful institution. Besides, LAIP implementation rest on the local agents created (and being strengthened). Community participation is active in all stages of the project – from initiation through participatory research; in implementation through regular planning meetings and direct involvement in activity execution; and in monitoring through quarterly review and *ad hoc* meetings. By using the local people as PECs, CFs, and TBAs local ownership of the project is being promoted. A police officer remarked:

> *This is our project. Most of the trainers and educators are resident of this village. The equipments are all here. And, food is supplied by our vendors. What more then should a project offer? This is different from what other projects do. All you have from them is to be present for their workshops and you call it a day. You may never see them again yet you will read in reports (if you can land on one) that the project is in your area. Whatever that means, for me it is being cheated …'.*

Fourth, LAIP also fit within the national HIV/AIDS framework such as the MACA developed by Uganda AIDS Commission. The monitoring report by the DDHS and Secretary for health LC V also confirmed this broader (national and district) policy fit. However, although, not all aspects of the national framework were detailed in LAIP proposal, a factor related to donor funding negotiation, recent adoptions of components such as orphans and vulnerable children support (OVC) with funding from Canadian Embassy; condom distribution with Global Fund support; and request for additional support for Safe sanitation from DCI are clear testimony that AFARD is broadening LAIP and positioning the project in a holistic aspect that any HIV/AIDS intervention should. It is also a clear benefit of using various donor funds complementarily rather than in duplication.

Finally, it is on such a positive fit and implementation strategy that the project stakeholders positively evaluated the project. The Chairperson LC III Panyimur sub county remarked:

> *'No such a project has been implemented in this sub county or even the district. Local people's participation is always given priority. Am always invited to Dei to officiate on issues related to the project and periodic reports are copied to my office. We know of how much money is coming in and how it is spent. LAIP is truly a local community project'.*

The LC V representative from the area also commented:

> *If all projects were like LAIP we would have been developed along time ago. We in Dei do not want LAIP to end after the two approved years. Through LAIP we are able to see how we can, supported, locally change our own community. From HIV/AIDS, we are now somehow able to see broader poverty issues. Such a technical support is all local communities need rather than other project where the 'owners' come to earn a living in the names of the local people'.*

4.2 Effectiveness of implementation

As is summarized in table 4 below, LAIP is being effectively implemented. All planned activities for the year have been implemented. Equally, all the set targets were surpassed. However, while awareness creation, pre-test counseling, and video, drama, and radio shows scored marked results, the production and dissemination of reading materials slackened. Leaflets and brochures received least production. This was attributed to high illiteracy of the community as such attention was instead diverted into the production of posters and stickers that convey pictorial messages. Further challenge was attached to pricing variation with the estimated budget. Finally, another area that witnessed a low return was the individual pre-test and post test counseling services. The inadequate VCT service delivery and adoption of joint counseling after the establishment of a post test club were the sole causes for such a decline in attaining the target respectively.

Table 4: Project achievement vis-à-vis set targets[4]

Theme/Activities	Target		Achievements	Success rate %	
	Year 1	**Entire project period**		Planned 1 year	Entire project lifespan
Information, education and communication					
1. Sensitization on HIV/AIDS					
- Lithers	120 people	240 people	266 people	221.7%	110.8%
- Unmarried young girls/boys	400 people	800 people	514 people	128.5%	64.3%
- Unmarried adult men/women[5]	240 people	480 people	251 people	104.6%	52.3%
- Married men and women	400 people	800 people	429 people	107.3%	53.6%
- Community leaders	80 people	160 people	138 people	172.5%	86.3%
2. Family life counseling	400 couples	400 couples	519 people	129.8%	129.8%
3. Pre-test counseling					
- Education	1200 people	2400 people	2556 people		106.5%
- Counseling	480 people	960 people	301 people		31.4%
4. Legal education on child sex abuse	-	120 people	-	-	-
5. Life skills training	200 people	200 people	191 people	95.5%	95.5%
6a. Video documentary production	1 documentary	2 documentaries	1 documentary	100.0%	50.0%
6b. Local IEC production					
- Brochures	2,848 copies	10,000 copies	1,574 copies	55.3%	15.7%
- Leaflets	11,056 copies	30,000 copies	5,608 copies	50.7%	18.7%
- Posters	2,500 copies	7,500 copies	4,550 copies	182.0%	60.7%
- Stickers	2,250 copies	3,750 copies	2,500 copies	111.1%	66.7%
- T-shirts and caps	300 units	480 units	398 units	132.7%	82.9%
6c. Video shows	12 shows	24 shows	33 shows	275.0%	137.5%

[4] Data for these calculations were derived from the various progress reports for the project first year of implementation.
[5] Majority fell under *Lither* (for men) and *cwarangutha* (for women).

6d. Drama shows	5 shows	10 shows	9 shows	180.0%	90.0%
6e. Radio spots and radio talk shows	9 spots	24 spots	10 spots	111.1%	41.7%
- Spots	12 show	18 show	12 shows	100.0%	66.7%
- Talk shows					
6f. Participating in World AIDS day	1 session	2 session	1 session	100.0%	50.0%
7. Awareness creation on CHBC	200 people	600 people	332 people	166.0%	55.3%
Care and support					
8. Post-test club and counseling					
- Individually	240 people	480 people	154 people	64.2%	32.1%
- Joint counseling	720 people	1,440 people	992 people	137.8%	68.9%
Local capacity building					
9. Training and equipping PECs	20 PECs	20 PECs	20 PECs	100.0%	100.0%
10. Training and equipping TBAs	10 TBAs	10 TBAs	10 TBAs	100.0%	100.0%
11. Training of condom distributors	10 distributors	10 distributors	20 distributors	200.0%	200.0%
12. Local drama group training and support	2 groups	2 groups	2 groups	100.0%	100.0%
13. Training of traditional healers	15 traditional healers	15 traditional healers	13 traditional healers	86.7%	86.7%
14. Training of community leaders	30 community leaders	30 community leaders	30 community leaders	100.0%	100.0%
Management support					
15 (1.1) Equipping AFARD	Basic equipments	Basic equipments	Basic equipments	100.0%	100.0%
15 (1.2) Training CFs	2 CFs trained	2 CFs trained	2 CFs trained	100.0%	100.0%
15 (1.3) Periodic reviews	4 sessions	8 sessions	4 sessions	100.0%	50.0%
15 (1.4) Annual planning	1 session	2 session	1 session	100.0%	50.0%

4.3 Efficiency[6]

The entire approved LAIP span cost was UGX 191,868,933 (approximately € 100,000 then). This was apportioned as 62% for information, education and communication; 6% for care and support; 12% for local capacity building; and 20% for direct management support components. To date, the expenditure details are as summarized in table 5 below.

LAIP is functionally efficient. Its gross efficiency and operational efficiency during the project design was 31.7% and 19.7% respectively.[7] During the implementation of year-one activities a 42.1% and 22.7% gross and operational efficiency were attained respectively which once compared to the plan indicate a considerable level of resource utilization efficiency. This is also exemplified by the cost per capita variations computed for three components in table 5 below.

More utilization efficiency was attained in sensitization on HIV/AIDS and community home based care and support, video and drama shows, peer education, and training of condom distributors.

Besides, the overall implementation of all planned activities for the year did take place and were conducted timely. For instance, local capacity building activities that were the pillar for further

[6] Calculation of costs excludes all in-kind contributions. Equally, all cash contributions from the community are omitted as they are not included in the books of accounts. Therefore, actual cost includes both DCI and AFARD contributions.
[7] Gross efficiency is computed by adding capacity building cost to management cost and dividing to the entire project cost for the period while operational efficiency only considers management cost in the computation.

project activity execution were finalized in the first quarter. Quarterly implementations are also planned to be executed timely save for on-going activities such as peer education and counseling that are part and parcel of PECs work.

Table 5: Financial efficiency matrix

Components	Total budget Allocations	Budget management		
		Planned budget year 1	Actual budget year 1	% utilized
Information, Education, and Communication	119,371,000	63,080,600	62,481,720	99.1%
Care and Support	11,724,000	5,544,000	5,544,000	100.0%
Local Capacity Building	23,038,300	23,038,300	23,038,300	100.0%
Management Support	37,735,693	26,947,359	27,474,200	102.0%
Total	191,868,993	118,610,259	118,538,220	99.9%

4.4 Project sustainability

In the short-run, the established local structures (PECs, TBAs, PTC, and drama group) are functionally viable. They are operating with minimal supervision and the TBAs are not being supervised by the health department. Besides, with the minimal financial support (excluding TBAs), they are able to deliver services to Dei community. However, while these cadres have the required skills to deliver such services save for TBAs who will be sought by expectant mothers, the long-term viability of the other local structures is weak. This is because the PECs and drama group are purely a project gloss that will disappear if not checked before the end of the project. The PTC is also still young and weak but with promising commitment and performance. For instance, from the funds meant for joint counseling and on-going peer counseling they were able to open a bank account in which they deposited both their membership fee and the said fund. With this fund they have managed to start a mini-credit scheme with the aim of binding membership cohesion, enabling members improve their life standard, and reduce dependence on project fund for on-going activity. This is contrary to the drama group that instead hastens to spend whatever limited funds they have raised.

As another sustainability strategy the community leaders will need is to become able to attract additional / external funding on their own. There will therefore be need for them to begin acquiring some more knowledge in simple project conception and proposal.

4.5 Plausible impacts

There are a number of positive signs that the project is achieving its goals. These signs indicate both 'reactions by and changes in the lifestyle of the people'. Below are some of the indicators.

4.5.1 Knowledge about HIV/AIDS

A rapid individual KAP survey was conducted among 151 people (66% males and 34% females) in Dei (a treatment site) and Singla (a control site) who were aged 14 years and above. The respondents were 83% indigenous to the fishing villages, of Alur origin (91%), aged 18 years and over (93%); 66%

with primary education; 40% formally married; 57% engaged in fishing activity for a living. For details see annex 2.

All the respondents interviewed had heard of HIV/AIDS. The radio and PECs/VHWs are the main sources of information in both LAIP and non-project areas. However, the print media is another vital channel in the project area (17.6%) compared to only 3.9% in the non-project area. Also, while most people (94.3%) in both sites consider AIDS as a germ, some myths still exist in non-project area since AIDS is still associated with witchcraft. Figure 1 below summarizes this finding. In the project site, there is an increasing ability to dispel myths of HIV/AIDS and link past deaths to it. An elder in LAIP area retorted:

> *AIDS was going to kill us. All we knew was that the gods or a witch was at work. Now I know what it is in its causes, signs, and how to prevent it. Seeking the right services of VCT and joint PTC is the best alterative to wasting one's resources consulting traditional healers.*

Figure 1: Sources of information and what AIDS is

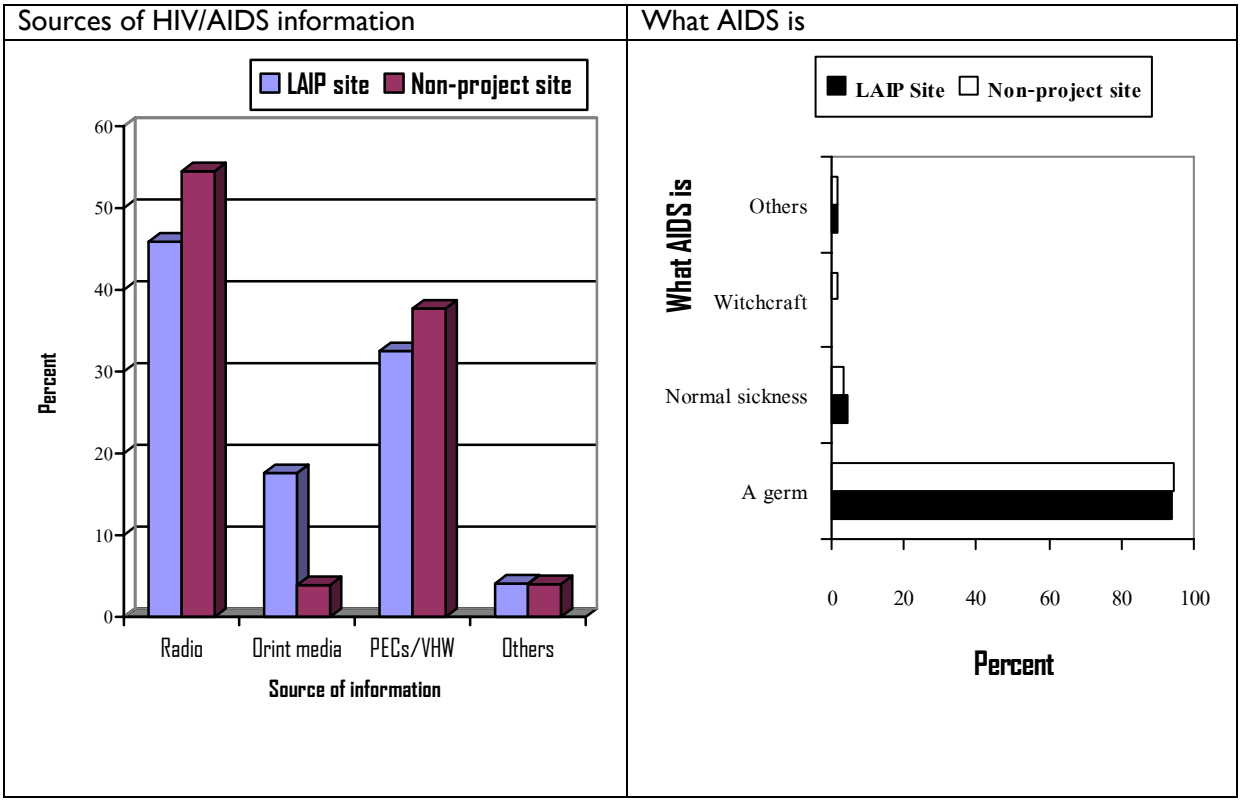


Table 6, 7, 8, and 9 below presents the difference in the level of knowledge on various facets of HIV/AIDS ranging from HIV/AIDS modes of transmission, symptoms, modes of prevention and support services, and how PLWA can live positively. A general observation from the tables reveals a marked outcome in form of knowledge creation among the population in LAIP site compared to those in non-LAIP area. Core areas of inadequate knowledge in the project site includes the malingering incorrect information in modes of prevention such as cleaning oneself soon after sexual intercourse and not sharing latrine; and information regarding support services such as the prevention of mother-to-child, life skills and OVC children's rights.

Table 6: Transmission Modes of transmission

Variables	LAIP site	Non-project site	Total
From infected pregnant mother to the unborn baby	100.0%	44.4%	67.1%
From infected mother to baby through breast feeding	100.0%	88.9%	93.6%
Use of unsterilized materials	100.0%	95.9%	97.7%
Contamination of open wound with secretion from an infected person	100.0%	40.0%	69.7%
Sexual intercourse with an infected person	100.0%	95.9%	97.8%
Comprehensive knowledge[8]	**100.0%**	**40.0%**	**67.0%**

Table 7: Symptoms of HIV/AIDS

Cluster variables	LAIP site	Non-project site	Total
Marked weight loss (technically >10% within months or less than a year	100.0%	83.9%	89.2%
Persistent fever	100.0%	70.2%	81.9%
Persistent Cough (>/= a month)	100.0%	61.7%	75.0%
Generalized skin rashes (including Herpes Zoster)	100.0%	70.0%	84.5%
Generalized enlargement of lymph nodes	100.0%	27.8%	49.0%
Oral thrush	100.0%	42.9%	59.3%
Recurrent diarrhea	100.0%	71.4%	83.1%

Table 8: Modes of prevention

Cluster variables	LAIP site	Non-project site	Total
Abstaining from sex especially if not married	100.0%	85.3%	92.6%
Being sexually faithful to one's marital partner	100.0%	94.3%	97.1%
Cleaning oneself soon after sexual intercourse	8.1%	12.2%	9.9%
Use of condom during sexual intercourse with a person whose status in unknown or a non-marital partner	93.2%	95.7%	94.4%
Use of contraceptive pills	9.8%	19.2%	14.2%
Testing and knowing your status	98.6%	97.0%	97.8%
Avoiding use of contaminated instruments like needles, razors	92.9%	90.6%	91.9%
Avoiding "medical" injections from untrained persons	85.3%	83.9%	84.7%
Not sharing latrines	38.7%	47.1%	42.5%
Using screened blood	38.3%	76.6%	58.1%

Table 9: Knowledge of AIDS related support services

Cluster variables	LAIP site	Non-project site	Total
Voluntary Counseling and Testing (VCT)	100.0%	90.5%	95.2%
Prevention of Mother-to-Child Transmission (during pregnancy)	97.2%	81.6%	88.2%
Skills training for Income Generation	100.0%	47.7%	62.9%
Life Skills training	88.9%	28.9%	40.4%
Orphaned and Vulnerable Children's Skills and Rights training	87.5%	15.8%	28.3%
Safe motherhood services in health facilities and through trained TBAs	100.0%	51.0%	72.5%
Community Awareness Programmes	100.0%	90.4%	93.9%

Table 10: Positive living by PLWA

[8] Comprehensive knowledge refer to cases where a respondent stated at least 3 correct modes of transmission.

Cluster variables	LAIP site	Non-project site	Total
Accepting to live openly among other people without hiding his/her status	100.0%	63.0%	82.8%
Eating well (nutritious and well balanced diet)	100.0%	71.0%	83.5%
Being faithful to ones partner	100.0%	89.1%	91.9%
Avoiding infecting other people	100.0%	75.0%	85.5%
Carrying out income generating activities and planning for the future	100.0%	42.5%	55.8%
Seeking advice and counseling	100.0%	62.2%	69.6%
Treating opportunistic infections promptly	100.0%	65.0%	74.1%
Avoiding risky behavior like drinking, smoking	100.0%	45.5%	60.0%
Using condoms whenever having sex with a partner	100.0%	50.0%	68.4%

Equally, because of the vitality of the knowledge created by the project, there is 'hunger for HIV/AIDS information' in the neighborhood of Dei. For instance, the PECs noted that, '*many people persistently stop us seeking for an elaboration on burning HIV/AIDS information after attending the awareness seminars. This is mainly on issues with doubts such as mother-to-child transmission; using of same cloth to clean sexual fluids after sex; sharing of safety pins when fishing, etc*'. The CFs also reported that at one time the chief of Mahagi demanded for the PECs to be facilitated to go and educate his people in DRC. Meanwhile, the Chairperson LC III Panyimur has continued to demand for the expansion of the project into other areas of the sub county where AIDS is slowly, steadily and surely infecting the people. He commented while officiating at the launching of the OVC fishing scheme:

> *My utmost cry to AFARD is not to focus its attention on Dei only and close its eyes on other fishing villages. AIDS is killing people in other fishing centers too or even more than here in Dei. Kindly, take the message there too and let people know how to prevent this monstrous disease. Otherwise, while Dei will be safe, elsewhere in Panyimur we shall be mourning. From what I see, another Rakai will be here soon. It is a matter of time!*

From the above remarks, the essence of the realization of predispositions to infection is gaining momentum. The individual survey asked what respondents considered the factors that makes people to continue getting infected and below is the findings. Table 11 reveals that while the primary predisposing factor is perceived to be inadequate knowledge on sexuality in both project and control areas, rampant disco/video shows and alcohol, factors related to poverty and bad culture (e.g. forced sex) were also noted. Rampant video shows, alcohol consumption were less mentioned in LAIP area because they have reduced in the one year. The effects of bad culture, buying fish at night, love for money, poverty, and prostitution are mentioned more in LAIP because of the improved or better knowledge / perception than in Singla.

Table 11: Factors predisposing people to infection

Cluster variables	LAIP site	Non-project site	Total
Alcohol consumption	9.5%	11.7%	10.6%
Bad culture	12.2%	2.6%	7.3%
Buying fish at night	4.1%	-	2.0%
Love for money	2.7%	-	1.3%
Limited knowledge on sexuality	29.7%	32.5%	31.1%
Poverty	27.0%	3.9%	15.2%
Prostitution	6.8%	3.9%	5.3%
Rampant disco/video shows	6.8%	36.4%	21.9%
Religion	1.4%	1.3%	1.3%
Don't know	-	7.8%	4.0%
Total	**100.0%**	**100.0%**	**100.0%**

4.5.2 Attitudes towards HIV/AIDS

In the individual KAP survey, people were asked some attitude related questions. While 99.3% acknowledge that AIDS exists, only 91.9% accept that it is very risky to have unprotected sex with multiple partners and only 83.2% accept that it is right to abstain and or be faithful to one's partner. Strikingly, as low as 42.3% (52.1% in LAIP area and 32.9%) recognize that they would avoid infecting other people when they know they are infected with HIV/AIDS.

Table 12: Attitudes towards HIV/AIDS

Core variables	Cluster variables	LAIP site	Non-project site	Total
VCT services	Heard of VCT	95.7%	88.7%	92.1%
	Tested for HIV status	46.3%	21.6%	33.3%
	Wiling to test for HIV-status	91.9%	84.4%	88.1%
Why not tested	Just don't want	50.0%	27.3%	38.4%
	Fear testing	-	1.3%	.7%
	No Access	28.4%	37.7%	33.1%
	No knowledge	4.1%	9.1%	6.6%
	No Need	-	1.3%	.7%
	No time	1.4%	-	.7%
	Partner refused	16.2%	23.4%	19.9%
	Total	**100.0%**	**100.0%**	**100.0%**
Willingness to interact with a persons infected and affected with HIV	Care for PLWAs	90.4%	86.8%	88.6%
	Care for OVC	95.9%	91.2%	93.7%
	Buy products from PLWAs	75.3%	73.3%	74.3%
	Encourage a family member with HIV/AIDS to confess his/her status	94.4%	93.2%	93.8%
	Share food with a person having HIV/AIDS	74.3%	74.0%	74.1%
	Greet someone you know have HIV/AIDS	85.1%	87.7%	86.4%
	Voluntarily sit next to someone you know have HIV/AIDS	89.2%	91.9%	90.5%
Individual response to PLWA	Isolate them	11.1%	19.7%	15.5%
	Allow them to die faster	17.8%	19.5%	18.7%
	Provide treatment and support for them to live longer and better life	85.1%	94.8%	90.1%
	Support them through counseling to live positively	90.5%	95.9%	93.2%
	Publicize their status so that people avoid having sexual contact with them	97.3%	74.0%	85.7%

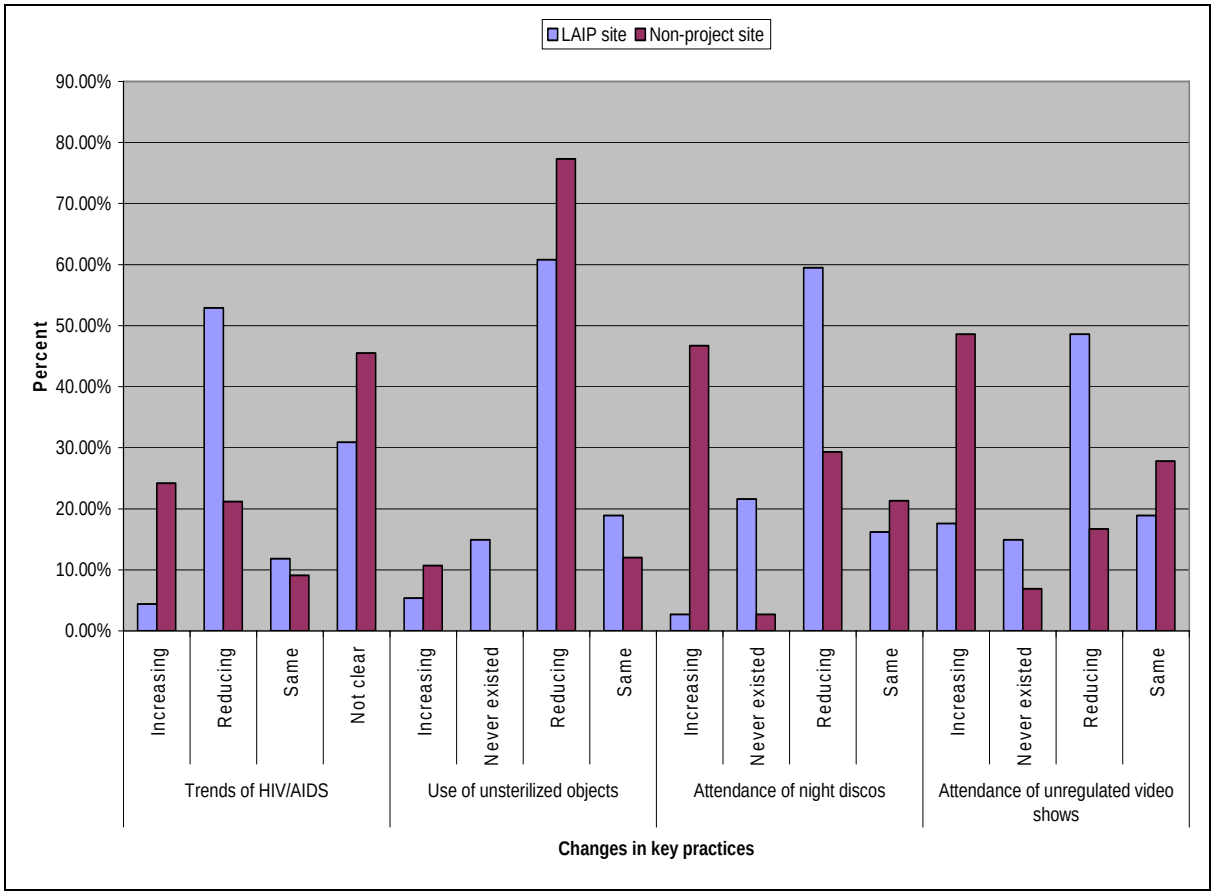
From table 12 above, it can be seen that gradually, people's attitudes as compared to pre-intervention have changed enormously. While AIDS was considered a dirty disease and many shunned it, now majority recognize its presence amidst the community and are willing to fight it. For instance, religious leaders' have accepted to promote the awareness and prevention of HIV/ADS. Sex that was considered a bedroom affair is now openly talked about just like condom that was considered 'covering a hoe blade when going to dig' is now in a big demand indicating that '*shambas* [fields] can be dug with covered hoes as long as the diggers remain alive and energetic'.

4.5.3 Practices to prevent and mitigate HIV/AIDS

The increase in knowledge and changing attitudes has yielded positive practices that catalyze reduction of exposure to infections, stigmatization, and increases social safety nets for mitigating the effects of HIV/AIDS. AIDS is considered to be reducing in LAIP area than in the non-project area as is shown in figure 2 below. This is based purely on community perception, as the study did not look

out for persons living with HIV/AIDS and the limited en mass access to VCT services. However, most of the predisposing factors such as through unsterilized objects, night discos and unregulated video shows are rampant in Singla where weekly fish market that attracts many people from other districts and as far as the Democratic Republic of Congo takes place.

Figure 2: Perceived trends of AIDS spread and predisposing factors



Some of the reported changes in LAIP area are as hereunder:

Open discussions about HIV/AIDS

HIV/AIDS is no longer a secret. The silence is now broken. People, especially the youths and religious leaders, now have open discussion and testimony on HIV/AIDS. PLWA's are now agents of change through community sensitization and sharing experiences. Traditional healers have accepted that AIDS exists and is beyond their 'magic cure'.

A widow and mother of two lamented:

> *What is it that one should fear talking about? Is silence better than the loss of human life? AIDS kills and nothing less than that. I will talk to my children about AIDS. Since sex is the prime cause, I will tell them how dangerous it is to engage in unnecessary sex. If they feel they must, let them have a condom. I would rather I buy [condom] for them than loose them at what only cost Ushs 1000. They are old enough and I know they cannot abstain. While the church will tell them not to have sex yet penitence allow sinners to confess and beg for God's mercy, with AIDS that is too late. You get it, the rest is postponing the problem. So, it is high time parents and leaders let the young ones know the danger. Likewise, I will insist on telling my fellow women to desist from 'sex theft'.*

Changing sexual and social behaviors

Respondents were asked about their sexual practices as is summarized in table 13 below. It is evident that the rate of sexual activeness is high but more alarming is that:

a) Multiple sexual partners still prevail in both LAIP and non-LAIP area although the majority of the people have one steady sexual partner. By age-group (see annex 3), it is females in the under 18 year category who are at more risk as they have more than 1 partner.

b) Intergenerational sex (at a ratio of 2:1 male to female engagement with those below their age group) with its associated child abuse is rampant (annex 4).

c) Transactional sex where pay is made for sex by both men and women in all age groups (annex 5) exists.

d) The practice of safer sex with the use of a condom is still low especially among females under 18 years (annex 6). Other than non-availability of condom supplies the inability to use condoms is mainly due to a negative attitude create by religious or ethnic background.

Table 13: Sexual practices

Core variables	**Cluster variables**	**LAIP site**	**Non-project site**	**Total**
Number of steady sexual partners	1 partner	71.9%	72.3%	72.1%
	2 partners	14.1%	17.0%	15.3%
	3 and over	14.1%	10.6%	12.6%
	Total	**100.0%**	**100.0%**	**100.0%**
Sex encounter	Had sex last one month preceding the study	73.4%	74.7%	74.1%
	Sex with a steady sexual partner	60.8%	34.8%	48.5%
	Paid for sex in kind/cash	34.0%	28.1%	30.7%
Age of partner	Children (Under 18 years)	16.3%	7.6%	11.3%
	Young adults (18-29 years)	57.1%	43.9%	49.6%
	Mature adults (>29 years)	26.5%	48.5%	39.1%
	Total	**100.0%**	**100.0%**	**100.0%**
Condom use	Condom was used in the encounter	20.0%	21.1%	20.7%
Why condom was not used	Dislike	14.9%	31.2%	23.2%
	Immoral	17.6%	6.5%	11.9%
	Not available	13.6%	20.8%	17.2%
	Not involved in sex	9.5%	18.2%	13.9%
	Partner refused	13.5%	14.3%	13.9%

However, despite the above, interviews with some respondents reveal that the high risk behaviors are gradually changing. For instance:

- Unsafe sex and the rate of sexual promiscuity have reduced. A shopkeeper noted that, '*condoms are now in high demand since they are in short supply. Many lither are willing to pay money for any condoms that initially they got for free from LAIP*.' The initial secret deals among women offering themselves or their daughters for sex with *lithers* as a bargain for buying fish as well as the brief 'sex theft' among married couples has tremendously reduced. A *lither* pointed that, *'LAIP has made sex too expensive to come by. Women who used to be readily available even to rotate among us are no more. They will tell you to get one permanent wife or desist from sex.* This comment was confirmed by women in the women FGD which noted

that, '*the high rate of promiscuity e.g. Nyapyach and Nyalip by married women and men respectively and ngangeyo with malayas is declining. Who does not fear for his/her life?*'

- The community is also shunning away from certain cultural practices that promote HIV/AIDS spread e.g., wife inheritance, sharing of sharps objects, witchcrafts as AIDS cure, and taking care of the sick without protection. Sexual engagement with widow(ers) is on the decline as one woman said, '*since am not sure what killed my husband, I better not engage in sex with anyone because if it is AIDS then I pass it on to that sexual partner and if it is not I may acquire it from that partner too.*'

- Traditional healers have also adopted proper practices that prevent predisposition to HIV/AIDS infection and are referring some clients for counseling. During their training they noted: '*AIDS is beyond us. We can not trace it from any of our magical lens. So, only if one stupidly insist that s/he has god's curse, we can no longer continue telling lies when finally we cannot cure the sickness and the patient will die leaving his/her relatives on our neck to either refund their costs incurred or defame our services.*

- Trained TBAs are practicing safe maternal delivery techniques and are referring mothers for health unit based post-natal services. As well, pregnant mothers are responding to safe delivery demand and going to health units for post-natal services (76 deliveries, 75 referral, and 81 immunizations were recorded **update**). In most cases, it was pointed by the TBAs, '*due to lack of means of transport, we offer our bicycles to be used to transport women due for delivery but with complications to Abok health center. Their husbands or in-laws willingly take them there and they get treatment before and after delivery both for themselves and their children against HIV/AIDS'.*

TBAs showing twins who had just been delivered

Services self-seeking behavior

More pregnant mothers know the risk of mother-to-child transmission. An unmarried pregnant girl who had not tested for HIV status commented:

> Even *if my husband or my-in-laws refuse to support me during my delivery since my parents are mad at me for having conceived outside marriage, I will seek the services of trained health workers so that I may prevent infecting my child with HIV/AIDS as the TBA I visited told me because am not sure whether I have the disease (AIDS) or not.*

Willingness to test and declare one's status

The awareness created about HIV/AIDS as a disease that does not only infect and affect 'unlucky people' yielded a high response to VCT by old and young and married and unmarried as well as sex workers as people now need to know their status. To date 458 people have tested (with >65% positivity among VCT attendants in Dei and >85% in Singla). A lither stated: *I need to know my HIV status so that I can start early enough to adopt a life saving strategy rather than waiting when it is too late to help myself'*. Together with such changes, and there is also the realization that services does exists to help sero-positive adopt positive living to live longer public declaration of status increased.

PLWA shunning stigmatisation

A Post Test Club established in the third quarter now has 83 members with >12.5% sero-positive people at advance stage of infection (after loosing 4 people to death). It is promoting positive living among PLWAs. PLWA's are slowly adopting prompt treatment of opportunistic infections. They are also using this groups to develop livelihood coping strategies that can enable them raise income, share survival risks, and gain recognition from local governments. As such, community acceptance of and support to PLWA's is slowly increasing. A PLWA testified:

> *Some people still argue that AIDS is not there. I just laugh at them because before I knew of my status, I was just as fool-headed like them. Now that I know, I'm willing to be a physical example for such people to know that AIDS is in our midst. It can only stay if we negligently invite it. So if you doubt what you hear about AIDS then believe what you will see me like. I was worried before I knew I had AIDS because I lost my body weight and became frequently sick. I was unable to fish any longer and all [resources] I had dwindled until I became a beggar. Now that I know, my confidence has increased and shyness has reduced. I no longer blame anybody for my misfortune. Rather, I work hard to live longer and safely.*

Collective community responses

Vulnerable children out of school fishing using hooks

The need to respond in the fight against HIV/AIDS has led to the entry by both sero-positive and –negative people in a Post Test Club (PTC) that was established. Likewise, a local drama group is in place and members of the two groups have merged into one vibrant group which is vigilant in awareness creation. Besides, an OVC project[9] has been established to seek a sustainable income generation strategy (in a local community-managed fishing projects) to support primary education of needy children. Finally, there is also on-going community policing against bad women's dressing while fetching water and in the center.

4.5.4 General assessment of LAIP

LAIP is considered by respondents in Dei (the project area) to have impacted greatly in the areas of increasing AIDS awareness, marital fidelity, and reduction of sexual intercourse that used to be rampant, rotational, and unprotected. With the people supported to access VCT services, it is also pointed that it made people know their HIV-status which compounded by the starting up of the PTC promoted positive living among PLWAs. However, LAIP suffers mainly from lack of direct support to PLWAs; specific focus on HIV/AIDS; and failing to supply condoms. This is shown in figure 3 and 4 below.

[9] This project costed about UGX 30 million and is funded by Canada Fund for Local Initiatives in the Canadian Embassy.

Figure 3: Key areas of change in Dei attributed to LAIP

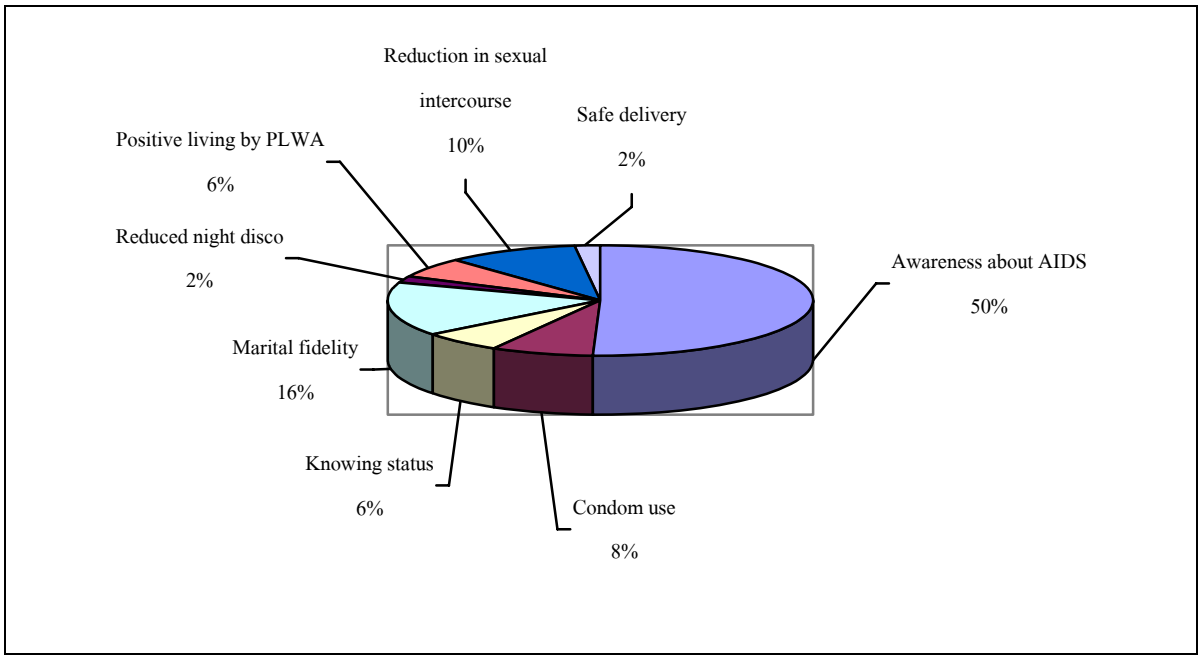
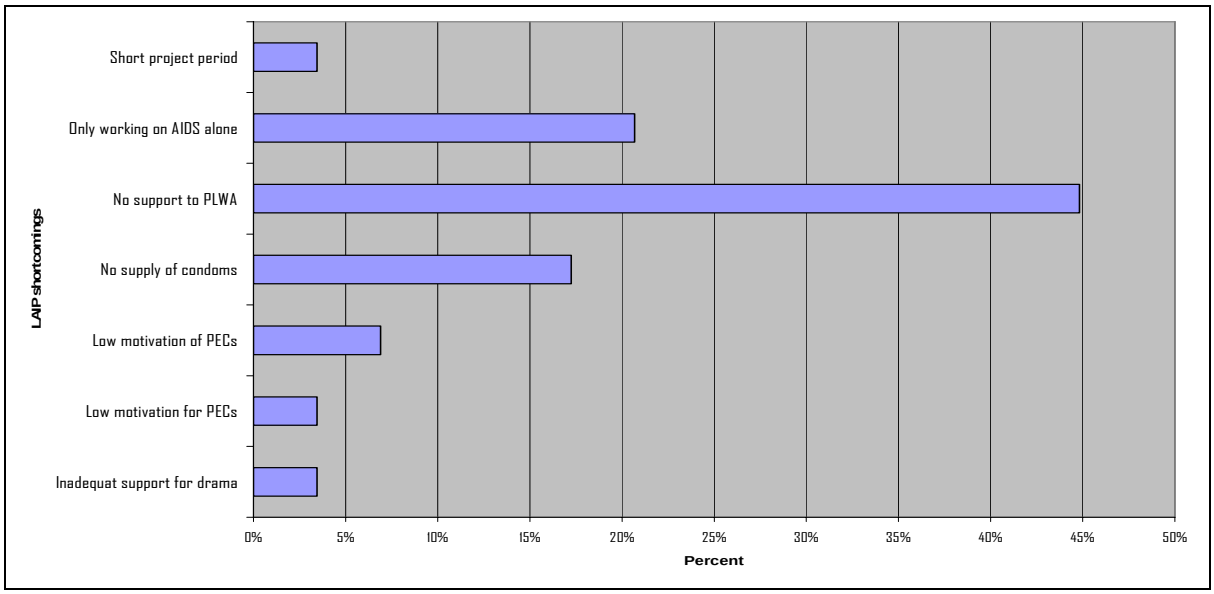


Figure 4: Key challenges to LAIP



5.0 EXTERNAL DRIVERS OF CHANGE

While with LAIP's intervention a number of changes are noticeable, it is practically difficult to attribute these changes to the project *per se*. with this in mind, it has been identified from the discussions with especially PECs that some external factors also made a vital contribution towards the changes noticed in KAP. Such factors include:

- *Distribution of condoms:* Condoms were secured from the DDHS office and Pakwach and Angal health units. This enhanced the guidance for and adaptation of safer sexual practices.

- *Support to and from VCT services by Pakwach HC to Dei Community:* With the ability to know one's HIV status, it became important to mobilize the people into a PTC where those who are already positive realize it as a family where they can meet and share their knowledge, problems, and solutions. This influenced more people to come forward.

- *Involvement of PLWA in sensitization:* Given that many people doubted the existence of HIV/AIDS even after getting basic information about it on the one hand and sero-positive people feared to declare their status on the other hand, the involvement of PLWA Association increased the acceptance by doubting Thomases and strengthened the self-stigmatized to reconsider their opinion and actions.

- *External financial support:* In this first year, LAIP facilitated AFARD to solicit funding from Canada Fund for Local Initiative for OVC support in Dei; Global Fund for social marketing of condoms; and UNICEF for OVC support in Erussi and Wadelai. From such funding AFARD's competency to rethink HIV/AIDS services delivery improved. Likewise, the community felt challenged. One of the community leaders lamented: '*if other people who have not yet even seen us in Dei are willingly supporting our expressed needs through AFARD, why can't we children [born] of Dei neglect such an initiative. We need to recognize such efforts and commit our energies to the plight of our own sons and daughters, brothers and sisters, and parents'*. In this way, community commitment to participate in the project activities, and to call others to change their ways of life increased. As a result, changes in the lifestyle and KAP toward HIV/AIDS are evident.

6.0 CHALLENGES FACING THE PROJECT[10]

Community related	Programme related	Administrative related	External factors
• 'LAIP has fund mentality' has weakened the building of local ownership. • Resistance to pay TBAs for every delivery made. • Pockets of predisposing factors still persist, e.g., the traditional use of same cloth to clean oneself after sexual intercourse; non-protection of women who offer assistance during delivery of pregnant women since not all women may seek assistance from trained TBAs during delivery; women who sell a species of tiny fish (Ragogi) often share safety pins used for removing fish bones that often prick their fingers • Community support for OVCs and PLWA is low	• Gender issues is still weakly appreciated and integrated • PTC sustainability demands beyond what the project had envisaged • Care for care givers is not provided for. • HIV/AIDS is treated as a medical issue only. • No direct support to PLWAs and OVCs	• Inability to synchronize project data with the national M&E framework • Weak coordination of reports from the project to sub county reporting system. • PECs are not well focused and needs continuous supervision	• Access to ARV is limited for PLWA • Limited supplies of condoms as ministry of health withdrew *Engabu* condoms from all health facilities. • Inadequacy of VCT services. • Limited capacity of local governments to mainstream HIV/AIDS into their activities • Periodic heavy rainfall that block access to Dei fishing village • Bi-seasonal outbreak of cholera increases death rates • Poor medical infrastructures limits outreach. • Poverty continues to predispose people to infections.

[10] Some issues identified as challenges are already addressed with effect from the 5th Quarter. For instance, PEC top-up allowance is provided for 1 year (additional UGX 10,000); TBAs also have both bicycle and performance allowance at the PEC rates; drama groups are now provided funds to directly spend; and PLWA in Post Test Clubs are being supported indirectly through the direct funding to the club for joint meetings, on-lending so that they create a sustainable safety system which they can own.

7.0 LESSONS LEARNT

In this one year, we have been able to learn that:

- *Behaviour change communication needs a coordinated complementary multi-channel approach.* Tackling negative KAP change requires a multi-pronged communication approach. Verbal (interpersonal) communication alone is not adequate. A wider source of information increases access to knowledge and reduces doubts from a single source. Much can be achieved if the information is packaged in a social category friendly manner. For instance, the use of videos, reading materials, and personal testimonies by PLWA greatly made public awareness by PECs more relevant, felt, and accepted. Yet, other than forgetting, people also tend to neglect information from persons who they see doing the contrary. Some *lithers* were initially being challenged: '*how can you a chief womanizer also talk of safe and against quick sex.* Therefore, effective communication also requires promoting ethical and moral values among the communicators to '*do as you say so that others do as you do*' although it takes time.

- *Social categorization is a basis for effective communication for social change.* Communication motivation demands a focused social categorization where each category behavior is analyzed and addressed. When people are in their own group, say youths, *malayas*, *lithers*, they have free interactions between themselves. This dispels fear that one could not have in the company of others. As such, it increases right health information seeking attitudes and practices.

- *A coordinated multi-actor approach enhances quality assurance and resource efficiency.* Through partnership with local government, PLWA, other CBOs, LAIP was able to gain procurement subsidy of TBA equipments; adequate supplies of condoms; low cost support for VCT provision; quality assurance in training design and execution; stakeholder monitoring; experience sharing with other actors; and exposure to current best practices.

- *Effective community empowerment occurs when they are involved in the entire project cycle.* For a project to belong to the people they must be at its forefront. The involvement of the local community – project beneficiary – is thus cardinal. Winning people's participation requires commitment to their 'full' participation. People's views need to be listened to; their livelihood practices such as work time respected; and a motivator provided to reduce the usual 'opportunity cost' way with which community activities are seen. Thus implementing agencies needs to provide a coordinating role and capacity building of local actors so that the people take in their hands what to do. This requires joint planning, implementation and monitoring with utmost transparency and accountability. It also facilitates accounting for work done; and periodic learning as challenges are identified, discussed and appropriate strategies adopted.

- *Local capacity building is a basis for sustainability.* Sustainability can be attained by building local capacity to effectively undertake in project implementation. Existing local organizations need to be strengthened and/or new ones formed to ensure that they take over the different aspects of the project and execute them in their locally compatible strategies. This prepares room for project downscaling in the operational area while presenting exit opportunity. It also ensures that the implementing agency can comfortably upscale into other areas without degenerating effects where it has been.

- *HIV/AIDS is broader than a sectoral focus.* While at the start it was apparent that HIV/AIDS is entirely a medical case, now it is clear that it is also a social and economic problem. The lifestyle of the people is cardinal in promoting or curtailing it. So, AIDS cannot be treated in

isolation from the broader poverty issues. This calls for a multi-dimensional approach. For instance, awareness creation can not be divorced from livelihood security. By ignoring income generation required for an improved livelihood PLWA remain unable to improve their nutrition; women remain exploited through sex demand for gaining access to buying fish; *malayas* retain survival in sex trade; and OVCs perpetually remain excluded from gaining access to life chance improving services. Thus, interventions using a single approach are unviable. There is, therefore, need to integrate prevention and mitigation so that synergies are built between controlling spread without falling as paupers dispensated with community stigmatization. For instance, a mere knowledge about HIV/AIDS without the ability to shun its mode of transmission that may be a source of income still makes the people vulnerable.

- *Participatory monitoring renders project logframe ineffective but put beneficiaries knowledge and practices at the forefront.* Outcome monitoring conducted in a participatory manner is the best alternative to ensure process and impact evaluation. In this way, a merger is built between various interests that resides in various stakeholders hence opportunity for 'power dialogue' is established. Clients' post-hoc indicators for change also promote organizational learning beyond the linear logframe approach.

- *Change as a process takes time.* It takes time for people to openly declare their sero-status. Testing services alone is not adequate but regular rapport building with the community increases the chance of trust upon which individual-to-individual counseling starts hence public and self confidence to declare one's sero-status and support initiatives to prevent farther spread.

- *Transparent project accountability to beneficiaries promotes local actors energies to work for their destiny.* Effective communication about a project activities, limitations, and funds help build working hand-in-hand with the community. Regular meetings, reviews, and field spot checks provide a basis to ensure that implementation is smooth, fears are allayed, and that the image of the project remains as clear and clean as possible. It also demonstrates managers' commitment and this beckon other community members to emulate.

8.0 CONCLUSION AND RECOMMENDATIONS

Overall the performance of LAIP in the one year has been successful. The project has rightly fitted within the national, and district HIV/AIDS policies, community needs and AFARD vision. It is being implemented with viable strategies; in a timely programming manner whereby all planned targets are being met and even where adjustments have been made the success rate is high. Such a high achievement is also reflected in efficient resource utilization. The project beneficiaries are applauding it and are conscious of the contributions it is making especially in widening the KAP and social support to the fight against HIV/AIDS in the community.

However, with the path to sustainability has been set most of the local structures established are non viable to operate on their own in the long run. This compounded to externally factored challenges to implementation sets back the successes scored and calls for broadening of approach to the fight against HIV/AIDS in Dei.

In this regard, given the challenges and lessons learnt, it is important that at LAIP (the project) level:

- LAIP continue with the BCC strategy and focus on strategic information packaging. This would require that communication information are customized to file the pertinent gaps identified like those related to modes of prevention, support services, and assaulting

predisposing factors that continue to persist in the community. The information delivery focus on specific categories is still vital to be pursued.

- The PTC needs strengthening in its leadership, operation, and its activities widened. Cross-sharing with fellow PLWA groups for joint counseling sessions; securing positive living skills; preparing PLWA legally through inheritance and will writing and memory book; and training care takers in infection and stress management skills will be vital initiatives to increase impacts.

- OVC project scope be increased. Fishing alone cannot generate adequate income. Besides, by targeting in-school OVCs those out of school are still left at the mercy of their patrons who exploit them at will thereby subjecting OVCs to life risking activities that may eventually expose them to infections.

- Livelihood security in the community is built. This can be done by promoting livelihood diversification away from fishing and fish processing. With signs of off-water activities paying to those involved in them, microenterprise development can be a promising entry point.

- The concept of safe health need to be broadened into building a Healthy Dei Community beyond HIV/AIDS safety. This will call for supporting VCT and sanitation components. In this way, support services to HIV/AIDS campaign will be availed while the notable cause to high disease burden will be reduced.

- Local institutions and structures especially of PTC and drama groups are strengthened so that they grow into sustainable groups. OD assessment and group dynamic trainings should be conducted. Better self-income generating activities should also be explored because a group without own fund is either parasitic on its members or is donor dependant without its own pride and safety.

- The magnitude of the problem in the neighboring Singla is a manifestation of the bigger and pending AIDS scourge in the fisher communities as is called for by the LC III Chairman. AFARD need to explore opportunities for upscalling. This should be targeting both Dei where reinfection problems are eminent and in the Dei neighborhood so that a positive KAP is established.

Annex 1: Individual Knowledge, Attitude and Practice Survey Questionnaire

Basic Information about respondents

Village	Parish	Sub county	District

BIO DATA OF RESPONDENTS

1. Sex (tick appropriate)	M	F
2. Age (Approx. whole number)		

3. Educational status (tick)	None	Primary	secondary		Post-Secondary Institutions	
4. Marital status	Formal marriage		Cohabiting	Single	Widow	Widower

5. Main type of economic activity (Tick the applicable one(s))	Peasant	Fishing	Fish mongering	Shop-keeping	Brewing / selling alcohol	Commercial sex work	Civil servant	Others (specify)

6. Geographic Origin	Indigenous to the village	Immigrant (from other country)	Voluntarily internally relocated from other part of Uganda	Internally Displaced Person (IDP) due to conflict	
7. Ethnic Origin	Alur	Lugbara	Acholi	Mugungu	Others (specify)

KNOWLEDGE

Knowledge of HIV Causation, Transmission and Clinical Presentation

1. Have you heard about HIV/AIDS? Y/N /___/

2. If "Yes" from what primary source did you hear about HIV/AIDS?

Radio	Print media	PECs/VHW	Others (specify)

3. What is HIV ?

A germ	A bad omen	Normal sickness	Bad air originating from witchcraft	Others (specify)

4. State 3 main ways by which HIV/AIDS is transmitted or may be acquired from one person to the other? (Mark "Y" for yes and "N" for No as applicable for each of them)

From infected pregnant mother to the unborn baby	
From infected mother to baby through breast feeding	

Use of unsterile materials like needles for injection, razor blade, kwasi, etc	
Contamination of open wound with secretion from an infected person	
Sexual intercourse with an infected person	

5. State 3 symptoms of HIV/AIDS(Mark "Y" for yes and "N" for No as applicable for each of them)

Marked weight loss (technically >10% within months or less than a year	
Persistent fever	
Persistent Cough (>/= a month)	
Generalised skin rashes (including Herpes Zoster)	
Generalised enlargement of lymphnodes	
Oral thrush	
Recurrent diarrhea	

6. What primary thing in your opinion is causing people to get HIV infection in your community?
   a. …….

Knowledge of Prevention and Mitigation methods and services

7. How can you prevent acquiring or transmitting HIV? (Mark "Y" for yes and "N" for No as applicable for each of them)

Abstaining from sex especially if not married	
Being sexually faithful to one's marital partner	
Cleaning oneself soon after sexual intercourse	
Use of condom during sexual intercourse with a person whose status in unknown or a non-marital partner	
Use of contraceptive pills	
Testing and knowing your status	
Avoiding use of contaminated instruments like needles, razors	
Avoiding "medical" injections from untrained persons	
Not sharing latrines	
Using screened blood	

8. State 3 ways by which any PLWAs can adopt to live positively? (Mark "Y" for yes and "N" for No as applicable for each of them)

Accepting to live openly among other people without hiding his/her status	
Eating well (nutritious and well balanced diet)	
Being faithful to ones partner	
Avoiding infecting other people	
Carrying out income generating activities and planning for the future	
Seeking advice and counseling	
Treating opportunistic infections promptly	
Avoiding risky behavior like drinking, smoking	
Using condoms whenever having sex with a partner	

9. State 3 available services that are essential for HIV/AIDS prevention and mitigation. (Mark "Y" for yes and "N" for No as applicable for each of them)

Voluntary Counseling and Testing (VCT)	
Prevention of Mother-to-Child Transmission (during pregnancy)	
Skills training for Income Generation	
Life Skills training	
Orphaned and Vulnerable Children's Skills and Rights training	
Safe motherhood services in health facilities and through trained TBAs	
Community Awareness Programmes	

10. Have you heard of VCT? (Tick) Y/N
11. What was your primary source of information?

Radio	Print media	PECs/VHW	Others (specify)

12. Have you tested yourself? (Tick) Y/N
13. If not, why? ……..

ATTITUDE

Attitude towards HIV and its prevention

14. Do you think HIV/AIDS truly exist or it is all a lie?
    a. HIV/AIDS Exist
    b. HIV/AIDS is just a lie
15. What do you think about the risk of contracting HIV through unprotected sex with multiple partners?
    a. There is no problem
    b. It is risky but the risk is being exaggerated by those who fear sex and others for their own reasons
    c. It is very risky

16. What do you think about an unmarried person who abstains from sex or a married person who faithfully maintains one steady sexual partner
    a. They are psychologically not normal
    b. They are missing something great
    c. They are doing the right thing
    d. Accumulated sexual inhibition may kill them

17. If you discover you are infected with HIV what will you do to other people?
    a. Infect as many as possible
    b. Avoid infecting others

***Attitude and practice towards* prevention / mitigation / Care**

18. Are you willing to: (Mark "Y" for yes and "N" for No as applicable for each of them)

Test for HIV/AIDS?	
Care for PHAs?	
Care for OVC?	
Buy products from PHAs?	
Encourage a family member with HIV/AIDS to confess his/her status	
Share food with a person having HIV/AIDS?	
Greet someone you know have HIV/AIDS?	
Voluntarily sit next to someone you know have HIV/AIDS?	

19. What do you suggest should be done to persons having HIV? (Mark "Y" for yes and "N" for No as applicable for each of them)

Isolated?	
Allow them to die faster?	
Provided treatment and support them to live longer and better life?	
Supported through counseling to live positively?	
Publicized so that people avoid having sexual contact with them?	

BEHAVIOUR

Risky Behaviour leading to transmission

20. How many steady sexual partners did you have in the last one year?

One	Two	Three or more

21. Did you have sex in the last 1 month? Y/N /___/

22. What was the age of the last partner? /_____/
23. If answer to 12 is yes, was it with a steady sexual partner? Y/N /___/
24. Did you use a condom in that sexual act? /___/
25. If not, what was the main reason?
    a. The partner refused
    b. I dislike Condoms
    c. Use of condom is a sign of prostitution
    d. There was no condom available
    e. Use of condom is against my moral or religious belief
26. Was cash or in-kind payment involved? Y/N /____/
27. Did you contract a sexually transmitted infection in the last 1 year? Y/N /___/

Behaviours that predispose to acquiring or transmitting HIV infection.

28. What is the situation about the following practices in your village?

28.1 Use of unsterile instruments for injection and scarification e.g. syringes, needles and razor blades
    a. Has never existed here
    b. Reduced in the last one year
    c. Increased in the last one year
    d. Remained the same in the last one year

28.2 Going to night discos and / or drinking places
    A. Has never existed here
    B. Reduced in the last one year
    C. Increased in the last one year
    D. Remained the same in the last one year

28.3 Attendance of night video shows by girls
    A. Has never existed here
    B. Reduced in the last one year
    C. Increased in the last one year
    D. Remained the same in the last one year

Assessing beneficiary opinion of LAIP

1. What impression have you got about the trend of HIV/AIDS in your village in the last one year?
    A. Increasing
    B. Reducing
    C. Unchanged
    D. Not clear

For those in Dei Fishing Village

2. State one primary positive change that LAIP has caused in Dei community in the last one year?

A:……

3. State one core thing LAIP is not doing right?

……
……

4. What remedy do you propose to these challenges?

……
……
……

Annex 2: Respondent Characteristics

Themes	Core variables	Cluster variables	LAIP site	Non-project site	Total
Demographic indicators	Sex	Males	70.3%	61.0%	65.6%
		Females	29.7%	39.0%	34.4%
		Total	**100.0%**	**100.0%**	**100.0%**
	Age group	Children (Under 18 years)	9.5%	3.9%	6.6%
		Young adults (18-29 years)	58.1%	51.9%	55.0%
		Mature adults (>29 years)	32.4%	44.2%	38.4%
		Total	**100.0%**	**100.0%**	**100.0%**
	Education	None	17.6%	13.0%	15.2%
		Primary education	68.9%	63.6%	66.2%
		Secondary education	13.5%	20.8%	17.2%
		Post secondary education		2.6%	1.3%
		Total	**100.0%**	**100.0%**	**100.0%**
	Marital status	Formally married	10.8%	67.5%	39.7%
		Cohabiting	48.6%	11.7%	29.8%
		Single	36.5%	19.5%	27.8%
		Widow/Widower	1.4%		.7%
		Divorced/separated	2.7%	1.3%	2.0%
		Total	**100.0%**	**100.0%**	**100.0%**
	Main occupation	Fishing	52.7%	61.0%	57.0%
		Farming	13.5%	15.6%	14.6%
		Fish mongering	6.8%	13.0%	9.9%
		Shop-keeping	4.1%		2.0%
		Brewing/Sales of alcohol	6.8%	3.9%	5.3%
		Commercial sex work		2.6%	1.3%
		Others	16.2%	3.9%	9.9%
		Total	**100.0%**	**100.0%**	**100.0%**
	Geographic origin	Indigenous to village	98.6%	67.5%	82.8%
		Immigrant from other country		5.2%	2.6%
		Voluntarily internally relocated from other parts of Uganda	1.4%	27.3%	14.6%
		Total	**100.0%**	**100.0%**	**100.0%**
	Ethnic origin	Alur	98.6%	83.1%	90.7%
		Acholi		2.6%	1.3%
		Mugungu	1.4%	10.4%	6.0%
		Others		3.9%	2.0%
		Total	**100.0%**	**100.0%**	**100.0%**

Annex 3: Number of steady sexual partners

Age	Sex	No. of steady sexual partners	Research site		Total
			LAIP site	Non-project site	
Children (Under 18 years)	Males	1.00	100.0%	100.0%	100.0%
		Total	100.0%	100.0%	100.0%
	Females	1.00	50.0%	100.0%	66.7%
		2.00	50.0%		33.3%
		Total	100.0%	100.0%	100.0%
Young adults (18-29 years)	Males	1.00	75.0%	81.3%	77.3%
		2.00	17.9%	12.5%	15.9%
		3.00	7.1%	6.3%	6.8%

		Total	100.0%	100.0%	100.0%
	Females	1.00	90.9%	90.9%	90.9%
		2.00		9.1%	4.5%
		3.00	9.1%		4.5%
		Total	100.0%	100.0%	100.0%
Mature adults (>29 years)	Males	1.00	58.8%	30.0%	48.1%
		2.00	17.6%	50.0%	29.6%
		3.00	23.5%	20.0%	22.2%
		Total	100.0%	100.0%	100.0%
	Females	1.00	60.0%	75.0%	69.2%
		3.00	40.0%	25.0%	30.8%
		Total	100.0%	100.0%	100.0%

Annex 4: Age of partners had sex with

Age	Sex	Age of sexual partner involved	Research site		Total
			LAIP site	Non-project site	
Children (Under 18 years)	Males	Children (Under 18 years)	100.0%	100.0%	100.0%
		Total	100.0%	100.0%	100.0%
	Females	Young adults (18-29 years)		100.0%	100.0%
		Total		100.0%	100.0%
Young adults (18-29 years)	Males	Children (Under 18 years)	23.8%	21.1%	22.5%
		Young adults (18-29 years)	76.2%	68.4%	72.5%
		Mature adults (>29 years)		10.5%	5.0%
		Total	100.0%	100.0%	100.0%
	Females	Children (Under 18 years)	11.1%	-	4.2%
		Young adults (18-29 years)	55.6%	60.0%	58.3%
		Mature adults (>29 years)	33.3%	40.0%	37.5%
		Total	100.0%	100.0%	100.0%
Mature adults (>29 years)	Males	Children (Under 18 years)	7.1%	-	3.0%
		Young adults (18-29 years)	42.9%	31.6%	36.4%
		Mature adults (>29 years)	50.0%	68.4%	60.6%
		Total	100.0%	100.0%	100.0%
	Females	Young adults (18-29 years)	25.0%	-	6.7%
		Mature adults (>29 years)	75.0%	100.0%	93.3%
		Total	100.0%	100.0%	100.0%

Annex 5: Paid for sexual intercourse

Age	Sex	Research site	
		LAIP site	Non-project site
Children (Under 18 years)	Males	100.0%	-
	Females	-	50.0%
Young adults (18-29 years)	Males	54.5%	40.0%

	Females	22.2%	30.8%
Mature adults (>29 years)	Males	15.4%	15.0%
	Females	-	25.0%

Annex 6: Used condom in sexual intercourse

Age	Sex	Condom used in sexual encounter	Research site		Total
			LAIP site	Non-project site	
Children (Under 18 years)	Males	Yes	100.0%	-	50.0%
		No	-	100.0%	50.0%
		Total	100.0%	100.0%	100.0%
	Females	No	100.0%	100.0%	100.0%
		Total	100.0%	100.0%	100.0%
Young adults (18-29 years)	Males	Yes	33.3%	38.1%	35.7%
		No	66.7%	61.9%	64.3%
		Total	100.0%	100.0%	100.0%
	Females	Yes	11.1%	12.5%	12.0%
		No	88.9%	87.5%	88.0%
		Total	100.0%	100.0%	100.0%
Mature adults (>29 years)	Males	Yes	-	19.0%	11.4%
		No	100.0%	81.0%	88.6%
		Total	100.0%	100.0%	100.0%
	Females	Yes	25.0%	10.0%	14.3%
		No	75.0%	90.0%	85.7%
		Total	100.0%	100.0%	100.0%