



Baseline Survey Report

The Knowledge, Attitude and Practices Related to HIV/AIDS Prevention and Mitigation among Fishing Communities in Nebbi District



Conducted by:

Dr. Alfred Lakwo

Agency For Accelerated Regional Development (AFARD), Nebbbi

Funded by:

Civil Society Fund (RFA08-001)

Uganda AIDS Commission, Kampala

May 19, 2008

ACKNOWLEDGEMENT

This study was conducted under the Community Development Management - Well-being Security theme. It was funded by part of the grant received from Civil Society Fund (RFA 08-001) for Fisher Community Anti-AIDS Project (FiCAP).

The Agency For Accelerated Regional Development (AFARD) is grateful for the efforts invested in discussing the data collection framework by various health practitioners from Nebbi Catholic Diocese and Jonam Health Sub-district. And to all the people who collected the field data especially Blaimo Kennedy, Naima Oyoma, Muber Juliet, Arombo Jeska, Onwang Salva, Watumbe O. Loius, Orochi Cons, Akumu Christine, Keuber Susan, and Unytha Stephe and the data entry clerks: Kemiss O. Pimundu, and Oyenboth Scovia, we are thankful.

Lastly, we also appreciate the active participation of the entire Panyimur community for willingly providing the information and to the Peer Educators-cum-Counselors for participating in the feedback meeting that shaped this report.

AFARD, however, takes full responsibility for the views and errors expressed herein.

Dr. Alfred Lakwo
Programme Director

ACRONYMS

AFARD	=	Agency For Accelerated Regional Development
ARV	=	Anti Retro Viral Infection drug
BCCE	=	Behavior Change Communication and Education
FiCAP	=	Fisher Community Anti-AIDS Project
FiYAP	=	Fisher Youth Anti-AIDS Project
IGA	=	Income Generating Activities
OVC	=	Orphans and Vulnerable Children
PECs	=	Peer Educators-cum-Counselors
PLHA	=	Persons Living with HIV/AIDS
PMTCT	=	Prevention of Mother to Child Transmission
VCT	=	Voluntary Testing and Counseling

EXECUTIVE SUMMARY

Introduction

The National Strategic Plan for HIV/AIDS 2007-2012 recognizes that Uganda has had an unprecedented reduction in the prevalence of HIV from 18% to 6.7%. However, sexual transmission remains the largest (76%) cause for new infection that is estimated at 3.2% per annum. Thus, the prevention of further HIV infection should target reduction of high risk sex especially among the high risk population like fishing communities.

The 2-year Fisher Community Anti-AIDS Project (FiCAP), funded by Civil Society Fund through Uganda Aids Commission and implemented by AFARD, therefore, aims at *"contributing to the reduction of sexual transmission of HIV among fishing communities in Panyimur Sub-County, Jonam County, Nebbi District"*.

Objectives and methodology of the baseline study

This baseline study aimed at:

1. Establishing the Knowledge, Attitude and Practice (KAP) status for periodic monitoring and evaluation purposes.
2. Identifying vital KAP gaps for designing local context responsive Behaviour Change Communication and Education (BCCE) intervention strategies.

In order to collect relevant data to meet the above objectives, **individual interview survey** was conducted among 503 respondents who were randomly and purposely sampled from the various social categories in the various villages in the entire landing sites in Panyimur Sub-County. **Community feedback meeting** was then held with the PECs wherein in-depth discussions and practical intervention options were identified, analyzed and prioritized.

Summary of findings

The study findings on key KAP status are summarised below:

- 93.0% of the population had heard about HIV/AIDS.
- The level of comprehensive knowledge about HIV/AIDS varied with those who ably mentioned at least 3 HIV/AIDS: modes of transmission (50.5%), symptoms (75.3%),

modes of prevention (55.7%), attributes to positive living (44.9%), and essential prevention/mitigation services (39.6%).

- 52.9% of the population had no source of information about sex while 24.9% largely depended on peers as a source of information about sex.
- Sexual activity was high as only 41.2% had never ever engaged in sexual intercourse. The median age at first sex was 16 years and that of current sexual partners was only 14 years.
- Willful (96%), forceful (4%), multiple (20%), casual (37%) including with married couples (37%), cross-generational (49%), and transactional (23%) sexual relations were common practices.
- While 81.3% had heard about condoms, only 53.3% used condoms and 36.8% consistently used it in their last sexual intercourse. The condoms were accessed mainly from shops/lodges (41.2%). Condom use was mainly self-initiated (69.5%), and used condoms were disposed off mainly in latrines (80.1%)
- Myths about HIV/AIDS were found among 5% of the population and stigmatization of PLHA was common place. Likewise, many people were still engaged in practices that predispose them to HIV infection.
- Finally, the population expected from FiCAP more than just awareness creation (25%) and condom use promotion (3%). They also want access to VCT services (26%) and ARV services (13%) besides economic empowerment (14%) and OVC support (7%).

Conclusions

From the study findings it is evident that:

- Generally, many people have heard about HIV/AIDS although comprehensive knowledge about HIV/AIDS transmission, symptoms, prevention, mitigation and support services are low and varied by age and sex.
- Sexual activity with willfully, many, and casual sexual partners is common practice. Laden with limited sources of information about sexuality and norms that accept sexual promiscuity as well as a high prevalence of cross-generational and transactional sexual practices, sex will continue to remain a major cause of HIV/AIDS transmission in the area.
- Despite the knowledge about condoms as a HIV/AIDS infection preventive measure, access to and consistent use of condoms are very limited especially among females.
- Attitude that promote stigmatization of PLHA persist.
- Majority of the population are engaged in risky behaviors, other than sexual intercourse, that still predisposes them to infection.
- The community expects FICAP to provide BCCE together with health services outreach and economic empowerment.

Recommendations

To address the above issues raised, aware of the project confines, it is prudent for AFARD to:

- Customize BCCE to the needs of the various social groups while ensuring equality is built in the level of comprehensive knowledge in the population.
- Apart from promoting peer-to-peer BCCE, strengthen an open door approach for inter-peer learning so that 'wisdom' is shared.
- Link with existing government services in order to promote access to VCT and ARV services and where possible to facilitate either community-facility dialogue for services responsiveness to be achieved or directly support such services outreach.
- Adopt peer approach to condom access promotion while at the same time build condom use negotiation skills particularly among females.
- Explore community care and support system in order to promote economic empowerment requisite for the continued support of OVCs and PLHA.

TABLE OF CONTENTS

ACKNOWLEDGEMENT	1
ACRONYMS	2
EXECUTIVE SUMMARY	3
LIST OF TABLES AND FIGURES	8
1 INTRODUCTION	9
1.1 Introduction	9
1.2 HIV/AIDS Status and Prevention in Uganda	9
1.3 About Fisher Community Anti-AIDS Project (FiCAP)	10
2 OBJECTIVES AND METHODOLOGY	11
2.1 Introduction	11
2.2 Why the study	11
2.3 The study objectives	11
2.4 Methodology	11
2.5 The study population	12
2.6 Report structure	13
3 KNOWLEDGE OF HIV/AIDS	14
3.1 Summary of findings on knowledge of HIV/AIDS	14
3.2 Facts and sources of information about HIV/AIDS	14
3.3 Knowledge about modes of transmission	16
3.4 Perceived main catalyst of transmission	17
3.5 Symptoms of HIV/AIDS	18
3.6 Prevention of HIV/AIDS	1
3.7 PLHA mitigation methods	17
3.8 Prevention and mitigation services	17
3.9 Voluntary Counseling and Testing services	18
4 SEXUAL PRACTICES	20
4.1 Summary of findings about sexual practices	20
4.2 Open discussion about sex	20
4.3 Sexual norms	21
4.4 Sexual engagement	22
4.5 Intergenerational sex practices	22
4.6 Transactional sexual practices	23

5 PERCEPTIONS AND USE OF CONDOMS	24
5.1 Summary of findings on perception and use of condoms	24
5.2 Access to and use of condoms.....	24
5.3 Why condoms was not used	25
6 ATTITUDE AND PRACTICES TOWARDS HIV/AIDS PREVENTION AND MITIGATION	27
6.1 Summary findings on attitude and practices for HIV/AIDS prevention	27
6.2 Acceptance of HIV/AIDS	27
6.3 Attitude toward PLHA	27
6.4 Predisposing behaviors.....	28
7 ENVISAGED CHANGES FROM FICAP	29
8 CONCLUSIONS AND RECOMMENDATIONS.....	30
8.1 Conclusions	30
8.2 Recommendations.....	30
Annex 1: Respondents characteristics (%)	31

LIST OF TABLES AND FIGURES

Table 1:	Comprehensive knowledge of HIV/AIDS by population groups (%).....	14
Table 2:	Heard of HIV/AIDS by population groups (%)	14
Table 3:	Knowledge of HIV/AIDS modes of transmission by population groups (%).....	16
Table 4:	Knowledge of symptoms of HIV/AIDS by population groups (%)	18
Table 5:	Knowledge of ways of HIV/AIDS prevention by population groups (%).....	1
Table 6:	PLHA mitigation mechanisms (%).....	17
Table 7:	Knowledge of HIV/AIDS mitigation services by population groups (%).....	18
Table 8:	VCT knowledge and practices (%)	19
Table 9:	Agreed to sexual norms and practices	21
Table 10:	Past and present sexual practices (%).....	22
Table 11:	Age of respondents who had sex last month by age of sex partner	23
Table 12:	Value of payments made (%)	23
Table 13:	Common condom practices	24
Figure 1:	Sources of HIV/AIDS information (%).....	15
Figure 2:	Modes of HIV/AIDS transmission (%)	16
Figure 3:	Main predisposing factors to HIV/AIDS infection.....	17
Figure 4:	Symptoms of HIV/AIDS infection (%).....	18
Figure 5:	Prevention of acquisition/transmission of HIV/AIDS (%)	1
Figure 6:	Prevention and mitigation services (%)	18
Figure 7:	Current and preferred sources of information about sex (%)	21
Figure 8:	Main sources of condoms (%).....	25
Figure 9:	Why not use condoms (%)	25
Figure 10:	Care and support for persons affected/infected by HIV/AIDS (%)	28
Figure 11:	Engagement in risky practices (%).....	28
Figure 12:	Expected changes from FiCAP	29

1 INTRODUCTION

1.1 Introduction

This section provides background information about the project. It starts by positioning the project within the national HIV/AIDS prevention framework and concludes by presenting the on-the-ground justification for the project intervention as well as the project focus.

1.2 HIV/AIDS Status and Prevention in Uganda

The National Strategic Plan for HIV/AIDS 2007-2012 recognizes that Uganda has had an unprecedented reduction in the prevalence of HIV from 18% to 6.7%. However, the rate has stagnated between 6.5% and 6.1% over the last 4 years with significant geographic (regional and rural-urban), gender and age variations.¹ The final report of the Uganda HIV Sero-behavioral Survey (UHSBS) conducted in 2004-5 notes that there is marked prevalence among those aged 15-49 years at 6.4% (7.5% for women and 5.0% for men).² Sexual transmission, however, remains the largest (76%) cause for new infection that is estimated at 3.2% per annum.

Fishing communities like on L. Albert in Nebbi District still remain prone to such risks of infection given their vulnerability and marginalization. The DFID study (2004) confirmed that fishing communities have high susceptibility to HIV/AIDS infection; high transmission and re-infection within and between communities; and increased vulnerability to the impact of infections.³ Thus, the prevention of further HIV infection should importantly target new infections by high risk sex especially among the high risk population.⁴

¹ Uganda AIDS Commission (November 2004). *The Uganda AIDS Status Report 2004*. Kampala.

² Ministry of Health (MOH) [Uganda] and ORC Macro. 2006. *Uganda HIV/AIDS sero-behavioral survey 2004-05*. Calverton, Maryland, USA: MOH and ORC Macro.

³ See Grellier, R, Tarzan, N, Lamberts, D, and Howard, C (October 2004). *The Impact of HIV/AIDS on Fishing Communities in Uganda. Situation Analysis*. MRAG and Options DFID (CNTR 035256). See also Orach, O.S., Cwinyai, W., and Lakwo, A. (May 2003). *Study Report on the Knowledge, Attitude and Practice concerning HIV/AIDS in Dei Fishing Village, Panyimur Sub county, Nebbi District. A Rapid Assessment of Need for Intervention*. AFARD. (see www.afard.net)

⁴ See Uganda AIDS Commission (2007) *Moving Towards Universal Access: National HIV & AIDS Strategic Plan for 2007/08 -2011/12*. Uganda AIDS Commission, Republic of Uganda (p.8-9, 13); Ministry of Health (2007) *Health Sector HIV & AIDS Strategic Plan 2007-2010*, Kampala (p.2).

1.3 About Fisher Community Anti-AIDS Project (FiCAP)

Panyimur sub county, located on Lake Albert, was found to be a high risk area given that the presence of weekly fish market in it attracts people from Southern Sudan, Democratic Republic of Congo, and the Ugandan districts of Gulu, Bulisa, Hoima and Masindi. Mobile traders (men and women alike) who come to the market are willing and able to pay for sex. As a result, there is rampant, transactional, intergenerational and high risk (unprotected) sex⁵ that all predispose the people (especially young people) to a high HIV infection.

No doubt, findings from the VCT services in Jonam County indicate that VCT attendance positivity rate stands at 20-30%. Although it can be said that such a rate is because those seeking VCT services are already suspecting a confirmatory sero-positive status, still it reveals the high potential 'HIV time bomb' this population is carrying.

The FiCAP, funded by Civil Society Fund and implemented by AFARD, therefore, aims at undertaking an intensive behavior change communication and education (BCCE) by promoting abstinence among youths who have not yet been initiated into sex and safer sex practices and fidelity among those already sexually active.

By so doing, FiCAP's goal is *"to contribute to the reduction of sexual transmission of HIV among fishing communities in Panyimur sub county, Jonam county, Nebbi district"* through specifically the objectives of:

1. Establishing and motivating a cadre of local people capable of sustaining efforts to prevent HIV spread.
2. Promoting positive behavior changes (especially sexual practices).
3. Increasing correct and consistent condom use

Within its two-year duration, FiCAP is (by design) expected to change the current negative sexual practices among fisher communities in order for the infection rates particularly from sexual transmission to be curtailed.

However, the exiting sexual practices as well as the knowledge, attitude and practices requisite for a positive behavior change in the fishing community are not known. That is why this study was conducted. The next section therefore dwells on explaining why and how of the study.

⁵ See Nebbi District Local Government (2004) *HIV/AIDS Strategic Plan 2004-2008*. Nebbi; and Lakwo, A., Orach O. S., and Cwinyaii, W. (November 2005) *A Path Worth Walking! Lakeshore AIDS Initiative Project (LAIP): Annual Internal Review Report*. AFARD (At: www.afard.net).

2 OBJECTIVES AND METHODOLOGY

2.1 Introduction

In this section, the justification, objectives, and the methodology used in conducting the baseline study are presented. And the demographic characteristics of the study population is analysed.

2.2 Why the study

The design of FiCAP was at a time when AFARD was closing its Irish Aid funded Fisher Youth Anti-AIDS Project (FiYAP). Due to lack of funds, no terminal evaluation of FiYAP was conducted. By implication, the design of FiCAP was therefore dependent on anecdotal data, which unfortunately could not present an entire picture of HIV/AIDS Knowledge, Attitude and Practice (KAP) in Panyimur sub county. This study was therefore conducted to bridge this knowledge gap.

2.3 The study objectives

This baseline study aimed at:

1. Establishing a KAP status for periodic monitoring and evaluation purposes.
2. Identifying vital KAP gaps for designing local context responsive BCCE intervention strategies. This is because a positive KAP promotion should build on existing community knowledge.

2.4 Methodology

In order to collect relevant data to meet the above objectives, five questions were asked:

- (a) To what extent are facts about HIV/AIDS known in the project area? The focus herein was to find out the level of knowledge of basic information about HIV/AIDS transmission, symptoms, prevention, and mitigation measures.
- (b) In what ways are sexual practices prevalent and risky in the community? This question sought to enlist the norms and practices relating to sexual engagement.
- (c) How are condom use perceived and adopted? This question linked to (b) above to explore how safe sexual practices were. It also sought to explore condom management systems.
- (d) How attitudes and practices are the people exhibiting to prevent and mitigate HIV/AIDS spread? Herein attention was given to exploring the willingness of the people

to actively engage with Persons Living with HIV/AIDS (PLHA) in order to promote positive living.

(e) What are the expectations of the community from FiCAP? This last question sought to understand the plausible expected impacts of FiCAP for the project to be relevant.

- **Individual interview survey** was conducted using open ended questions administered by trained enumerators to respondents who were randomly and purposely sampled from the various social categories in the various villages in the entire landing sites in Panyimur sub county.
- **Community feedback meeting** was held with the PECs wherein the preliminary survey findings were discussed in-depth and practical intervention options identified, analyzed and prioritized.

2.5 The study population

This baseline study covered the entire geographical boundaries of Panyimur sub county. It involved a total of 503 respondents drawn from all the three parishes of Nyakagei (40%), Boro (40%), and Ganda (20%). Of these (for details see annex 1);

- 51% were males and 49% females who were 78% indigenous, 91% of Alur ethnicity and 94% Christians.
- The youth constituted 41% of the respondents while parents accounted for only 25%
- 57% were currently married as compared to 43% either single, separated/divorced or widow/widower
- 26% and 58% had no and primary educational attainment respectively.
- 48% were engaged in fishing and 26% in trade as a means of livelihood.

Evident from the above is that fisher communities are composed of:

- More male than female population; a situation that breeds competition for women especially as there is more youth population.
- Multi-cultural population drawn from different social backgrounds that renders the concept of an existing traditional social norm redundant as each group continues to pursue their own social relation practices.
- People who primarily depend on fishing as their main source of livelihoods even though it is mainly the indigenous who diversify their living by also practicing farming.
- Mainly illiterate and semi-literate population whose educational background does not enable them to effectively use written communication channels.

Such a population is very volatile as no one norm guides their social and sexual relations. The economic advantages they have from the daily fish income exposes them to risky sexual relations/behavior as fewer women are rotated among the many men

2.6 Report structure

This report is organized into 8 parts. While part 1 presents the project brief and this part presents the study methodology and population, part 3 focuses on the findings on existing knowledge of basic facts about HIV/AIDS. In part 4 sources of information about sex and existing sexual practices are presented.

While part 5 dwells on the perception and use of condoms in sexual engagement, part 6 focuses on prevailing attitude and practices that can prevent or mitigate HIV/AIDS. Finally part 7 provides information on what the community envisages as vital impacts they should derive from FiCAP and part 8 presents the study conclusions and recommendations.

3 KNOWLEDGE OF HIV/AIDS

3.1 Summary of findings on knowledge of HIV/AIDS

This section presents the findings on the key knowledge about HIV/AIDS transmission, prevention, and mitigation. The focus on knowledge is based on the common premise that positive attitude and practices are based on the knowledge one has. And building positive attitude and practices primarily requires creating a better and relevant knowledge base. Therefore, level of comprehensive knowledge in the community, that is rather low, is summarized in Table 1 below.

Table 1: Comprehensive knowledge of HIV/AIDS by population groups (%)

(Comprehensive) knowledge	Total	Sex		Age group		
		Male	Female	10-14 years	15-24 years	>24 years
Heard of HIV/AIDS	93.0	49.5	43.5	4.6	45.3	43.1
Know at least 3 ways of HIV/AIDS transmission	50.5	27.0	23.5	2.2	25.8	22.5
Know at least 3 symptoms of HIV/AIDS	75.3	42.3	33.0	3.2	35.2	37.0
Know at least 3 ways of HIV/AIDS prevention	55.7	35.4	20.3	3.2	25.6	26.8
Know at least 3 ways of positive living by PLHA	44.9	30.2	14.3	1.0	22.7	20.9
Know at least 3 essential prevention/mitigation services	39.6	20.1	19.5	1.8	18.5	19.3

3.2 Facts and sources of information about HIV/AIDS

Asked whether they had heard about HIV/AIDS and from what source, as Tables 1 shows, 93% reported that they had heard about HIV/AIDS. Of these, more males than females reported having heard of HIV/AIDS. Likewise, as can be seen from Table 2, parents reported having limited knowledge about HIV/AIDS as compared to the youths, nomadic fishermen and single women.

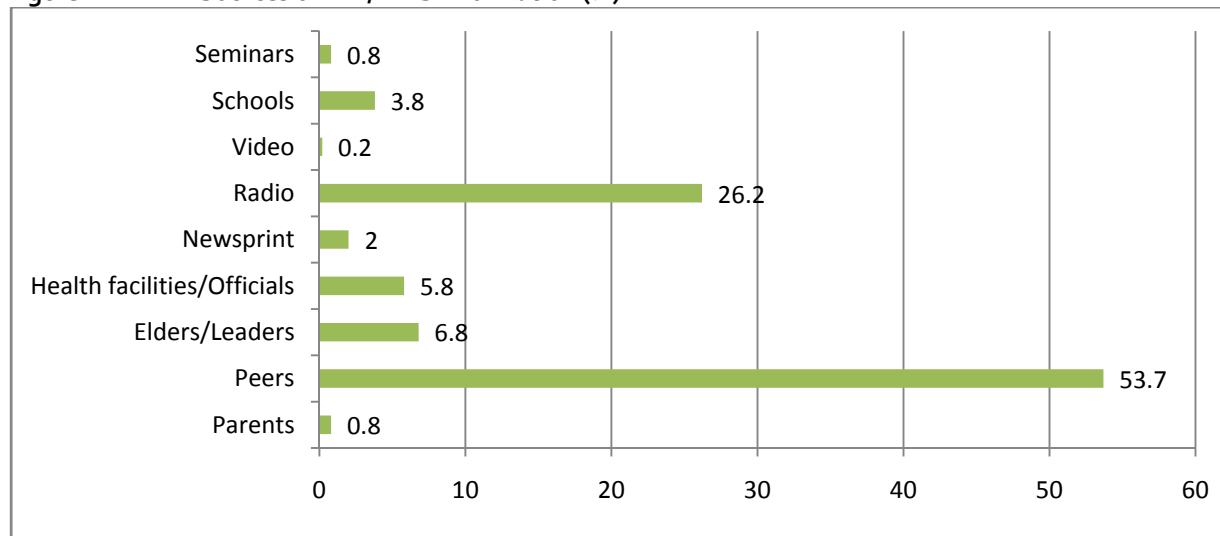
Table 2: Heard of HIV/AIDS by population groups (%)

	Males	Females	Total
Youth	52.4	44.2	96.6
Parents	43.7	43.7	87.3
Community leaders	45.8	45.8	91.7
Traders	46.8	44.7	91.5
<i>Lithers</i> (nomadic fishermen)	87.2	8.5	95.7
<i>Cwara Ngutha</i> (Single women)	-	92.6	92.6

Besides, only 69.8% defined HIV/AIDS as a virus/germ while 21.9% presented myth surrounding AIDS when they pointed out that it is “bad omen” and 8.3% referred to it as “any other normal sickness”.

Overall, the various sources of HIV/AIDS information reported in the community are presented in Figure 1 below.

Figure 1: Sources of HIV/AIDS information (%)



Evident from this figure is that many respondents received their information about HIV/AIDS from their peers (53.7%) and radio (26.2%). It is also evident that seminars (though already considered rampant nowadays) are least used to disseminate information in this area as the Chairman LC 1 of a fishing village noted, *'no one has ever sensitized us about HIV/AIDS'*. Equally parents (aunts and uncles inclusive) are considered to have abdicated their roles of providing (health) education to their children. A PEC pointed that,

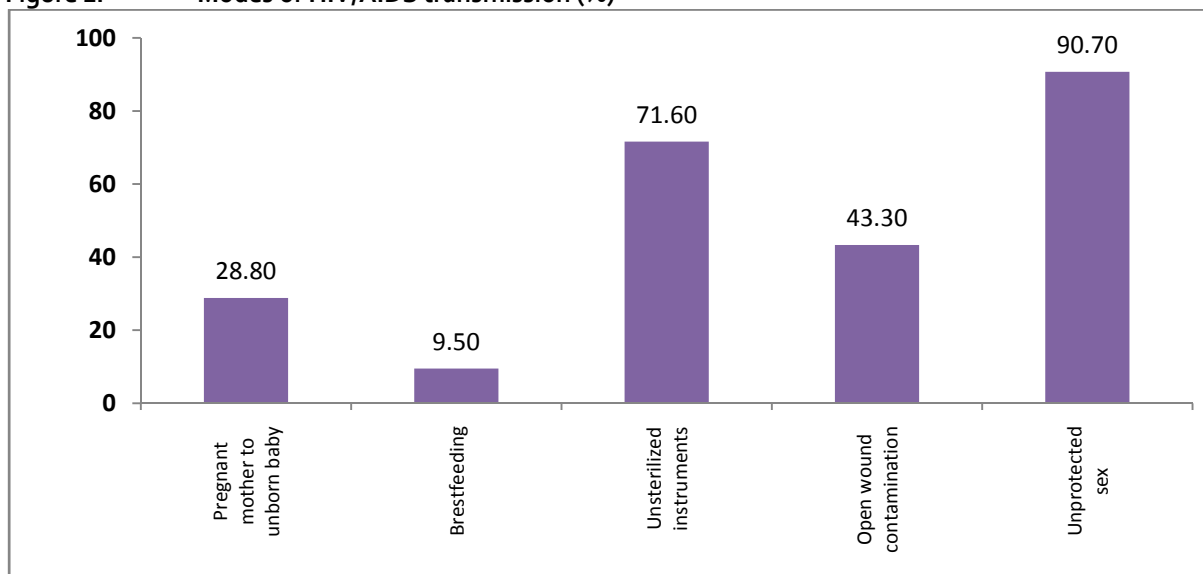
Many parents are busy running after survival needs and are therefore left with no time to sit down their children for a talk on life and its virtues. Such parents are also trapped into having poor communication with their own spouses (where they exist) on issues of sex, AIDS, and positive living'.

The above findings show that first, there is a great need for increasing the awareness about HIV/AIDS in the community. Second and finally it shows that FiCAP can build its work of increasing awareness about HIV/AIDS by complementarily using already existing communication channels as well as new methods that were less used before in the project area.

3.3 Knowledge about modes of transmission

Respondents were also asked to identify the various ways by which HIV/AIDS is transmitted from one person to another. Figure 2 presents a summary of the findings.

Figure 2: Modes of HIV/AIDS transmission (%)



Evident from the figure is that a wider knowledge about transmission due to unsafe sex and use of unsterilized instruments (like safety pins and needles) exist. To the contrary, many people still lack information about mother-to-child transmission be it through breastfeeding or during pregnancy.

However as Table 3 shows, there is a low level of comprehensive knowledge about HIV/AIDS given that only 50.5% ably stated at least 3 ways of transmission. Generally, there is a gender bias in the knowledge about HIV/AIDS as males are more informed than females.

Table 3: Knowledge of HIV/AIDS modes of transmission by population groups (%)

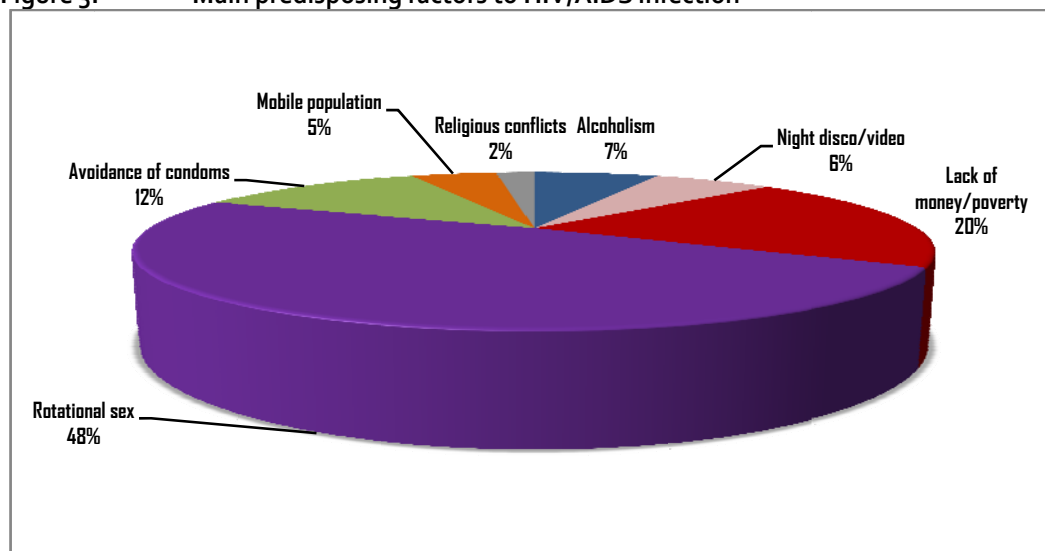
Modes of transmission	Total	Sex		Age group		
		Male	Female	10-14 years	15-24 years	>24 years
Pregnant mother to unborn baby	28.8	11.1	17.7	1.6	13.5	13.7
Breastfeeding	9.5	3.8	5.8	0.4	5.0	4.2
Sharing unsterilized instruments	71.6	39.8	31.8	3.4	34.4	33.8
Contamination by open wounds	43.3	27.0	16.3	3.0	20.9	19.5
Unprotected sex	90.7	46.1	44.5	4.2	42.9	43.5
Knew at least 3 ways of transmission	50.5	27.0	23.5	2.2	25.8	22.5

These two findings have implications on the scope of work FiCAP will have to do but more so in balancing the level of comprehensive knowledge among all modes of transmission. Unchecked, predisposition to infection from mother to child will remain high as it was noted that, *'many women actually did not receive antenatal care services and prefer to deliver at home assisted by Traditional Birth Attendants'*.

3.4 Perceived main catalyst of transmission

In order to get more insights into the predisposing factors to infection, respondents were asked to identify one core catalyst they felt was escalating HIV/AIDS infections in their area. Figure 3 below presents a summary of the responses.

Figure 3: Main predisposing factors to HIV/AIDS infection



In line with the known main modes of infection, it was reported that three main factors namely: rotational sex (48.5%), lack of money/poverty (19.9%), and avoidance of condoms (12.1%) were the main catalysts. However, while males reported that the leading causes of infections are rotational sex (29.8%) followed by alcoholism (5.6%), to the females and youths it was rotational sex (18.7% and 21.3%) and lack of money/poverty (14.9% and 10.1%) respectively.

In the feedback meeting, a female youth reiterated that it is more of *"irresponsible and unsafe sex (with unknown partners) for money that is killing our people otherwise we would be having the lowest prevalence rate of HIV/AIDS"*.

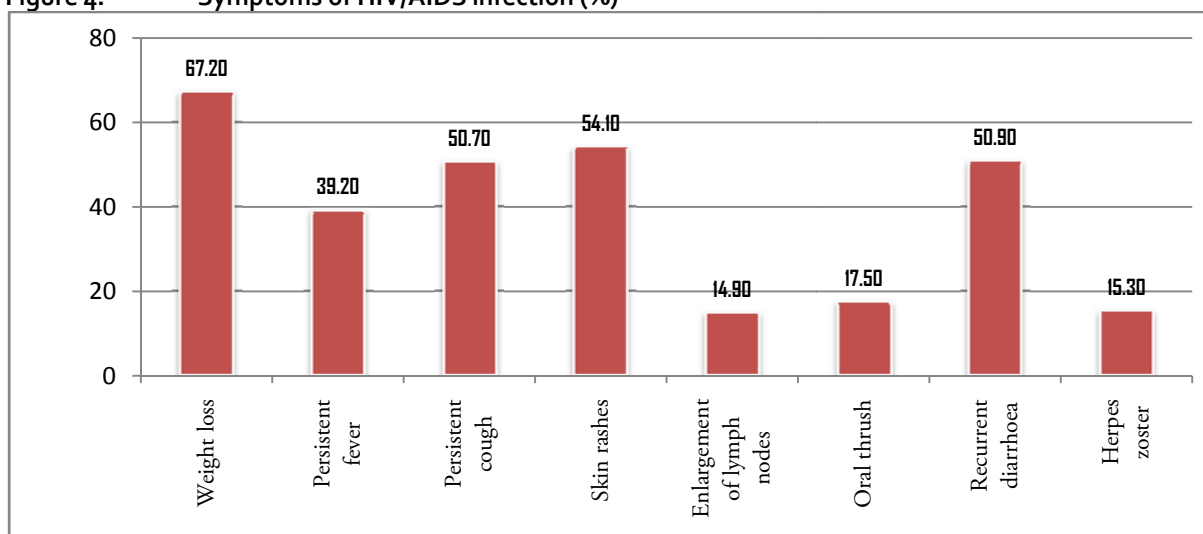
The above finding and assertion confirms the Ministry of Health observation that the persistence of high HIV/AIDS prevalence is due to, among other reasons, behavioral and economic factors. Besides, it shows the strong nexus between HIV/AIDS spread and poverty issues. Thus, it provides a pointer that the fight against HIV/AIDS spread can no longer be accomplished by awareness creation alone but also by enabling vulnerable populations to meet their basic needs.

3.5 Symptoms of HIV/AIDS

Further, respondents were asked to mention the symptoms of HIV/AIDS that they knew. The symptoms they mentioned with ease included weight loss, skin rash, recurrent diarrhea, and persistent cough (see Figure 4). The enlargement of lymph nodes, herpes zoster, oral thrush and persistent fever were less known (cases with less than 50% score).

A member of the PECs wondered thus, 'how can a persistent fever and oral trash be associated with HIV/AIDS when it is a basic sign of malaria that is very prevalent these days?' With such doubts another PEC retorted, 'many people are less concerned whether or not they are infected'.

Figure 4: Symptoms of HIV/AIDS infection (%)



The level of comprehensive knowledge about the symptoms of HIV/AIDS was also found to exist in 3 in 4 people. Table 4 shows that overall 75.3% ably stated at least 3 symptoms of HIV/AIDS in an infected person. The males were also found to know more symptoms of HIV/AIDS than females. The youths 15-24 years also lacked adequate information. But in all sex and age categories the enlargement of the lymph nodes, herpes zoster and oral thrush are least known symptoms of HIV/AIDS.

Table 4: Knowledge of symptoms of HIV/AIDS by population groups (%)

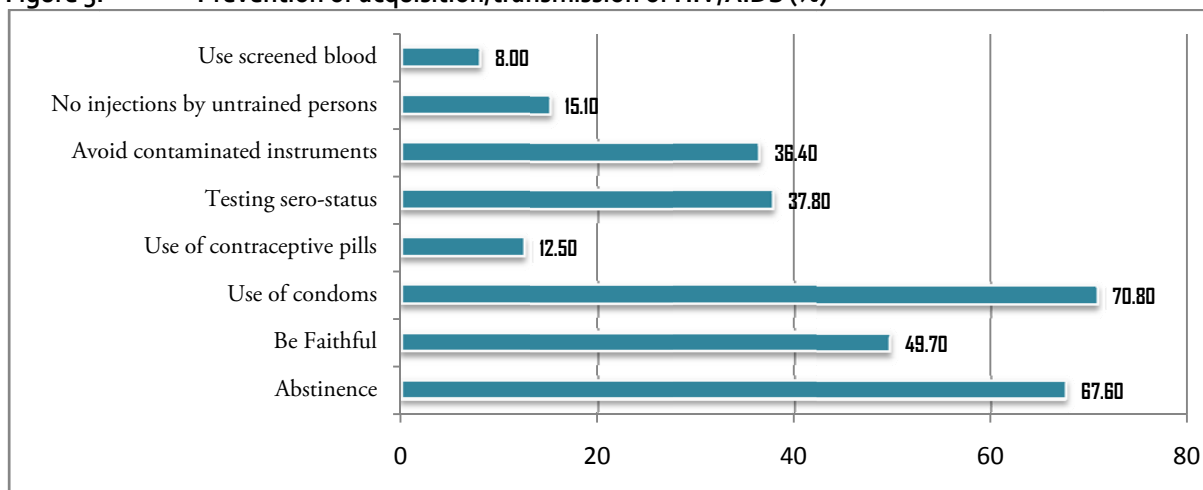
Key symptoms	Total	Sex		Age group		
		Male	Female	10-14 years	15-24 years	>24 years
Weight loss	67.2	37.0	30.2	3.2	32.4	31.6
Persistent fever	39.2	25.0	14.1	2.0	16.3	20.9
Persistent cough	50.7	27.0	23.7	2.0	22.1	26.6
Skin rashes	54.1	30.8	23.3	1.8	22.9	29.4
Enlargement of the lymph nodes	14.9	7.4	7.6	0.4	6.2	8.3
Oral thrush	17.5	9.3	8.2	0.6	8.7	8.2
Recurrent diarrhoea	50.9	27.6	23.3	2.0	24.5	24.5
Herpes zoster	15.3	7.0	8.3	0.2	6.4	8.7
Knew at least 3 symptoms	75.3	42.3	33.0	3.2	35.2	37.0

From the findings, it is evident that many people are still unable to be even self-suspicious of their sero-status given that they are unable to interpret certain symptoms of infections. Likewise, an already infected person such ignorance can perpetuate 'unconscious' spread of HIV in the community.

3.6 Prevention of HIV/AIDS

Asked how they could prevent themselves from being infected by HIV/AIDS, majority of the people, as is evident from Figure 5 below, mentioned by Condom use (71%) and Abstinence (68%). Being faithful, an added strategy considered a strong moral approach to prevention, was mentioned by only about 5 in 10 people. As was responded to under causes, there was limited knowledge of an effective blood management as a means in curtailing HIV/AIDS spread.

Figure 5: Prevention of acquisition/transmission of HIV/AIDS (%)



However, as Table 5 reveals, although 55.7% mentioned at least 3 ways of HIV/AIDS prevention, significant gender gaps existed given that males were more knowledgeable than females. Likewise, adults 25 years and over were more knowledgeable than youths on many facets of prevention mechanisms.

Table 5: Knowledge of ways of HIV/AIDS prevention by population groups (%)

Modes of prevention	Total	Sex		Age group		
		Male	Female	10-14 years	15-24 years	>24 years
Abstinence	67.6	36.6	31.0	4.0	31.4	32.2
Be faithful	49.7	27.8	21.9	1.4	20.5	27.8
Use condoms	70.8	43.7	27.0	2.0	34.2	34.6
Use contraceptive pills	12.5	7.4	5.2	1.0	6.6	5.0
Test sero-status	37.8	24.1	13.7	2.8	17.1	17.9
Avoid unsterilized instruments	36.4	23.3	13.1	1.6	15.9	18.9
Avoid injections by untrained persons	15.1	9.9	5.2	1.0	5.2	8.9
Use screen blood	8.0	5.0	3.0	0.0	3.6	4.4
Knew at least 3 ways of prevention	55.7	35.4	20.3	3.2	25.6	26.8

From the above findings, it is clear that there is a gap with respect to Be Faithful message, and therefore, the ABC model popular in the country is incomplete. Added to other modes

of HIV/AIDS spread that are less known in the area, all these imply that the ability of the population to prevent further spread is still low.

3.7 PLHA mitigation methods

That HIV/AIDS spread either between an infected and uninfected person (new infection) or between an infected and another infected person (re-infection), respondents were also asked about how Persons Living with HIV/AIDS (PLHA) should mitigate the further spread as well as the effects of HIV/AIDS. Only 44.5% (mainly males) mentioned at least 3 strategies. As Table 6 below shows, the most commonly known mechanism by both males and females and by both youth and adult age categories is about "eating well" although children mainly knew of seeking counseling. A PLHA asked, '*Why should I bother using a condom when I am already infected?*' Asked whether she only had sex with her husband, she said, 'not always'. This PLHA had to be informed that 'you are actually spreading the disease in the community'.

Table 6: PLHA mitigation mechanisms (%)

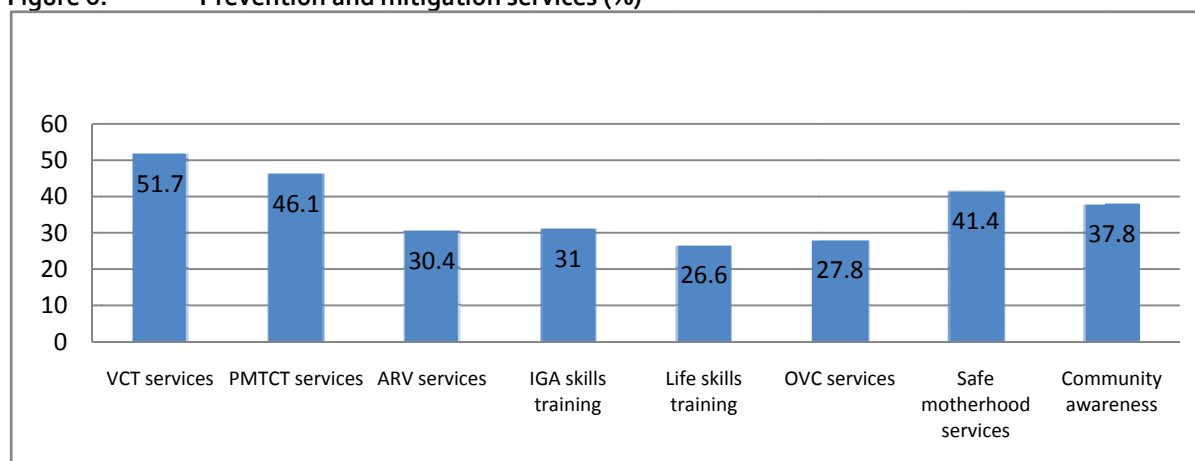
Mitigation mechanisms	Total	Sex		Age group		
		Male	Female	10-14 years	15-24 years	>24 years
Accept one's status and live openly	33.0	24.7	8.3	1.0	14.7	17.3
Eat nutritious and balanced diet	56.5	33.2	23.3	2.6	23.7	30.2
Be faithful to one's partner	40.6	22.7	17.9	1.0	16.9	22.7
Avoid infecting others	37.2	20.1	17.1	1.4	16.1	19.7
Run IGA and plan for the future	26.4	16.9	9.5	0.6	11.3	14.5
Seek advice on counseling	49.3	28.0	21.3	3.6	22.9	22.9
Treat opportunistic infections	44.9	24.9	20.1	2.0	22.3	20.7
Always use a condom when having sex	29.0	15.1	13.9	1.2	10.1	17.7
Knew at least 3 ways of mitigation	44.5	30.2	14.3	1.0	22.7	20.9

This finding where the importance of counseling, treating opportunistic infections and engaging in safe sex is less known has double implications. First and for those already tested positive, it means that their ability to adopt positive living is very low. Second and for those who have not tested, it also means that a majority of the people are not able to support PLHA to adopt positive living.

3.8 Prevention and mitigation services

In relation to the above, respondents were also asked of what prevention and mitigation services they knew about. Figure 6 reveals that less than half the population had relevant knowledge about mitigation services other than VCT services because '*it had been offered to the area before*', confirmed an LC 1 Chairman. Life skills, OVC, ARV and IGA skills services were the least known services to be used in the prevention of the spread and mitigating of the effects of HIV/AIDS.

Figure 6: Prevention and mitigation services (%)



Yet, as Table 7 shows, only 4 in 10 people ably mentioned at least 3 support services. Unlike under comprehensive knowledge about transmission, symptoms, and prevention, the same ratio of males and females comprehensively knew of mitigation services (2 in 10 people). Males, however, knew comparatively less about life skills and OVC services.

Table 7: Knowledge of HIV/AIDS mitigation services by population groups (%)

Mitigation/Prevention measures	Total	Sex		Age group		
		Male	Female	10-14 years	15-24 years	>24 years
VCT services	51.7	23.7	28.0	3.4	26.6	21.7
PMTCT services	46.1	21.3	24.9	2.8	21.5	21.9
ARV services	30.4	10.9	19.5	2.0	14.3	14.1
IGA skills training	31.0	12.1	18.9	1.8	14.5	14.7
Life skills training	26.6	7.2	19.5	1.6	13.1	11.9
OVC services	27.8	8.5	19.3	1.8	14.3	11.7
Safe motherhood services	41.4	16.7	24.7	2.2	20.5	18.7
Community awareness programmes	37.8	15.9	21.9	1.8	18.1	17.9
Knew at least 3 mitigation services	39.6	20.1	19.5	1.8	18.5	19.3

Given that the promotion of HIV/AIDS prevention requires reaching out to those who are both sero-positive and -negative and influencing behavior change in “own attitude and practices”, it is important to note that the limited awareness of vital support services can curtail effective positive behavior change. On services demand side, this finding means a limited ability to demand for vital life-saving and behavior improving services. Meanwhile on the services supply side, it promotes a wrong services delivery chain as limited demand is commonly taken to imply “no need to supply”. Critical for FiCAP is, therefore, the need to adopt a service promotion approach that instills into potential users the vitality of demanding such services.

3.9 Voluntary Counseling and Testing services

Voluntary Counseling and Testing (VCT) services as a key component in prevention and mitigation was also asked about separately. While 80.9% reported having heard of VCT services, it is mainly (same level of 40% for both males and females) by age-group the adults and youths who heard the most leaving a big information gap among children (See Table 5).

Table 8: VCT knowledge and practices (%)

	Total	Sex		Age group		
		Male	Female	10-14 years	15-24 years	>24 years
Heard of VCT services	80.9	40.2	40.8	3.6	38.0	39.4
Tested sero-status	30.0	15.9	14.1	0.6	15.3	14.1
Willing to test sero-status	83.7	44.3	39.4	4.2	38.2	41.4

The main sources of information about VCT reported were from peers (42.3%), health facilities/officials (23.5%), radio (17.9%) and leaders/elders (10.7%), only 30% had so far tested their sero-status.

However, only a negligible number of 3 in every 10 persons who heard of VCT services had tested their sero-status. In the feedback meeting it was echoed that,

Health officers from Pakwach Health Centre that serve the area, (i) come only once in 3-4 months; and (ii) only test 40 people per visit because they claim they have no funds with which to buy more testing facilities. As such, many people who had for long wanted to test were not tested and were beginning to lose hope of being certain about their HIV status.

From the above citation and the data analyzed, a very high unmet need for VCT services exists as 83.7% of the populations were willing to undertake their sero-status test (see Table 8). This high demand for VCT services were found mainly among males and adults than in females and youths.

But for the 16.3% who were unwilling to test, their main reasons included: 41.0% claimed they knew that they are safe, 37.3% however feared coping should they test positive; while 21.7% stated that VCT services were never secret but publicized.

From the findings, it can be said that FiCAP has a role to play in promoting the provision of VCT services in the area as the willingness to test is a litmus test that many people can be mobilized not only to test but also for the after testing activities. This should however be done mindful of the gender gaps in VCT seeking behavior and unfounded fears about VCT services.

4 SEXUAL PRACTICES

4.1 Summary of findings about sexual practices

Unsafe sex is already known as the leading cause of HIV/AIDS transmission. This involves mainly casual and unprotected sexual intercourse with multiple partners. In this section, existing sexual norms and practices are explored. The findings reveal that:

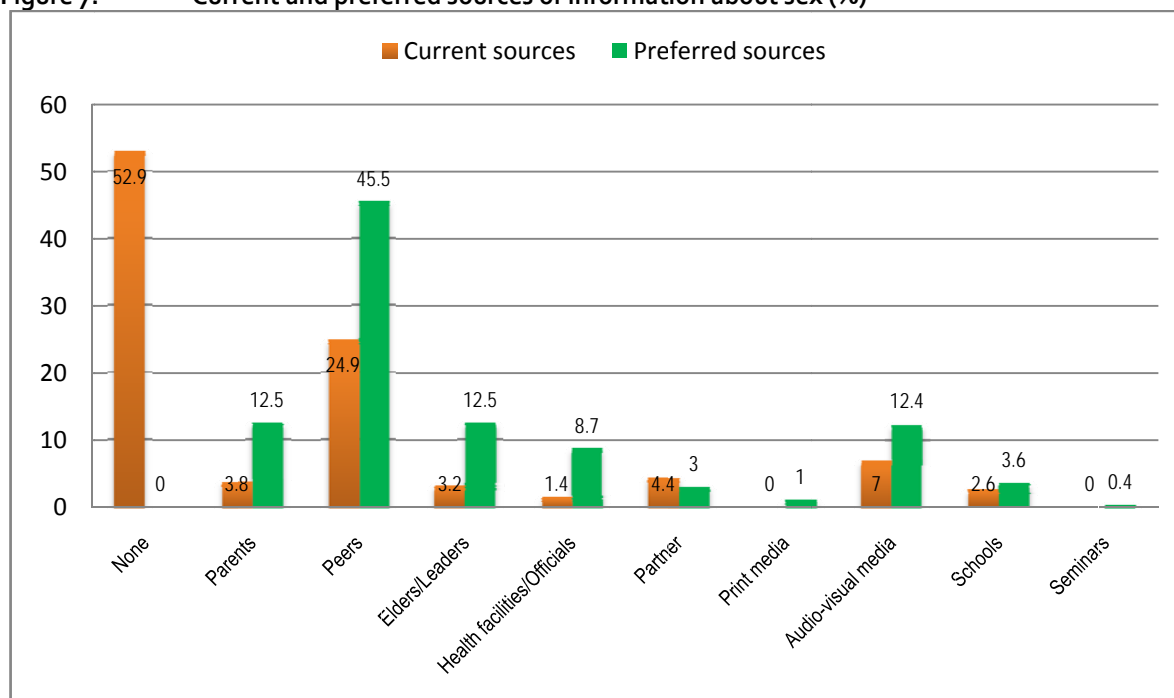
- 52.9% of the population had no source of information about sex while 24.9% largely depended on peers as a source of information about sex.
- Sexual activity was high as only 41.2% had never ever engaged in sexual intercourse.
- While the median age at first sex was 16 years that of current sex partners was only 14 years.
- Willful (96%), forceful (4%), multiple (20%), and casual (37%) including with married couples (37%) sexual relations were common practices.
- Cross-generational (49%) sexual practices were also very common as only 48.8% of those who had sex had it with their rightful age groups.
- A very cheap transactional (23%) sexual practice was on-going with the average cash-value paid for sex in cash as Ushs 10,608 and in-kind Ushs 4,616.

4.2 Open discussion about sex

In exploring about avenues for discussion about sex in the community respondents were asked first, their main source of information about sex, and second, with whom they primarily discussed issues of sex. As Figure 7 reveals, it was found out that 52.9% reported having no source of information about sex. The majority of those who had sources of information about sex mainly depended on their peers (24.9%). Not surprising, when asked what source of information they would prefer for accessing sex education, majority of the respondents mentioned peers (45.5%). Parents and elders were less preferred medium of BCCE. The Community Facilitator for Wangkado pointed that,

Traditionally children were expected to be taught about sex by their elders - uncles (for boys) and aunties (for girls). But in a multi-cultural setting like ours where many people do not have their relatives around who do you expect to take up the role? Parents are also shying away from this role. This leaves many people with no choice but to use other channels like their peers with whom one has no shame and fear to talk about anything. Besides, the youth consider ideas of elders as obsolete.

Figure 7: Current and preferred sources of information about sex (%)



4.3 Sexual norms

To understand further what norms guide sexuality in the area, all respondents were also asked whether it was right for certain practices to be engaged into and the responses are summarized in Table 9 below.

Table 9: Agreed to sexual norms and practices

Norms and practices	Total	Sex		Age group		
		Male	Female	10-14 years	15-24 years	>24 years
Unmarried boys/ girls to have sexual relations	70.0	35.6	34.4	3.2	33.2	33.6
Married couples to have extra-sexual relations	57.9	26.0	31.8	3.2	26.0	28.6
Girls to remain virgins until they marry	81.3	36.4	44.9	4.6	37.0	39.8
Boys to remain virgins until they marry	79.9	35.8	44.1	4.6	36.2	39.2
Boys to have many sexual partners	64.6	29.6	35.0	2.6	30.8	31.2
Girls to have many sexual partners	53.9	22.1	31.8	2.4	26.0	25.4

Evident is that while virginity is highly desired for both boys and girls (although mainly by females and parents than by males and youths) to the contrary premarital sex and with multiple sexual partners is equally accepted for both boys and girls. Such norms are even inculcated in children to the extent that they know that infidelity is acceptable. Such a contradiction in norms presents the fragile social relations within which anybody adopts and practices any form of sexual relationship as what should have been deterring contrary norms are not in place.

4.4 Sexual engagement

Asked about their past and current (within the last one month preceding the survey) sexual intercourse practices engaged in, it was found that:

- Only 41.2% of the total respondents had never engaged in any sexual intercourse.
- The median age at first sex was 16 years although 1.3% (equal for both boys and girls) initiated sex at age 10.
- Of the 58.8% who had sexual intercourse, males (32.4%) were more involved in sex than females (26.4%).
- While majority were in willful sexual relations (96%), forceful (4%) and cohesive (13%) sexual encounters also existed.
- Causal sexual relationship (37%) including with married couples (37%) was also being practiced.
- 20% of the respondents had multiple sexual partners.

Table 10: Past and present sexual practices (%)

		At initiation of sex			In current sexual engagement		
		Males	Females	Total	Males	Females	Total
Age group	10-14 years	13.1	18.6	31.7	52.2	40.0	92.2
	15-24 years	37.1	29.5	67.4	1.5	2.9	4.4
	25 years and over	0.9	-	0.9	2.0	1.5	3.4
	Total	51.9	48.1	100.0	55.6	44.4	100.0
Nature of relationship	Forced	4.6	11.3	15.9	1.0	3.0	4.0
	Persuaded	24.2	13.9	38.1	24.0	3.5	27.5
	Willing	24.2	21.8	46.0	36.0	32.5	68.5
	Total	52.9	47.1	100.0	61.0	39.0	100.0
Type of relationship	Steady partner	18.6	7.2	25.8	34.1	16.2	50.3
	Casual partner	36.5	30.1	66.6	23.4	13.8	37.1
	Coercive partner	2.4	5.3	7.6	8.4	4.2	12.6
	Total	57.5	42.5	100.0	65.9	34.1	100.0
Status of sexual partner	Single	52.4	30.2	82.5	33.5	18.2	51.8
	Married	2.6	8.0	10.6	27.6	10.0	37.6
	Divorced/Separated	1.2	4.7	5.9	4.7	2.9	7.6
	Widow/Widower	0.7	0.2	0.9	1.8	1.2	2.9
	Total	56.8	43.2	100.0	67.6	32.4	100.0
Number of sexual partners	One partner	4.8	16.9	21.7	23.9	31.2	55.1
	Two partners	4.8	9.7	14.5	10.1	2.0	12.1
	Over 2 partners	33.4	16.9	50.3	7.4	1.0	8.3
	None	7.8	5.8	13.5	9.3	15.1	24.5
	Total	50.7	49.3	100.0	50.7	49.3	100.0

Noting that there are more males than females together with very low comprehensive knowledge about HIV/AIDS and that fragile sexual norms prevail in the fishing communities, the above sexual practices presents a high risk of increased sexual transmission of HIV/AIDS. It, therefore, calls for customizing BCCE to tilt the existing bad and risky sexual practices.

4.5 Intergenerational sex practices

Asked about the age of sexual partners with whom current sexual intercourse was on-going, the median age of current sexual partners was 14 years. 49% of the respondents who had sexual intercourse were involved in intergenerational sex.

While adults aged 25 years and over were more sexually active unfortunately their sexual partners were mainly those aged 10-14 years old. Five of the nine people aged 10-14 years specifically had sexual intercourse with those aged 25 years and over. This is a manifestation of child-sex abuse, which according to the PECs has been going on unreported to the police or local authorities.

Table 11: Age of respondents who had sex last month by age of sex partner

Age of respondents	Age of sex partner			Total
	10-14 years	15-24 years	25 years and over	
10-14 years	3.0	-	-	3.0
15-24 years	37.8	2.6	.4	40.8
25 years and over	49.4	3.0	3.9	56.2
Total	90.1	5.6	4.3	100.0

4.6 Transactional sexual practices

Further, respondents were asked whether they had sexual intercourse for cash or in-kind payment and who initiated such payments. Of those who had sex, 5.2% and 17.3% reported making cash and in-kind payments respectively. Contrary to the prevailing belief that it is men and adults who normally pay for sex, it was also found out that 1.6% females, 3.4% youths and 0.4% children paid in cash while 8.9% females, 8.9% youths and 0.8% children paid in-kind.

Such payments were initiated by mainly self (64.7%) and partners (33.6%).⁶ However, more women (32.5% than men (11.7%) initiated cash payments, while more men (70%) initiated payments in-kind than women (45.5%).

The cash value paid started as low as Ushs 500 although it averaged Ushs 10,608 and Ushs 4,616 for cash and in-kind payments respectively. As Table 12 shows, a majority paid between Ushs 500 to Ushs 5,000 (76.9% in cash and 88.4% in kind). This is because as the PECs pointed:

Many young people who are bought by both men and women alike simply accept to be used for a small some of money to meet their basic survival needs like clothing, beer, body oil, or panties for girls. As such, a small fee is offered without any resistance. But for the professional sex workers whose lives depends on sex trade their rates are higher.

Table 12: Value of payments made (%)

Amount paid	In cash	In kind
Up to 2,500	26.9	72.1
2,500 – 5,000	50.0	16.3
5,000 – 10,000	15.4	3.5
Over 10,000	7.7	8.1
Total	100.0	100.0

⁶ Initiators of payments (%)

Initiator	Males	Females	Total
Self	27.7	37.0	64.7
Partner	19.3	14.3	33.6
Others	1.7	-	1.7
Total	48.7	51.3	100.0

5 PERCEPTIONS AND USE OF CONDOMS

5.1 Summary of findings on perception and use of condoms

Condom use is one known vital facet of preventing the further spread of HIV/AIDS besides Abstinence and Be faithful. This section presents the summary of findings on condom use in Table 13.

Table 13: Common condom practices

	Total	Sex		Age group		
		Male	Female	10-14 years	15-24 years	>24 years
Ever heard about condoms	81.3	45.9	35.4	4.0	40.6	36.8
Used condom in the last sexual intercourse	53.3	31.8	21.5	2.0	30.0	21.3
Used condoms consistently in the last sexual intercourse	36.8	22.7	14.1	1.4	21.7	13.7
Self initiated condom use	69.5	46.3	23.2	1.9	41.3	26.3
Disposed off used condoms in latrine	80.1	30.9	10.3	1.1	21.7	18.4
Accessed condoms from shops/lodges	41.2	53.2	27.0	2.6	45.3	32.2
Used condoms in fear of HIV/AIDS infection	73.2	48.7	24.5	3.0	41.1	29.1
Did not use condoms because it breed distrust	14.2	9.9	4.3	0.4	6.0	7.8

5.2 Access to and use of condoms

Respondents were asked whether they heard about condoms, used it (and consistently) in their last sexual intercourse, why they did so, who initiated condom use, where they got condoms from, and where they disposed off used condoms. From Table 13 it is evident that 81.3% heard about condoms although more males and especially youths did so. Further, only 5 in 10 reported having used condoms in their last sexual intercourse. Most of the users were males than females and youths than adults. However, only a paltry 3 in 10 of those who used condoms reported having used it consistently still by more males and youths than females and adults.

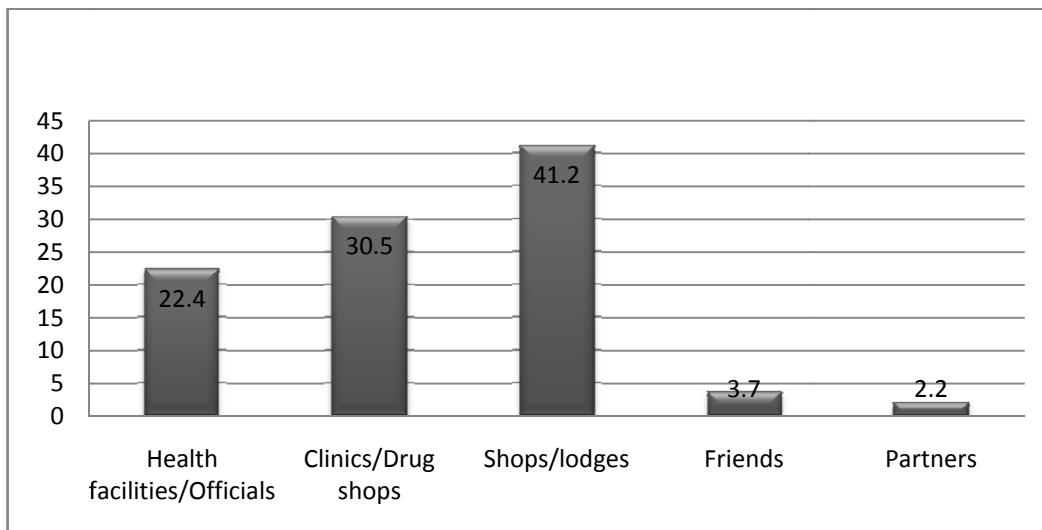
The main reasons advanced for having used condoms in the last sexual encounters were fear of HIV/AIDS infection (73.2%) and fear of pregnancy (17.0%) by both males and females.

Condom use was reported to have been mainly self initiated (the respondent) although the ability of females to initiate condom use was still half that of males. It was only in a few instances that non-partners involved in one way or the other in the sexual intercourse (8.9%) initiated condom use.

The condoms were accessed mainly from facilities like shops/lodges and health units (see Figure 8) rather than from friends and partners.

On the safe disposal of used condoms, respondents reported that they disposed off used condoms in latrines (80.1%), the bush (13.1%), and other places like in the lake (6.7%).

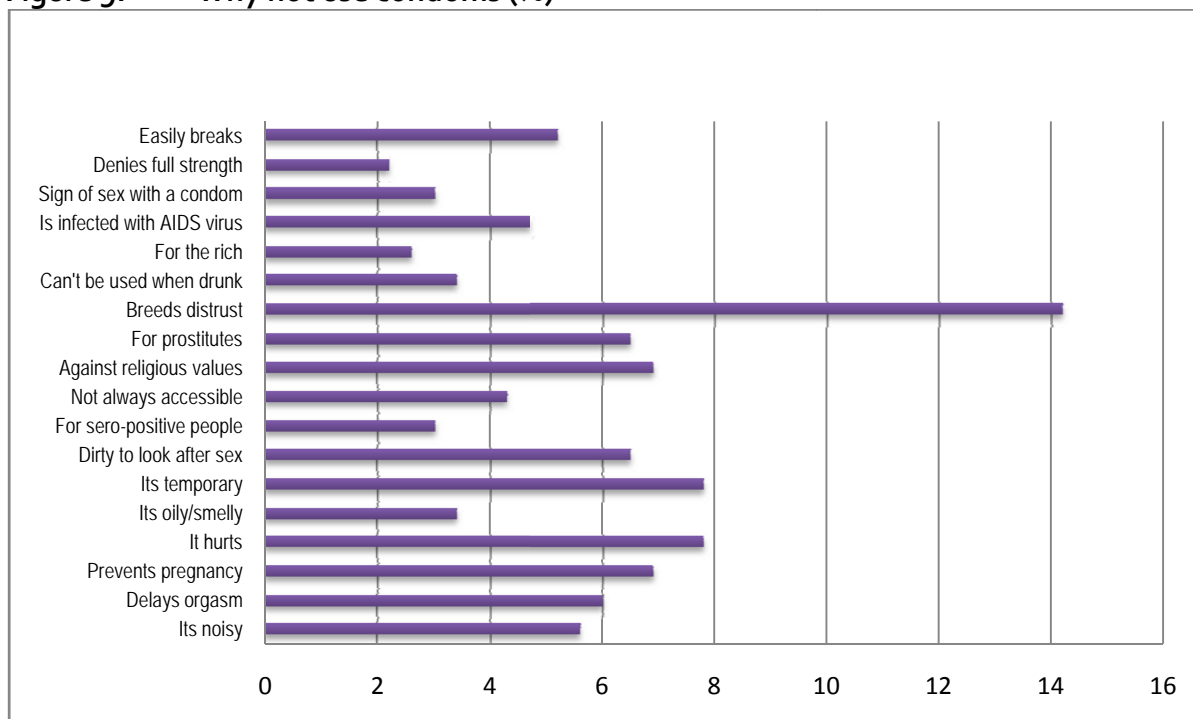
Figure 8: Main sources of condoms (%)



5.3 Why condoms was not used

Those who did not use condoms in the last sexual intercourse were asked why they opted not to. The main reason advanced for not using condoms was that it breeds distrust (14.2%) because why should someone want to use a condom if s/he has not engaged in sexual activity outside the usual relationship. Other reasons are summarized in Figure 9 below.

Figure 9: Why not use condoms (%)



The critical challenges related to condom use include the limited access to a steady supply of condoms, the negative ways in which sexual intercourse are conducted, limited information and misconceptions about the pros and cons of condoms and religious dogmas as are summarized in the three citations below.

One youth respondent pointed,

It is not easy to have enough condoms for use as and when you want to. We used to get condoms from the health centre but it took a very long time [referring to the withdrawals from use of *Engabu*] to start getting supplies again. Even then, the condoms are not just enough. As such, one has to be selective of who to have sex with using a condom and who not to use a condom with.

A PEC reiterated a story they encountered while on mock training exercise when the youths in one fishing village pointed out that,

Why do you people ask me whether or not I used a condom in any sexual encounter? Do you know that first; sexual intercourse here is about 'quick sex' given that there is no lodge where your girl/boy can wait for a long time. Second, do you consider the pain of getting money and other gifts to give to a girl for her to offer you sex? Why then can't a condom con its own girl and have sex with? Besides, if sex is between a man and a woman, when you have another object [like a condom] in between then what is that act called? Is it still called sex or it is sex with a condom? Would you then die from a hostile parent for having slept with his daughter when actually you slept with a condom?

Finally a female PEC also remarked that,

As a Christian I cannot allow any man to use a condom on me. Sex is meant to be between a man and a woman. And it must yield, with God's blessing, human life. What would you get when all the semen you should have received is finally thrown away as a useless thing? Even if not all semen yields human beings, at least one should not be denied it. A condom is simply sinful.

6 ATTITUDE AND PRACTICES TOWARDS HIV/AIDS PREVENTION AND MITIGATION

6.1 Summary findings on attitude and practices for HIV/AIDS prevention

The focus of this section is on how people place themselves in the chain of active actors to promote the prevention and mitigation of HIV/AIDS both in their feelings and practices within risky behaviors that predisposes one to infections. Evident from the findings is that:

- Myths about HIV/AIDS exist among 5% of the population.
- 14% still desire infecting others should they know they are HIV-positive.
- Stigmatization of PLHA is common practice.
- Many people are still engaged in practices that predispose them to HIV infection.

6.2 Acceptance of HIV/AIDS

Respondents were asked whether they considered that HIV/AIDS truly exists. It was found that 4.6% of the respondents still believed that HIV/AIDS is just a lie as one noted,

Why the fad about HIV/AIDS when malaria is actually killing more people than the so-called AIDS itself? This AIDS thing is all an American concoction to stop people from having many sexual partners and children altogether.

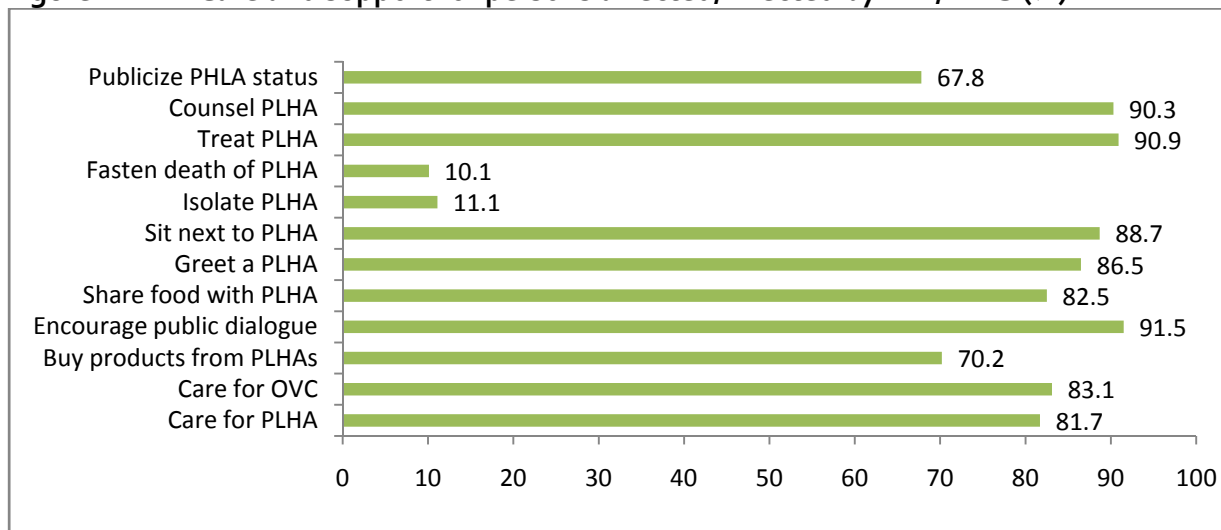
It was therefore not surprising that when asked what they will do on knowing that they are sero-positive, 13.9% pointed out that they would continue with their normal unrestricted sexual behaviors, even when they are likely to infect other people.

6.3 Attitude toward PLHA

Questions about attitude and practices related to living with, and supporting, PLHA were asked. Figure 10 summarizes the findings. Evident therein is that the respondents and consequently the community exhibit a very high empathy and acceptance of PLHA and OVCs. Every 8 in 10 respondents pointed their willingness to provide care and support for persons infected and affected by HIV/AIDS.

However, some stigmatization persists as about 68% reported they would publicize the sero-status of a PLHA while 10% and 11% said that they would hasten their deaths or isolate the PLHA respectively.

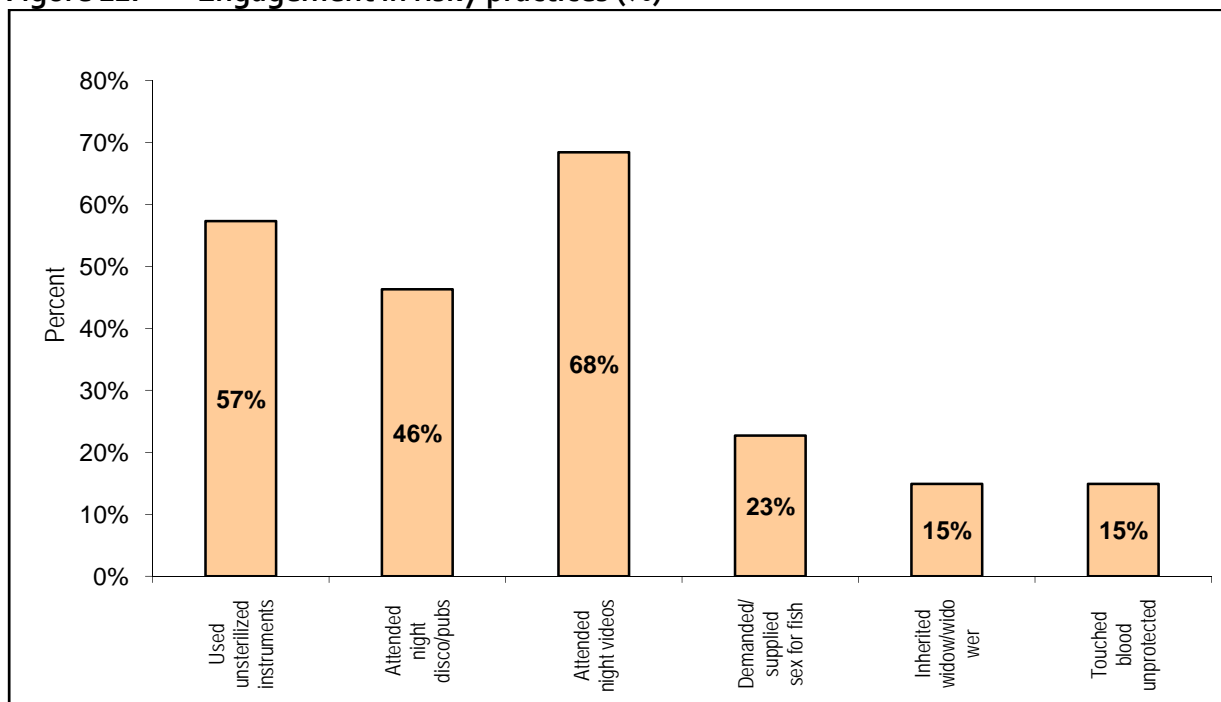
Figure 10: Care and support for persons affected/infected by HIV/AIDS (%)



6.4 Predisposing behaviors

While knowing about HIV/AIDS is one thing and actively practicing its prevention and mitigation is the other, respondents were also asked to state whether they engaged last year in some of the high risk activities common in their communities. Figure 11 reveals that risk of infection is high as 5 in every 10 people reported having shared unsterilized instruments and 1 in every 10 people touched blood unprotected.

Figure 11: Engagement in risky practices (%)



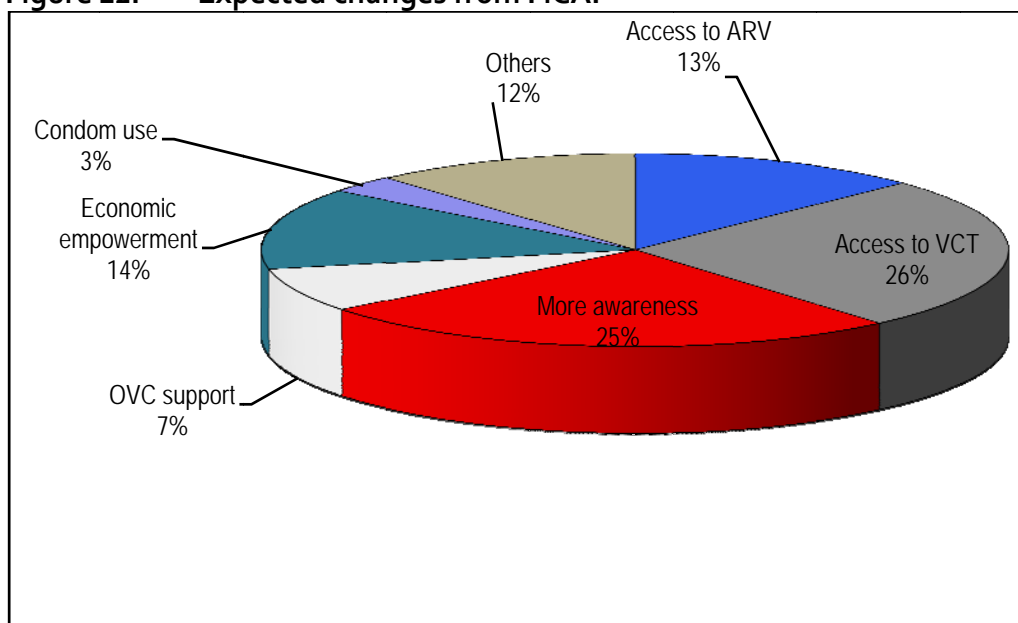
7 ENVISAGED CHANGES FROM FICAP

Finally, the study also asked a generic question in order to explore what the community expects from FiCAP in terms of changes in their lifestyles. Figure 12 below shows that some of the envisaged changes like awareness creation (expected by 25%) and condom use promotion (expected by 3%) are in line with FiCAP primary aims of preventing sexual transmission of HIV/AIDS.

In addition, respondents proposed a multi-faceted approach like promoting VCT services among those who have not yet tested their sero-status and continued access to ARV among PLHA.

Finally, beyond the health focus, they also mentioned the need to look at the economic dimensions (the HIV/AIDS – poverty nexus) as is exemplified by the need for OVC support and economic empowerment.

Figure 12: Expected changes from FiCAP



8 CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

The findings (summarized in 3.1, 4.1, 5.1, and 6.1) from the study evidently show that:

- Generally, many people have heard about HIV/AIDS although comprehensive knowledge about HIV/AIDS transmission, symptoms, prevention, mitigation and support services are low and varied by age and sex.
- Sexual activity with willfully, many, and casual sexual partners is common practice. Laden with limited sources of information about sexuality and norms that accept sexual promiscuity as well as a high prevalence of cross-generational and transactional sexual practices, sex will continue to remain a major cause of HIV/AIDS transmission in the area.
- Despite the knowledge about condoms as a HIV/AIDS infection preventive measure, access to and consistent use of condoms are very limited especially among females.
- Attitudes that promote stigmatization of PLHA persist.
- Majority of the population are engaged in risky behaviors, other than sexual intercourse, that still predisposes them to infection.
- The community expects FICAP to provide BCCE together with health services outreach and economic empowerment.

8.2 Recommendations

To address the above issues raised, aware of the project confines, it is prudent for AFARD to:

- Customize BCCE to the needs of the various social groups while ensuring equality is built in the level of comprehensive knowledge in the population.
- Apart from promoting peer-to-peer BCCE, strengthen an open door approach for inter-peer learning so that 'wisdom' is shared.
- Link with existing government services in order to promote access to VCT and ARV services and where possible to facilitate either community-facility dialogue for services responsiveness to be achieved or directly support such services outreach.
- Adopt peer approach to condom access promotion while at the same time build condom use negotiation skills particularly among females.
- Explore community care and support system in order to promote economic empowerment requisite for the continued support of OVCs and PLHA.

Annex 1: Respondents characteristics (%)

Characteristics	Number	Males (%)	Females (%)	Total (%)
Population	503	50.7	49.3	100.0
Ethnicity				
• Alur	459	46.5	44.7	91.3
• Others	44	4.2	8.7	8.7
Social categories				
• Youths	208	22.1	19.3	41.4
• Parents	126	11.1	13.9	25.0
• Community leaders	48	4.6	5.0	9.5
• Traders	47	4.4	5.0	9.3
• <i>Lither</i> (Migrant fishermen)	47	8.5	0.8	9.3
• <i>Cwara ngutha</i> (sex workers)	27	-	5.4	5.4
Age groups				
• 10-14 years (teenagers)	26	1.4	3.8	5.2
• 15-24 years (youths)	237	22.5	24.7	47.1
• 25 years and over (adults)	240	26.8	20.9	47.7
Marital status				
• Single	169	18.1	15.5	33.6
• Married	288	31.2	26.0	57.3
• Divorced/Separated	16	-	3.2	3.2
• Widow/Widower	30	1.4	4.6	6.0
Religious status				
• Christians	472	47.7	46.1	93.8
• None	5	-	1.0	1.0
• Moslems	26	3.0	2.2	5.2
Educational status				
• None	133	3.2	23.3	26.4
• Primary	294	34.6	23.9	58.4
• Secondary	73	12.3	2.2	14.5
• Post-secondary	3	0.6	-	0.6
Occupation				
• Fishing/fish mongering	241	34.4	13.5	47.9
• Farming	61	3.0	9.1	12.1
• Trade	133	8.5	17.9	26.4
• Housewives	6	-	1.2	1.2
• Students	35	3.4	3.6	7.0
• Public servants	27	1.4	4.0	5.4
Residencship				
• Indigenous	390	38.0	39.6	77.5
• Immigrants	50	6.2	3.8	9.9
• Mobile trader	63	6.6	6.0	12.5