



Fisher Community Anti-AIDS Project (FiCAP)

# **PROJECT COMPLETION REPORT**

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Prepared by Agency for Accelerated Regional Development (AFARD)  
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# ACKNOWLEDGEMENT

For the last 2 years, Uganda AIDS Commission through the Civil Society Fund (RFA 08-001) has supported the Agency For Accelerated Regional Development (AFARD) to implement the Fisher Community Anti-AIDS Project (FiCAP). This report presents a summary of the project performance and it suggests way forward.

AFARD is grateful for the invaluable contributions made by various stakeholders during the 2 years of FiCAP implementation. Special thanks go to Uganda AIDS Commission, CSF and the various management agencies that worked tirelessly and patiently to ensure that the project implements planned activities. Of course all would have been in vain if the beneficiaries and the host local governments did not give AFARD and the project invaluable support.

However, AFARD is fully responsible for the views and errors expressed herein.

Dr. Alfred Lakwo  
**Programme Director**

# ACRONYMS

AFARD	=	Agency For Accelerated Regional Development
ART	=	Anti Retro Viral Therapy
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
PLWA	=	Persons Living with HIV/AIDS
PMTCT	=	Prevention of Mother to Child Transmission
PTC	=	Post Test Club
VCT	=	Voluntary Testing and Counseling

# EXECUTIVE SUMMARY

## Introduction

Over the last two decades, HIV/AIDS prevalence rate declined in Uganda from 18% to 6.7%. However, further reduction has been hampered by, among other factors, high risk sexual transmission that accounts for 3.2% of new infection annually. Among the most affected people are the fisher communities who, by nature of their lifestyle, are most at risk of contracting HIV. It is for this reason that Uganda Aids Commission, through its Civil Society Fund, supported AFARD with a 2-year grant for the implementation of Fisher Community Anti-AIDS Project (FiCAP). FiCAP's goal was to *"contribute to the reduction of sexual transmission of HIV among fishing communities in Panyimur Sub-County, Jonam County, Nebbi District mainly through behavior change communication and education (BCCE).*

## Purpose and key structures of the report

This report was compiled after rigorous data collection using literature review, individual survey, and participatory evaluation meetings involving AFARD staff, Peer Educators-cum-Counsellors (PECs), local government officials and Panyimur fishing communities. It has four objectives, namely:

1. It presents the extent to which FiCAP achieved its planned outputs.
2. It shows the results FiCAP produced in the Knowledge, Attitude and Practice (KAP) related to HIV/AIDS prevention and mitigation in Panyimur community.
3. It analyses the capacity of PECs for continued service provision in the fishing communities in Panyimur Sub County.
4. It explores the lessons learned, persisting challenges and proposes way forward for deepening current gains made by FiCAP in the fight against HIV/AIDS among fishing communities.

## Summary of findings:

### 1. Achievement of planned outputs

With regard to planned activities, all outputs were achieved. In a few cases, achievements were more than planned. Equally, due to flexible management system, some unplanned activities were implemented, for instance, the retraining of PECs, support for Voluntary Counselling and Testing (VCT) outreach, and leverage with local leaders. Such achievements show that FiCAP was both effective and efficient in its outreach.

### 2. Change in KAP related to HIV/AIDS prevention and mitigation in Panyimur community

- A 7 per cent point change (from 93% at baseline to 100% now) was achieved as all people have heard about HIV/AIDS.
- The level of comprehensive knowledge about HIV/AIDS increased substantially. Those who ably mentioned at least 3 HIV/AIDS: modes of transmission increased from 50.5% to 80.3%; symptoms from 75.3% to 89%; modes of prevention from 55.7% to 85.7%; positive living from 44.9% to 79.7%; and essential prevention/mitigation services from 39.6% to 84.7%.
- There was a decrease in casual sexual relationship from 37% to 25.4% and in cross-generational sex from 49% to 2.2%. Equally, those who did not have sex increased from 41.2% to 42.9%. However, among both young adults and adults multiple sexual relationships increased from 20% to 37.3% and transactional sexual relationship from 22.5% to 53.5%.

- Yet, despite the increase from 81.3% to 87.4% of those who heard about condoms, condom use in the last sexual intercourse declined from 53.3% to 34.2% and consistent condom use even fell further from 36.8% to 25.5% mostly because of condom shortage. Positively though, the community adopted better condom management practice with used condoms disposal that saw a marked increase from 80.1% to 97.6%.

### 3. PEC capacity for sustainable services delivery

The PECs were found to be ahead of the other members in the fishing communities in regard to knowledge of the basic facts about HIV/AIDS prevention and mitigation. They helped form Post Test Clubs (PTCs) which are now providing HIV/AIDS prevention and mitigation services in all the project fishing villages. However, the PTCs need improvements in their governance, leadership and resource mobilization strategies. Equally, their care and support anchor (on the credit schemes) need effective management practices.

### 4. Lessons learned, persisting challenges and way forward

Inasmuch as the delivery of BCCE customized to local situations through the PECs and with multi-communication channels increased awareness, gaps remain with regard to deeper knowledge about HIV/AIDS. For instance, issues related to mother-to-child transmission and contact with open wounds, prevention by use of screened blood, access to medical services from quack personnel, and HIV status testing, and positive living through the timely seeking of counselling and treatment of opportunistic infections requires more attention. Most worrying is the limited change in safer sexual practices; something that was attributed to the short project timing as well as the inadequacy of government-centred condom supplies.

It is therefore important that for FiCAP to deepen the gains it has made in the various fishing communities, the following are done:

- a) The PECs should be refreshed on basic facts as well as critical education and counselling strategies.
- b) FiCAP continues to secure and provide condoms to the PECs for peer-based distribution-with- education.
- c) The various PTCs should be strengthened as hubs for continued locally managed service delivery.

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# PART 1 THE OVERVIEW

## 1.1 HIV/AIDS Status and Prevention in Uganda

Over the last two decades, Uganda registered a marked decline in HIV/AIDS prevalence rate from 18% to 6.7%.<sup>1</sup> The 2004-5 Uganda HIV Sero-behavioral Survey (UHSBS) noted however that there is high prevalence rate among the population aged 15-49 years at 6.4% (7.5% for women and 5.0% for men).<sup>2</sup> This rate has stagnated in the last 5 years between 6.5% and 6.1% with significant geographic (regional and rural-urban), gender and age variations.<sup>3</sup>

In the daily Monitor newspaper of 25 April 2010, the Director General of Uganda AIDS Commission, Dr David Kihumuro Apuuli, warned that HIV/AIDS prevalence rates are now shifting from the young to the old people who have financial stability and can afford, from their independent decision position, to do anything with their lives. He noted that the distribution of HIV/AIDS by age indicates that adults (30-34 years) have the highest infection rate (12.1% men and 8.1% women) as compared to 15-19 years (with 2.7% and 0.3% for boys and girls respectively).

Evident from the above is that further reduction has been hampered by high risk sexual transmission that accounts for 3.2% of new infection annually. Among the most affected are the Most At Risk Population (MARF) such as the fishing communities on L. Albert in Nebbi District. The DFID study (2004) as well as the National Strategic Plan for HIV/AIDS 2007-12 confirmed that fishing communities have high susceptibility to HIV/AIDS infection, high transmission and re-infection, and increased vulnerability to the impact of infections.<sup>4</sup> Thus, the prevention of further HIV infection should importantly target new infections by high risk sex especially among the high risk population.<sup>5</sup>

## 1.2 About Fisher Community Anti-AIDS Project (FiCAP)

Panyimur sub county, located on Lake Albert, was found to be a high risk area given that it hosts a weekly fish market that attracts people from Southern Sudan, Democratic Republic of Congo, and the Ugandan districts of Zombo, Gulu, Lira, Apac, 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 was rampant, transactional, intergenerational and high risk (unprotected) sex<sup>6</sup> that all predisposed the people (especially young people) to high HIV infection. It was therefore not surprising that findings from VCT services in Jonam County indicated that VCT attendance positivity rate stood at 20-30%. Although it can be said that such a rate was because those seeking VCT services were already suspecting a confirmatory sero-positive status, still it revealed the high potential 'HIV time bomb' this population is living with.

It is for the above reasons that Uganda Aids Commission, through its Civil Society Fund, supported AFARD with a 2-year grant to implement Fisher Community Anti-AIDS Project (FiCAP). FiCAP focused on behaviour 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. In so doing, it aims at "contributing to the reduction of sexual transmission of HIV among fishing communities in Panyimur Sub-County, Jonam County, Nebbi District".

1 See the National Strategic Plan for HIV/AIDS 2007-2012.

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

4 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](http://www.afard.net))

5 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).

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

## 1.3 Objectives and methodology of the report

As a learning organization, AFARD mandatorily conducts end of project reviews both to account to the various stakeholders for what was done, and with what results, and draw lessons for future improvements. This report fulfils these dual needs. It looks at planned project deliverables and the envisaged changes in the KAP in Panyimur Sub County as were benchmarked by the 2008 baseline survey. The key issues handled in the report are summarized in table 1 below.

Table 1: Summary of report objectives, key questions and methods

Objectives	Key questions	Data collection methods
1. To assess FiCAP's achievements of its planned deliverables.	To what extent were planned project activities achieved?	Literature review of quarterly activity and consolidated reports
2. To assess the extent to which FiCAP changed the KAP related to HIV/AIDS prevention and mitigation in Panyimur community.	To what extent did FiCAP change: (a) People's awareness of the basic facts about HIV/AIDS (what HIV/AIDS is, and its modes of transmission, symptoms, prevention, and mitigation measures. (b) The highly risky sexual norms and practices in the community? (c) The negative perception about, and low use of, the condom? (d) The poor attitude and practices regarding prevention and mitigation of HIV/AIDS (promoting positive living among PHAs)?	Individual surveys of 517 randomly and purposively sampled community members  Participatory evaluation meetings with 100 stakeholders
3. To assess the capacity of PECs for continued service delivery in Panyimur community.	To what extent are PECs as frontline FiCAP implementors: (a) Aware of the basic facts about HIV/AIDS (what HIV/AIDS is, and its modes of transmission, symptoms, prevention, and mitigation measures. (b) Organized to continue providing HIV/AIDS prevention and mitigation services to Panyimur community?	Individual surveys with 60 PECs  Participatory evaluation meetings with 100 stakeholders
4. To identifying key lessons and challenges in order to recommend better ways and means of deepening gains made by FiCAP.	(a) What lessons can be learned from this project? (b) What critical challenges persist in the prevention and mitigation of HIV/AIDS in Panyimur community? (c) How can such challenges be overcome locally?	Participatory evaluation meetings with 100 stakeholders

## 1.4 Report structure

This report is presented in 5 parts as follows:

- Part 1 presents the project overview as well as the methods used in developing the report.
- Part 2 presents the extent to which FiCAP achieved its planned outputs.
- Part 3 shows the results FiCAP produced in the Knowledge, Attitude and Practice (KAP) related to HIV/AIDS prevention and mitigation in Panyimur community.
- Part 4 analyses the capacity of PECs in order to continue with service provision in the fishing communities of Panyimur Sub County.
- Part 5 explores the lessons learned, persisting challenges and makes recommendations for deepening current gains made by FiCAP in the fight against HIV/AIDS among fishing communities.

## PART 2 OUTREACH PERFORMANCE

### 2.1 FiCAP's focus

FiCAP aimed at *"contributing to the reduction of sexual transmission of HIV among fishing communities in Panyimur Sub-County, Jonam County, Nebbi District"*.

The specific objectives of FiCAP were:

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); and
3. Increasing correct and consistent condom use.

Within its two-year duration, FiCAP was expected to increase comprehensive awareness in order for the existing negative sexual practices among fisher communities to change thereby reducing infection rates particularly from sexual transmission. This study aimed at assessing such changes.

### 2.2 Key project activities

The implementation of FiCAP focused on:

- a) Establishing locally elected, trained, equipped and motivated local change agents (the PECs) for ten different peer groups in all the five epicenter fishing villages that served the outlier villages.
- b) Developing BCCE messages participatorily with the PECs after a thorough review of what gaps existed as per baseline findings and also gaps that emerged during implementation.
- c) Supporting a multi-channel communication strategy composed of peer-based seminars, posters, video shows, drama shows and periodically radio talk shows to draw attention quarterly on a critical message. This approach was enhanced by the customization of messages for the various social categories.
- d) Building linkages with local governments to ensure cross-skilling and sourcing supplies of condoms and VCT outreaches as well as accessing clinical referral services as part and parcel of the post testing response.
- e) Grounding the ownership and sustainability of the project in the hands of the local population through the championing of Post Test Club formation as the centrifugal force for continued prevention and mitigation of HIV/AIDS in Panyimur community.

From all the activities noted above, FiCAP was expected to change the baseline study findings that indicated that the project area lacked the requisite knowledge, attitude and practice to prevent and mitigate HIV/AIDS.

### 2.3 Achievements of planned outputs

Table 2 below presents a summary of the planned and achieved project outputs. It is evident from the table that almost all targeted outputs were successfully achieved with some cases of over achievements. However, the figures in most of the outputs (see various annexes) do not tally with the data from the quarterly and bi-annual reports. The reason for this variation was that the manner of data reporting was too limited by the format provided by CSF.

Table 2: Summary of project achievements

Activities	Target Outputs	Achievement	Success rate (%)	Remarks
<b>Specific objective 1: A cadre of 60 local people capable of sustaining efforts to prevent HIV spread is established and motivated.</b>				
1.1 Sensitize the community about the project	Hold 5 meetings	5 meeting held	100%	These meetings identified 10 other satellite fishing centres to be served by the 5 planned epicenters for effective outreach. See annex 1 for details.
1.2 Hold community meetings to identify CFs & Peer Educator/Counselors	Hold 5 meetings	5 meetings held	100%	This assessment was participatory and identified trusted volunteers. 60 people (50% females) were identified.
1.3 Train Peer Educator/ Counselors.	Train 50 Peer Educator/ Counselors	50 PECs and 10 CFs were trained	120%	CFs were also trained because they conduct both peer education and counselling on top of coordinating their PECs' operation.
1.4 Procure basic tools and equipments	5 video sets with PAS + generators, 60 bicycles, 1 computer and 1 digital camera procured	A laptop computer; adobe CS3 software, a digital camera, 60 bicycles, 200 T-Shirts, 7 video decks, 7 TVs, 5 stabilizers, 5 generators and 10 shoulder megaphones, 60 model penises.	100%+	The additional video equipment were to replace those that were short circuited and also to ensure the FO reviewed tapes before public watching to avoid scenes that would be socially unacceptable. See annex 2 for details.
<b>Specific objective 2: Positive behavior changes (sexual practices) is promoted among 29,650 people in 5 fishing villages</b>				
2.1 Conduct a baseline survey	Conduct 1 baseline study	1 baseline study conducted	100%	This study also provided a reprogramming basis for community BCCE design
2.2 Hold awareness creation seminars	240 awareness sessions	240 sessions	100%	Overall, 32,745 people were reached of which 17,924 were male and 14,821 females. See annex 3 for details.
2.3 Train youths in life skills	Train 400 youths	400 youths (50% females) trained	100%	
2.4 Train parents in life skills	Train 300 parents	300 parents trained	100%	
2.5 Hold radio talk shows.	Hold 4 talk shows	4 talk shows were held	100%	The messages aired with phone-in discussions ranged from information about the project, basic HIV/AIDS information and about the World AIDS day commemoration.

Activities	Target Outputs	Achievement	Success rate (%)	Remarks
2.6 Stage video shows	Same as 2.2 above	Same as 2.2 above	100%	The video tapes used were Silent epidemic, Every one's child, It's not easy, Dangerous decision, and There is hope
2.7 Produce and disseminate local IEC materials.	Produce 8,000 posters and 8,000 leaflets produced and disseminated	6,000 posters were produced	38%	The alteration was because: (i) posters proved user friendly for its pictorial presentation than leaflets that needed basis literacy skills; something many people in the area lacked; and (ii) increased cost of poster production
2.8 Hold drama shows	8 sessions	36 sessions	450%	The use of a local drama group in the neighboring village helped reduce on hire cost. In all, those whose attendance was recorded were 43,100 composed of 19,300 males and 23,800 females.
2.9 Support routine PEC operations	Support 50 Peer Educator/ Counselors' and 10 CFs monthly	50 Peer Educator/ Counselors' and 10 CFs supported monthly	100%	The PECs individually reached out to 35,840 people through one-on-one education and 13,759 people through one-on-one counseling sessions. For details see annex 4.
2.11 Conduct quarterly review meetings	40 sessions	40 sessions	100%	In attendance were 1,712 (886 male vs. 826 female) drawn from local councils, beach management unit leaders, religious leaders, PECs/CFs, sub county leaders, district leaders and AFARD staff.
2.12 Document best practices	60 copies of magazines produced and disseminated	100 copies produced and disseminated	167%	100 copies. Explaining the best practice and FiCAP as a project.
2.14 Sharing and Networking	8 meetings	8 meetings	100%	In attendance were 357 people (194 male and 163 female). Participants came from the 5 new PTCs, the 2 old AFARD founded PTCs (Dei and Lokokura), Sub county leaders and AFARD. Equally, AFARD renewed its network membership with UNASO, NASON, NNGOF, NDNGOF, UWASNET, PELUM
<b>Specific objective 3: Correct and consistent condom use increased</b>				
3.1 Train Peer Educator/ Counselors as condom peer distributors	Train 50 PECs	50 PECs and 10 CFs were trained	120%	The inclusion of CFs was to allow for effective on the ground backstopping of PECs should the need arise.
3.2 Hold condom promotion seminars	Hold 10 awareness sessions	10 awareness sessions held	100%	Overall, 505 people attended the condom promotion awareness sessions (303 males and 202 females)
3.3 Stage video shows	Integrated with 2.6			See 2.6



Activities	Target Outputs	Achievement	Success rate (%)	Remarks
3.4 Produce and disseminate local print medias	Integrated with 2.7			See 2.7
3.5 Support Peer Educator/ Counselors operations	60 PECs supported to perform their roles			See 2.9
<b>Unplanned but implemented activities</b>				
Retraining of PECs		50 PECs & 10 CFs were trained		This was a follow up training in palliative and pediatric counseling skills; a gap identified during the first year of PEC operation.
Provision of VCT services		25 VCT outreaches were supported (5 per fishing village)		Pakwach Health centre conducted the VCT outreaches and tested 1,908 people (648 males and 1,260 female). Of this, 77 people tested HIV positive (27 male and 50 female) and 35 of these PLWA are members of Post Test Clubs (15 male and 20 female).
Dialogue meeting with community leaders		1 meeting was held with 53 civil, political, and religious leaders		This meeting aimed at negotiating the acceptance of ABC education package among the various religious and community leaders who had hitherto resisted PECs education

## 2.4 People reached by FiCAP

FiCAP envisaged within the 2 year period to reach out to 26,950 people. Table 3 below shows that the project finally reached out to 32,745 people (representing 121.5% of the population adjusted by 3.2% annual growth rate)<sup>7</sup>. However:

- More females (52%) than men (48%) and more young people (44%) were reached out to with various behavior change education information than adults.
- Condom promotion was less attended by females (47%) than men (53%) signifying the limited power females have in condom utilization.
- However, more females attended VCT services (60%) than men. This was because first, female PECs were better mobilizers of their peers. Second, many males prefer to know their HIV status through the status of their wives or girlfriends with due ignorance of discordance.

<sup>7</sup> This figure only caters for those reached to through awareness seminars and it excludes all other outreaches to avoid double counting.

Table 3: The breadth of FiCAP's outreach

Outreaches	Young people		Adults		Total		
	Males	Females	Males	Females	Males	Females	Total
Sensitization seminars	11,529	10,994	5,118	5,104	16,647	16,098	32,745
Condom promotion	191	141	77	96	268	237	505
Drama shows	-	-	-	-	19,300	23,800	43,100
PECs - education	12,422	13,186	6,046	5,528	18,468	18,714	37,182
PECs- Counseling	4,614	5,054	3,368	3,350	7,981	8,404	16,385
VCT	-	-	-	-	648	1,260	1,908
<b>Total</b>	<b>28,756</b>	<b>29,375</b>	<b>14,609</b>	<b>14,078</b>	<b>63,312</b>	<b>68,513</b>	<b>131,825</b>
<b>% share</b>	<b>49</b>	<b>51</b>	<b>51</b>	<b>49</b>	<b>48</b>	<b>52</b>	<b>100</b>

## 2.5 Financial utilization

Table 4: Budget performance

ACTIVITY	BUDGET	ACTUAL	VARIANCE
<b>Objective. 1: Establish a Cadre of 50 local people of Resource</b>			
Activity 1.1: Sensitize the community about the project	3,395,000	3,395,000	0
Activity 1.2: Hold community meetings to identify Comm. Facilitators & Peer Educators/Counselors	3,295,000	3,295,000	0
Activity 1.3: Train Peer Educators-cum-Counselors	46,232,000	46,232,000	0
Activity 1.4: Procure basic tools and equipments	36,870,000	36,550,000	320,000
Total for Objective 1	89,792,000	89,472,000	320,000
<b>Objective. 2: Promote positive behavior change (sexual practices) among fisher communities.</b>			
Activity 2.1: Conduct a baseline survey	5,723,400	5,723,400	0
Activity 2.2: Hold awareness creation seminars	56,800,000	56,800,000	0
Activity 2.3: Life skills training for youths	18,180,000	18,180,000	0
Activity 2.4 Life skills training for parents	8,905,000	8,905,000	0
Activity 2.5: Hold radio talk shows	4,400,000	4,400,000	0
Activity 2.6: Stage Video Shows	5,760,000	5,760,000	0
Activity 2.7: Re-produce & disseminate local IECs	15,800,000	13,750,000	2,050,000
Activity 2.8: Hold drama shows	12,800,000	12,800,000	0
Activity 2.9: Support routine PEC /CF operations	36,000,000	36,000,000	0
Activity 2.10: Commemorate World AIDS days	13,080,000	13,080,000	0
Activity 2.11: Conduct quarterly review meetings	19,920,000	19,920,000	0
Activity 2.12 Document Best Practices	2,804,400	3,950,000	(1,145,600)
Activity 2.13: End of project survey	5,153,000	5,153,000	0
2.14 Sharing and Networking	2,700,000	2,399,500	300,500
Total for Objective 2	208,025,800	206,820,900	1,204,900
<b>Objective. 3: Increase correct and consistent condom use</b>			
Activity 3.1: Train Peer Educators as condom peer distributors	5,760,000	5,760,000	0
Activity 3.2: Hold condom promotion seminars	4,530,000	4,530,000	0

Total Objective 3	10,290,000	10,290,000	0
<b>Activity 4.0 PROGRAM MANAGEMENT</b>			
4.1 Personnel cost			
Programme Director (15% of time)	7,200,000	7,200,000	0
Community Development Manager (33%)	10,800,000	10,800,000	0
Finance & Administration Manager (23%)	8,280,000	8,280,000	0
Field Officer	12,000,000	12,000,000	0
4.2 Fringe Benefits			
NSSF	3,828,000	3,828,000	0
Medical insurance	3,062,400	3,062,400	0
End of project evaluation(participatory)	5,725,000	5,725,000	0
4.3 Travels			
To Kampala by Management	1,200,000	1,310,000	(110,000)
Within the district by management	6,000,000	4,149,200	1,850,800
Reporting to Management by Field Officer	1,680,000	1,470,000	210,000
4.4 Internet cost	2,880,000	2,440,462	439,538
4.5 Computer and office consumables	7,200,000	7,981,500	(781,500)
4.6 Annual Audit Contribution	2,001,000	2,001,000	0
<b>Total Management cost</b>	<b>71,856,400</b>	<b>70,247,562</b>	<b>1,608,838</b>

<b>CONTINGENCY</b>			
Activity 5.0 Contingency	18,998,210	22,009,611	(3,011,401)
Bank charges	-	508,111	(508,111)
Asset Engraving	-	110,000	(110,000)
Certificates	-	300,000	(300,000)
Video Tapes	-	200,000	(200,000)
VCT Outreach	-	11,375,000	
Retraining PECs in Palliative care and child counseling		8,160,000	(8,160,000)
Purchase of model Penises	-	390,000	(390,000)
Repair and service of Generator	-	284,000	(284,000)
Community leaders' dialogue meeting	-	682,500	(682,500)
<b>PROJECT COST</b>	<b>398,962,410</b>	<b>398,840,073</b>	<b>122,337</b>
			<b>Cost excludes last withdrawal bank charges</b>

## PART 3: RESULTS OF FICAP IMPLEMENTATION

### 3.1 Knowledge of HIV/AIDS

#### 3.1.1 Status of knowledge of basic facts about HIV/AIDS

Table 5 below shows that overall, FiCAP has made positive change with regard to general knowledge of the basic facts about HIV/AIDS. With the entire respondents having heard about HIV/AIDS, and 24% more correctly defining HIV/AIDS as a virus, the project has enabled the fishing communities to gain a good grasp of how HIV/AIDS can be transmitted, prevented and mitigated, as well as its symptoms and positive living and support services.

Table 5: Comprehensive knowledge of HIV/AIDS (%)

Basic facts about HIV/AIDS	Baseline 2008	End of project 2010	Variance
Heard of HIV/AIDS	93.0	100.0	7.0
Know HIV/AIDS as a virus	69.8	94.2	24.4
Know that HIV/AIDS exists	95.4	98.5	3.1
Know about ART services	71.2	97.1	25.9
Know that ARV is taken for life	25.6	77.2	69.2
Know of prevention of mother-to-child transmission	39.4	82.4	43.0
Know at least 3 ways of HIV/AIDS transmission	50.5	80.3	29.8
Know at least 3 symptoms of HIV/AIDS	75.3	89.4	14.1
Know at least 3 ways of HIV/AIDS prevention	55.7	85.7	30.0
Know at least 3 ways of positive living by PLWA	44.9	79.7	34.8
Know at least 3 essential prevention/mitigation services	39.6	84.7	45.1

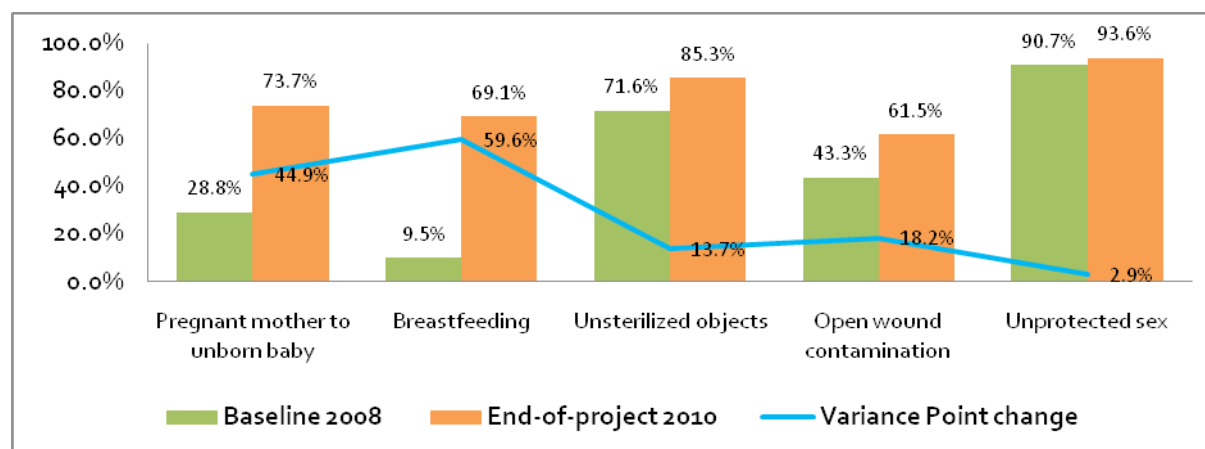
#### 3.1.2 Knowledge about modes of transmission

Apart from the general improvements in the knowledge about HIV/AIDS noted above, respondents were also asked to identify the various ways by which HIV/AIDS is transmitted from one person to another. Figure 1 presents a summary of the findings.

Evident from figure 1 above is the marked increment in the knowledge about HIV transmission in the areas of mother-to-child transmission during pregnancy and through breastfeeding. These modes of transmission were less widely known as compared to unsafe sex and use of unsterilized instruments during the baseline survey.

This finding was supported by the participatory evaluation meetings where it was reported that, *"because of FiCAP, many women, with the help of their husbands, are seeking antenatal care services"*. In this regard, the health assistant noted that, *'in the last 2 years, the number of supervised delivery has continued to increase in the health center among women with both HIV negative and positive status'*.

Figure 1: Knowledge of modes of HIV/AIDS transmission



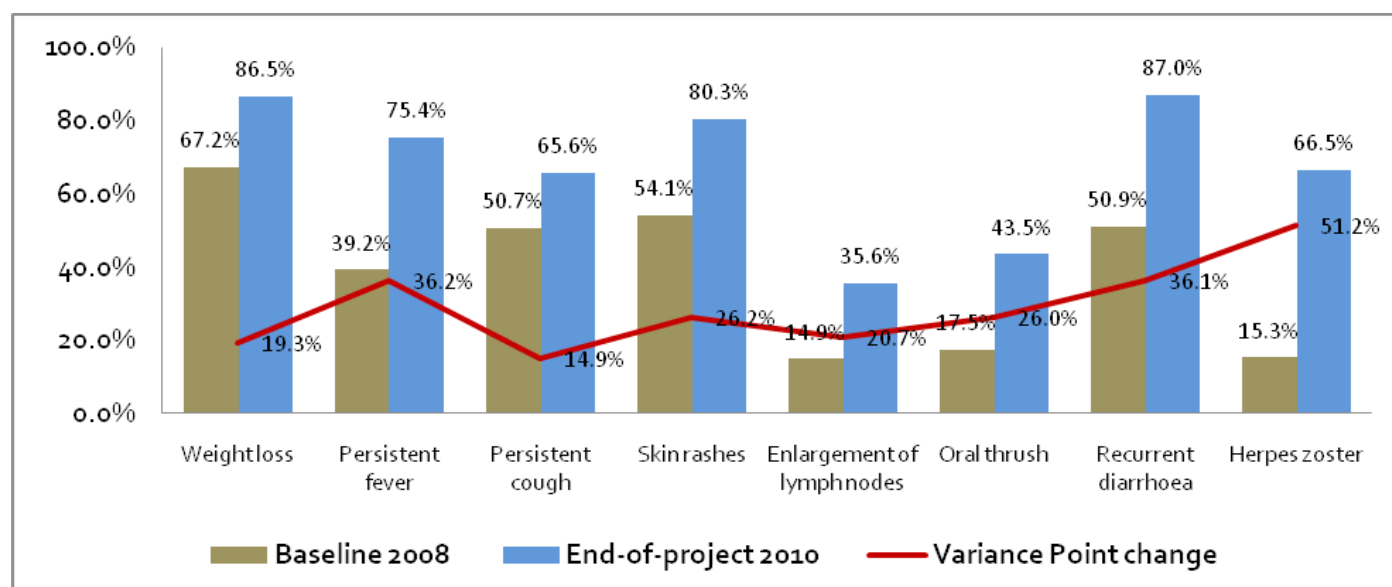
### 3.1.3 Symptoms of HIV/AIDS

Like with modes of transmission, Figure 2 below reveals that more gains were made in the knowledge of symptoms of HIV/AIDS. During the baseline survey, symptoms were confused with other sicknesses e.g., herpes zoster (associated with witch craft), recurrent diarrhea (linked to gastro intestinal worms), and persistent fever (with malaria).

Such increased awareness, the PECs reported, made many people to start demanding to know their HIV status hence the high unmet demand for VCT services. They noted that;

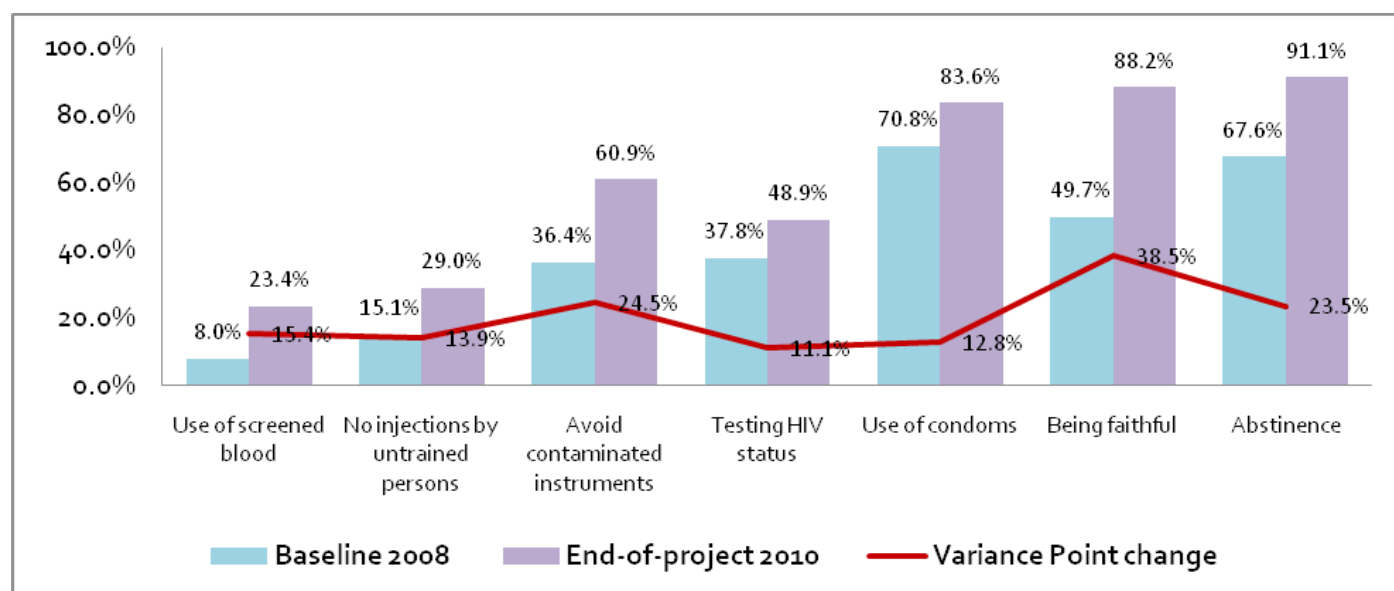
*Those who initially forgot about their risky lifestyles and linked such symptoms to other diseases became attentive once made aware of whether or not they had HIV. To find out, they started pressurizing the project to not only create awareness but also to provide testing services so that they may know their HIV status. Indeed, excess numbers of people always turned up whenever there was VCT outreach. And, many more are yet to be tested.*

Figure 2: Symptoms of HIV/AIDS infection



### 3.1.4 Prevention of HIV/AIDS

Figure 3: Knowledge of mode of HIV/AIDS prevention (%)



In order to assess whether gains were made in awareness about HIV/AIDS prevention, respondents were asked how they could prevent themselves from being infected by HIV/AIDS. The findings shown in figure 3 above reveals that more knowledge was registered in the awareness about being faithful (38.5%), avoiding contaminated instruments (24.5%), and abstinence (23.5%). Limited awareness however continues to linger about risky practices such as ignorance about one's HIV status, taking injections from quack health personnel and sharing of blood.

### 3.1.5 Positive living methods

Everyone is either affected or infected by HIV/AIDS scourge. Respondents were also asked about how Persons Living with HIV/AIDS (PLWA) should live positively in order to mitigate the effects of HIV/AIDS. Table 6 below shows the findings.

It is evident that more people are willing to accept their HIV status and live faithfully with their partners. This is contrary to the baseline status where a PLWA asked, 'Why should I bother using a condom when I am already infected?' A member of the Post Test Club (PTC) who was present in the evaluation meeting remarked;

*Before I knew my HIV status, it was easy for me to contemplate spreading the disease to other people should I know that I am HIV positive. However, when I knew that I was HIV positive, I abstained from sex given the series of pre-test counseling done by the health officials from Pakwach and post-test counseling conducted by the PECs that made me realize that it was prudent to live even longer positively than to engage in any risky sexual practices that would instead hasten my death.*

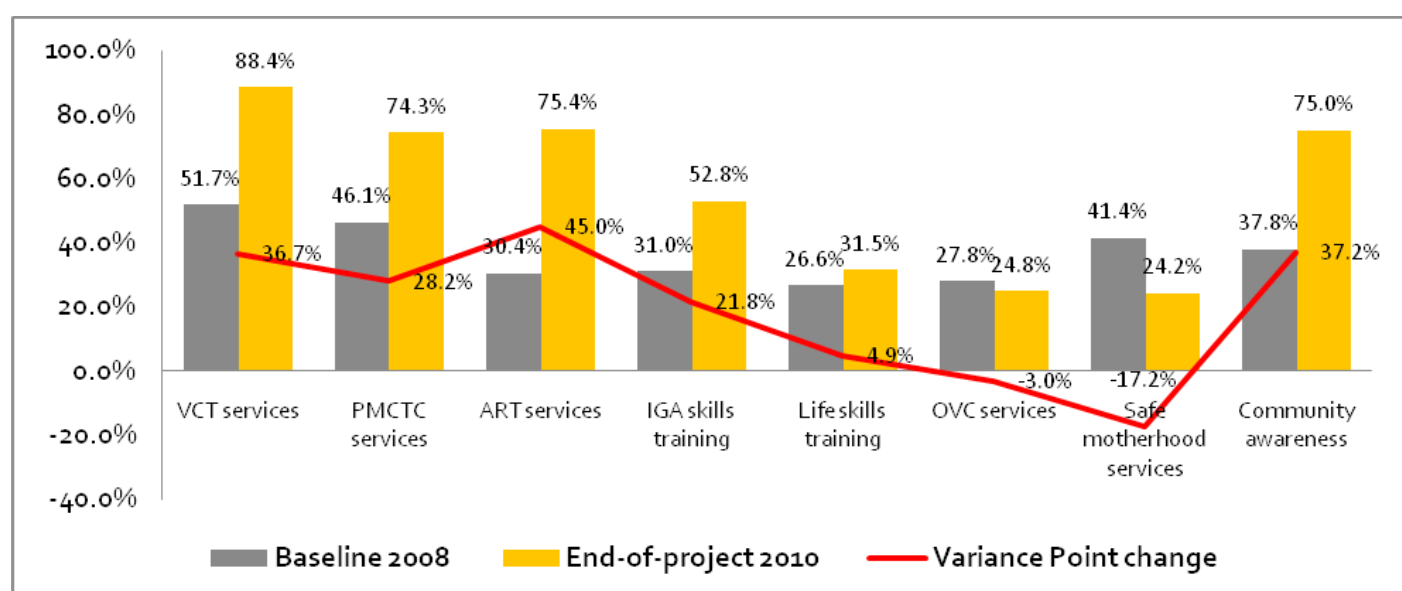


Table 6: Knowledge of PLWA mitigation mechanisms (%)

Mitigation mechanisms	Baseline 2008	End of project 2010	Variance
Accept one's status and live openly	33.0	78.5	45.5
Eat nutritious and balanced diet	56.5	85.7	29.2
Be faithful to one's partner	40.6	80.7	40.1
Avoid infecting others	37.2	68.1	30.9
Run IGA and plan for the future	26.4	44.5	18.1
Seek advice on counseling	49.3	59.8	10.5
Treat opportunistic infections	44.9	59.2	14.3
Always use a condom when having sex	29.0	61.1	32.1

### 3.1.6 Prevention and mitigation support services

Figure 4: Knowledge of prevention and mitigation support services



The study also assessed the extent of change in the knowledge about support services. Figure 4 above shows that both gains and losses were made. While more people gained awareness about ART services (45%), community awareness creation (37.2%), and VCT services (36.7%), some people actually forgot about safe motherhood and OVC services. Further analysis of this finding with respect to PECs awareness also revealed that few PECs (only 35% and 38%) were knowledgeable about safe motherhood and OVC services.

## 3.2 Sexual norms and practices

### 3.2.1 Access to sex information

The cardinal mode of HIV/AIDS transmission among fishing communities is high risk (unsafe) sex due in part to limited sex education and communication. In such a multi-cultural environment, many fisher folks are left to learn by (s)experience. Thus, respondents were asked whether or not they had access to sex information. Table 7 below shows that, contrary to the past when majority of the people lacked access to sex education/communication (about

53%), at the end of project period, all respondents had access to such information. The frontier of sex education also increased from the dominance of peer-to-peer learning. Parents and community leaders too have joined hands to freely discuss issues related to sex without fear. On this note, a religious leader during the evaluation meeting pointed out that;

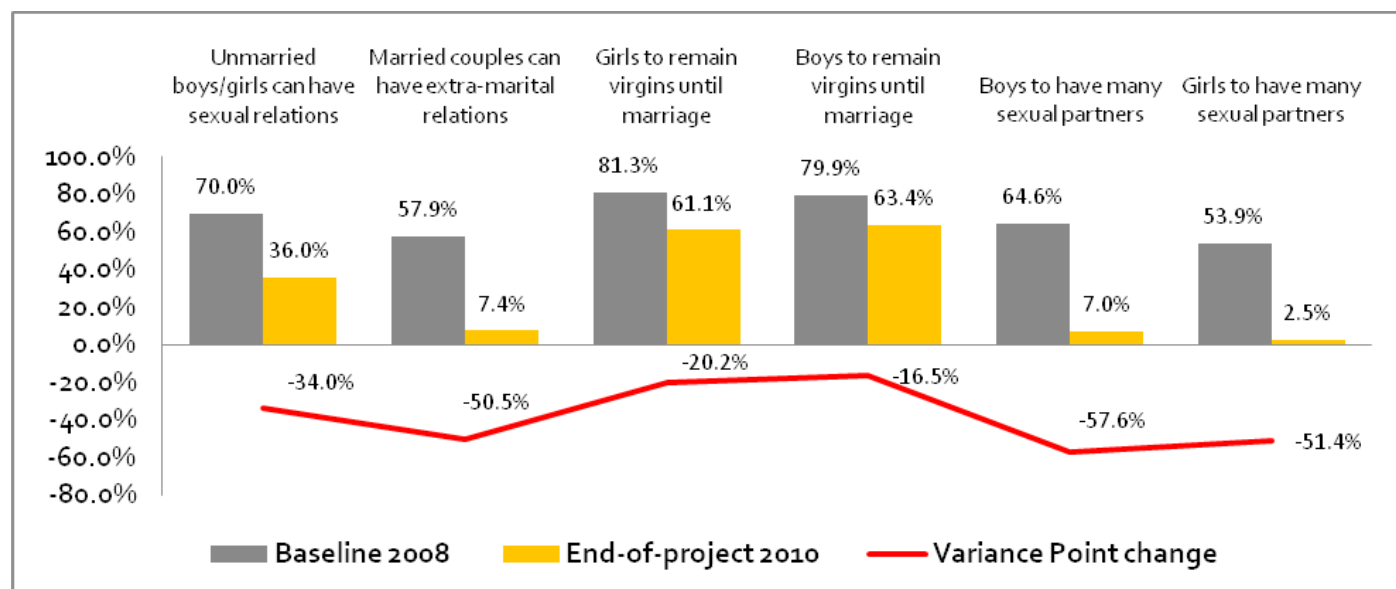
*Before we knew the critical messages of HIV/AIDS, it was a shame to talk about sex with the youths and our congregations. However, after the community leaders' dialogue meeting, it became clear that we may be saving souls that are in pain. We opted to invite the PECs to also talk to our flocks on the details of HIV/AIDS.... It is working! Many youths now feel free to come and consult us on what they are not sure about... As a result, sexual promiscuity is on the decline especially among young people.*

Table 7: Access to sex information (%)

Sex education/communication	Baseline 2008	End of project 2010	Variance
Proportion with access to sex information	47.1	100.0	52.9
Discussed sex information with parents	48.9	55.1	6.2
Discussed sex information with peers	87.5	82.6	-4.9
Discussed sex information with partner	84.5	80.9	-3.6
Discussed sex information with community leaders	61.8	67.3	5.5

### 3.2.2 Sexual norms

Figure 5: Changes in sexual norms



That unsafe sex does not occur in a vacuum but within socially ascribed norms, participants were also asked about the critical motivating beliefs that were found during the baseline study. Figure 5 below reveals the findings. It is evident that there has been a general positive decline in rejection of unsafe sex. Premarital sex, extra-marital sex, and multiple sexual partners were rejected. However, the same figure also shows that there is still some degree of acceptance that depicts abstinence and virginity as not important. This was echoed by the youths in the evaluation meeting that, "what is critical is to be careful with your sexual partner. One can have a partner at a time instead of the traditional more than two".

### 3.2.3 Sexual practices

Table 8: Changes in sexual practices

Sexual practices	Baseline 2008	End of project 2010	Variance
People who did not engage in sexual intercourse (%)	41.2	42.9	1.7
Median age at first sex (years)	16.0	15.0	-1.0
People in willful sexual engagement (%)	96.0	67.7	-28.3
People with casual sexual partners (%)	37.1	25.4	-11.7
People with multiple sexual partners (%)	20.4	37.3	16.9
People engaged in intergenerational sex (%)	49.4	2.2	-47.2
Median age of sex partner (years)	14.0	25.0	11.0
Transactional sex in cash (%)	5.2	23.7	18.5
Transactional sex in kind (%)	17.3	29.8	12.5
Payments initiated by self (%)	64.7	43.3	-21.4

FiCAP was also envisaged to change the unfettered and risky sexual practices among the fisher folks. From the findings about sexual activity respondents engaged into a month preceding the survey (see table 8), it is evident that some gains were made in the reduction of sexual activity (by about 2%) in the following area: casual sexual partners (by about 12%), intergenerational sex (by about 47%) and in the median age of sexual partners (shifting more to mainly adults).

To the contrary, there was increase in early age of sex initiation coupled with a rise in transactional sex and having multiple sexual partners. Even if practiced by those mainly 15 years and above, it means many young people are still affected and that there is increasing risks of (re)infection if unprotected sex is used as is shown below.

## 3.3 Condoms management

### 3.3.1 Use of condoms

With sexual transmission noted as the primary cause for the unrelenting high HIV incidence rate, safer sexual practices through the use of condoms is vital in preventing further spread of infections. Respondents were asked about their awareness about, and use of, condoms. The result is summarized in Table 9 below, which shows that in spite of the increase by 6.1% in the awareness about condoms, there was a consistent decline in almost all facets of condom access, use and decision-making. Such changes were reported in the participatory evaluation meeting to be associated with the unsteady supply of condoms. A beach management official wondered, *"how can people adopt a consistent use of condom when supplies are erratic? It often took 2-3 months before another supply is provided"*. As such, a youth PEC noted that *"because of the unsteady supplies together with transactional sex, people largely depended on others in accessing condoms"*.

Table 9: Knowledge, main sources and use of condoms (%)

Key indicators	Baseline 2008	End of project 2010	Variance
Ever heard about condoms	81.3	87.4	6.1
Sources of condoms			
- Health facilities/officials	22.4	8.7	-13.7
- Clinics/drug shops	30.5	26.7	-3.8
- Shops/lodges	41.2	25.3	-15.9
- Peers	3.7	39.0	35.3
Condom use			
- Used condom in the last sexual intercourse	53.3	34.2	-19.1
- Used condoms consistently in the last sexual intercourse	36.8	25.5	-11.3
Key indicators	Baseline 2008	End of project 2010	Variance
Initiator of condom use			
- Self initiated condom use	69.5	63.7	-5.8
- Partner	21.6	18.9	-2.7
- Others (e.g., peers)	8.9	17.4	8.5

Further discussions on condom use revealed that it is one of the most difficult aspects to adopt in the sexual lifestyle of fisher folks. A sex worker noted that,

*Here in the landing site, sex is not planned for like in urban areas. You simply have it as and when you agree to have one. Location does not matter because people have sex anywhere that is convenient for them as long as no one is watching. With such rampant quick sex, who has the energy to first run and secure a condom? Beware, good condoms also need good storage and you cannot continue walking with condoms in your pocket all the time.... Unless people get to know that safe sex must be organized in both time and place, there will be limited change in the existing risky unprotected sex.*

### 3.3.2 Condom disposal

Table 10: Used condoms disposal areas (%)

Places of disposal	Baseline 2008	End of project 2010	Variance
Bush	13.1	6.1	-7.0
Latrines	80.1	97.6	17.5
Garbage pits	1.5	1.4	-0.1
Others	5.2	1.0	-4.2

The uptake of condom use requires effective disposal. Asked about where they disposed off used condoms, respondents presented effective condom disposal management. Table 10 below shows that there was about 18% increase in most of the used condoms being disposed off in latrines. Such practices leaders noted, "Has helped in making sex private contrary to the past when we would be uneasy seeing a used condom disposed off anyhow".

### 3.3.3 Why used condoms

Figure 6: Reasons for using condoms

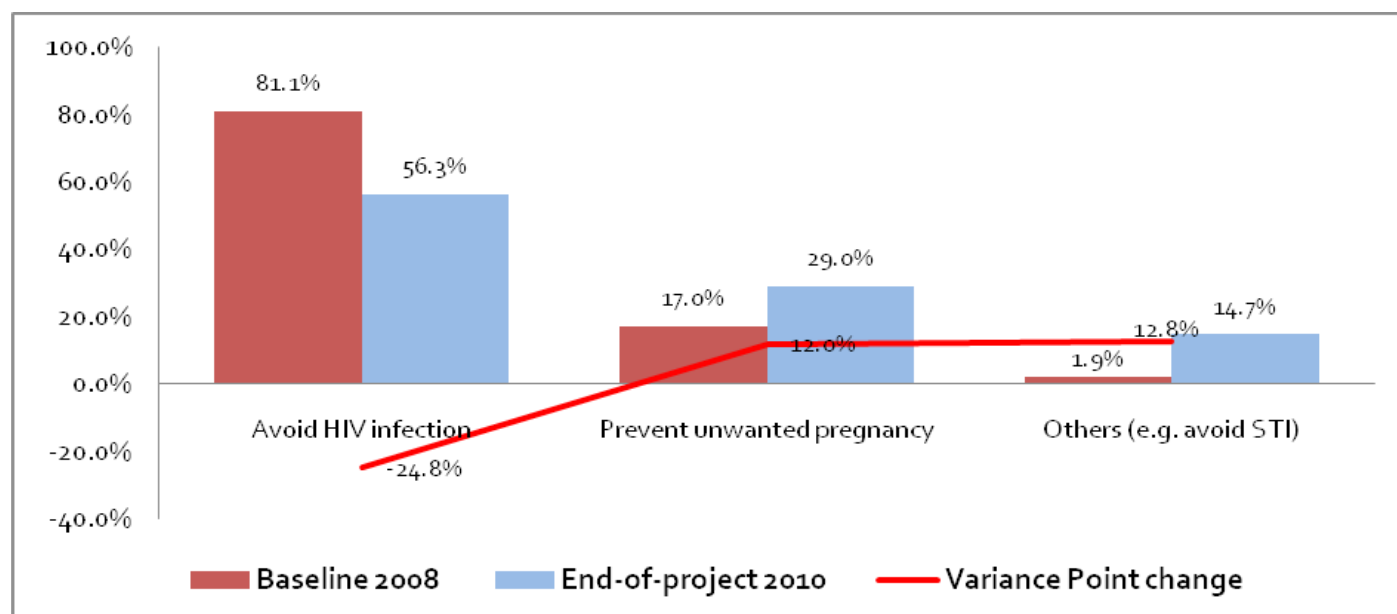


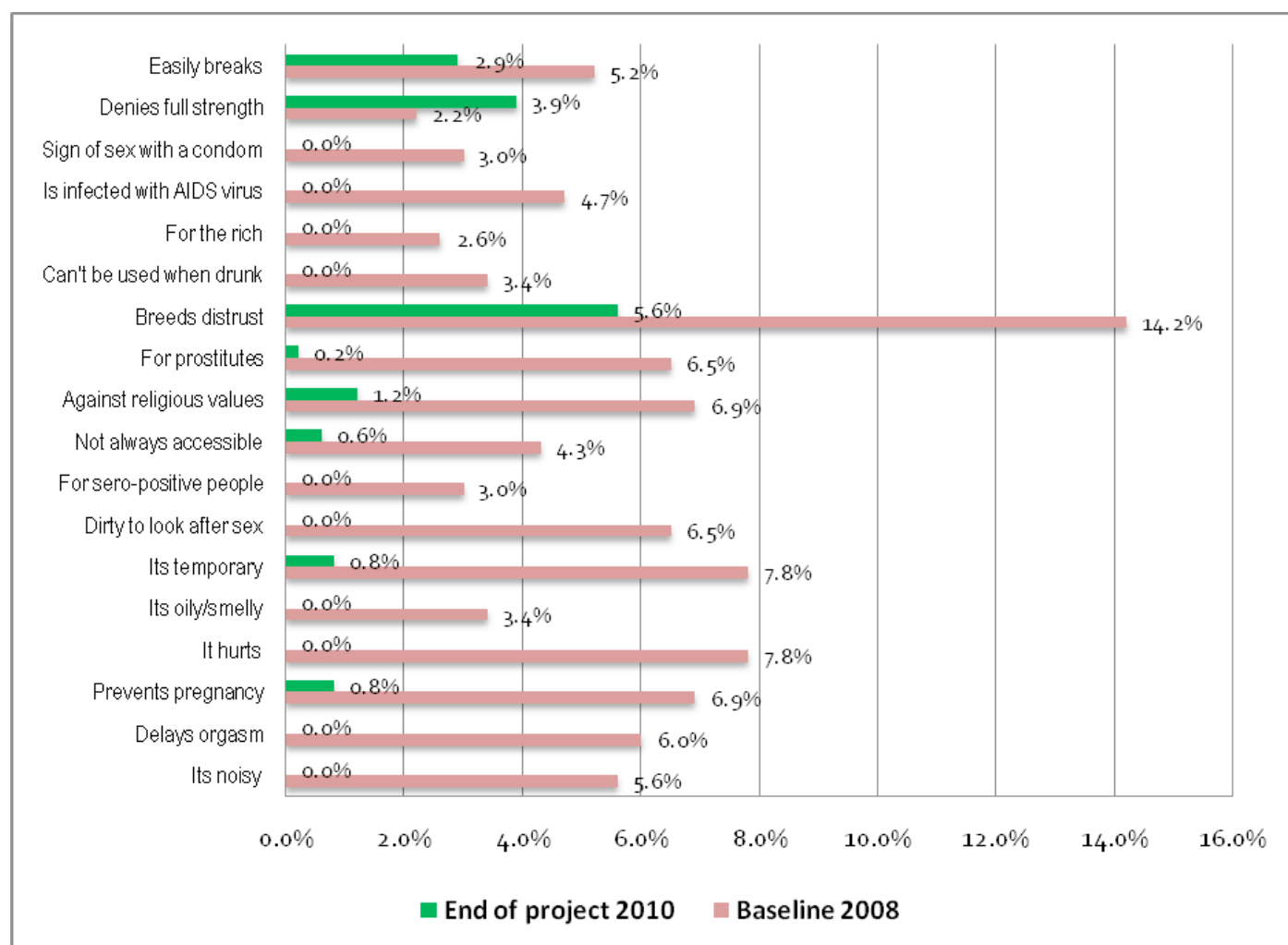
Figure 6 above shows why the fisher folks in Panyimur use condoms. Important to note is that while during the baseline survey many people largely knew condom use as a means of HIV/AIDS prevention, with FiCAP such limited knowledge was widened to include the awareness that condoms can also play a role in family planning as well as preventing infections of other sexually transmitted diseases. A male youth noted that,

*Before the awareness created by the PEC, I shunned condom use because my main aim of having sex was to get as many children as possible. Overtime, I realized that I had 6 illegitimate children and never wanted children anymore. Thus, I have now stuck to condom use to avoid unwanted children. For the last 1 year, I have not yet made any girl pregnant. I feel happy that I have found a simple solution in just using a condom.*

### 3.3.4 Why condoms were not used

Those who did not use condoms in the last sexual intercourse were asked why they opted not to. Figure 7 shows that from the various reasons advanced for not using condoms during the baseline study, many myths have disappeared. For instance, misconceptions that condoms are already infected with the HIV, it is for the rich, it delays orgasms and cannot be used when drunk were dispelled. The few reasons that are persisting for resistance to condom use include issues of distrusts, condom strength, and religious beliefs among others.

Figure 7: Reasons for not using condoms



## 3.4 Attitudes and practices towards HIV/AIDS prevention and mitigation

### 3.4.1 Voluntary Counseling and Testing

The HIV/AIDS scourge can be prevented and mitigated if people changed their attitude and practices towards risky behaviors that predispose them to (re)infection. To assess how much has changed in this respect, respondents were asked about basic precautionary behavior regarding HIV/AIDS.

In regard to Voluntary Counseling and Testing (VCT) services as a key component in prevention and mitigation, Table 11 shows that there has been a marked increase (17.4%) in awareness as well as proactive responses to testing (increased by 43.5%). The high increase in the number of people who tested their HIV status was because the project provided quarterly support (from the contingency fund) towards facilitating officials from Pakwach Health Centre IV to conduct VCT outreaches. During such visits, the PECs played a motivational and backup role of effectively mobilizing people as well as conducting pre-test and post-test counseling. This made it possible for the visiting health officials to test more than 40 people per visit as was the norm.

Through the VCT, the proportion of people willing to deliberately infect others drastically declined by about 13% in the two years of the project as one PLWA confessed:

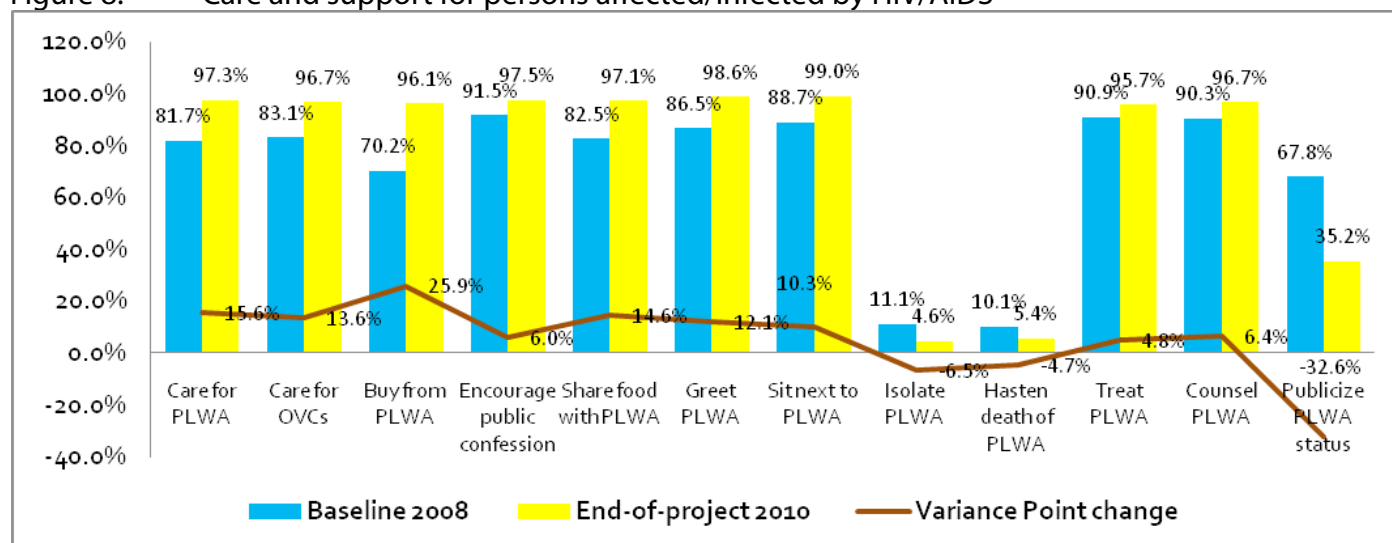
*When I was preparing to go for the HIV test, I wondered what I would do if I was found HIV positive. For the whole night I was afraid of what next. I zeroed on the fact that I will die with other people too. I would infect as many people as possible. However, during the post-test counseling I was made to know that, first, I needed to cross-check my HIV status in the next 3 months. Meanwhile, I was cautioned to be carefully with reckless lifestyle because it will expose me to re-infection (probably from a more dangerous type of HIV). I adhered to all the advices and retested after another 3 months. When I was confirmed HIV positive, I had to stick to the fear of “if I misbehaved I may expose my sick self to deadly infections”...[A]s I talk now, I have not had sex nor shared any sharp instrument like a razor blade or safety pin with anybody and I will not willingly do that.*

Table 11: VCT knowledge and practices (%)

	Baseline 2008	End of project 2010	Variance
Accepts that HIV/AIDS exists	95.4	98.5	3.1
Heard of VCT services	80.9	98.3	17.4
Tested sero-status	30.0	73.5	43.5
Willing to test sero-status	83.7	85.9	2.2
Willing to infect many people once known HIV positive	13.9	1.4	-12.5

### 3.4.2 Attitudes toward PLWA

Figure 8: Care and support for persons affected/infected by HIV/AIDS



Questions about attitudes and practices related to living with, and supporting, PLWA were also asked. Figure 8 summarizes the findings. Evident therein is that the respondents' exhibit a very high empathy and acceptance of PLWA and OVCs as part of them. Over 70% are willing to provide care and support. Equally, even the rather high community stigmatization status during baseline status positively declined by about 33% for negative publicity.

The marked improvement in the social and self-acceptability of PLWA and OVCs was attributed during the participatory evaluation meeting to the emergence of Post Test Clubs (PTCs) in all the major fishing villages. The PTCs where both HIV negative and positive members work together has rekindled the old social safety net system where the able provided for the unable. A PLWA member of the PTC in Boro remarked: "Today we can stand up and talk freely without fear and humiliation thereafter because the PTC has given us acceptance. Together with HIV negative colleagues we raise funds to support access to ART. We also accompany PECs on their peer education sessions".

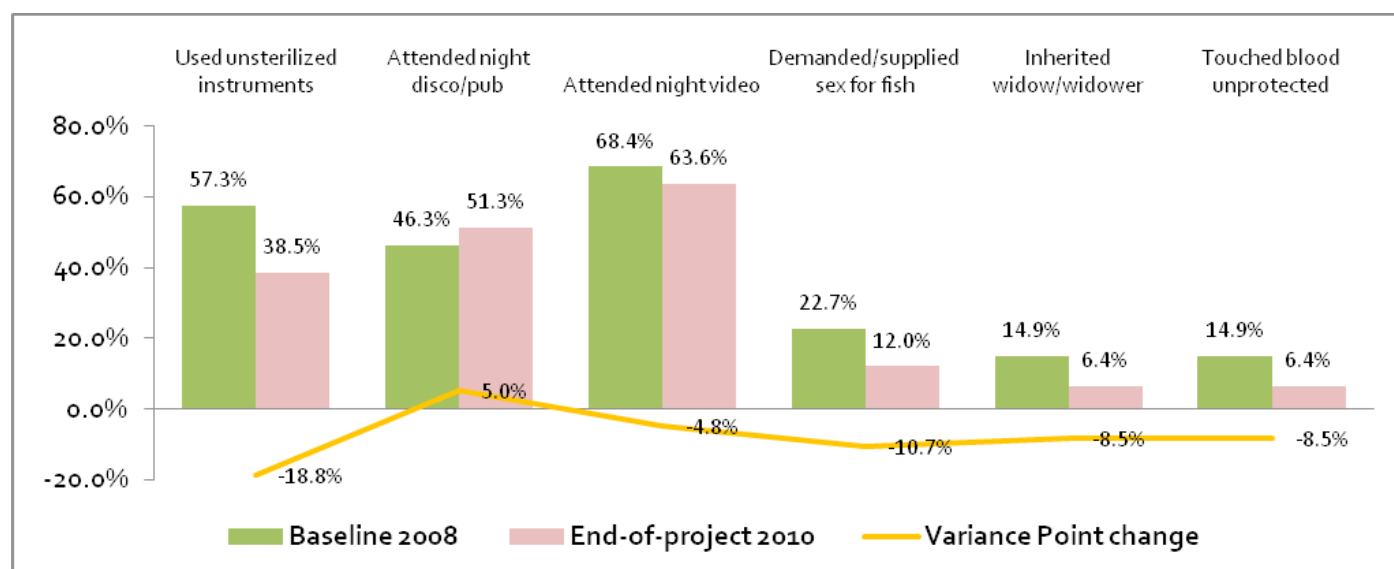


### 3.4.3 Predisposing behaviors

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 in some of the activities considered of high risk within the one month preceding the survey. Figure 9 shows that there was a marked decline (between 5-19%) in most of the predisposing activities. Sharing unsterilized instruments, widow inheritance, sex for fish, and touching blood unprotected all declined. What showed an increase was attendance of night disco/pub (by about 5%). This risky avenue the local government noted continues to persist because of the fish market as one official remarked:

*Fish traders (of course including sex workers) start coming to Singla on Saturday evening. Until mid-day of Tuesday when the sales is closed, many people cannot help but to spend much of their time in disco and bars. It is here where sourcing for sexual partners as well as having sex indiscriminately sparks off. With money and the influence of alcohol, women and men, boys and girls all ably seek partners for whom they pay either in cash or in kind (mainly by buying alcohols)...[A]ttempts to stop such trade, unlike with night video, were vehemently resisted by the business community.*

Figure 9: Engagement in risky practices



## 3.5 Community responsiveness

### 3.5.1 Justification for community concern

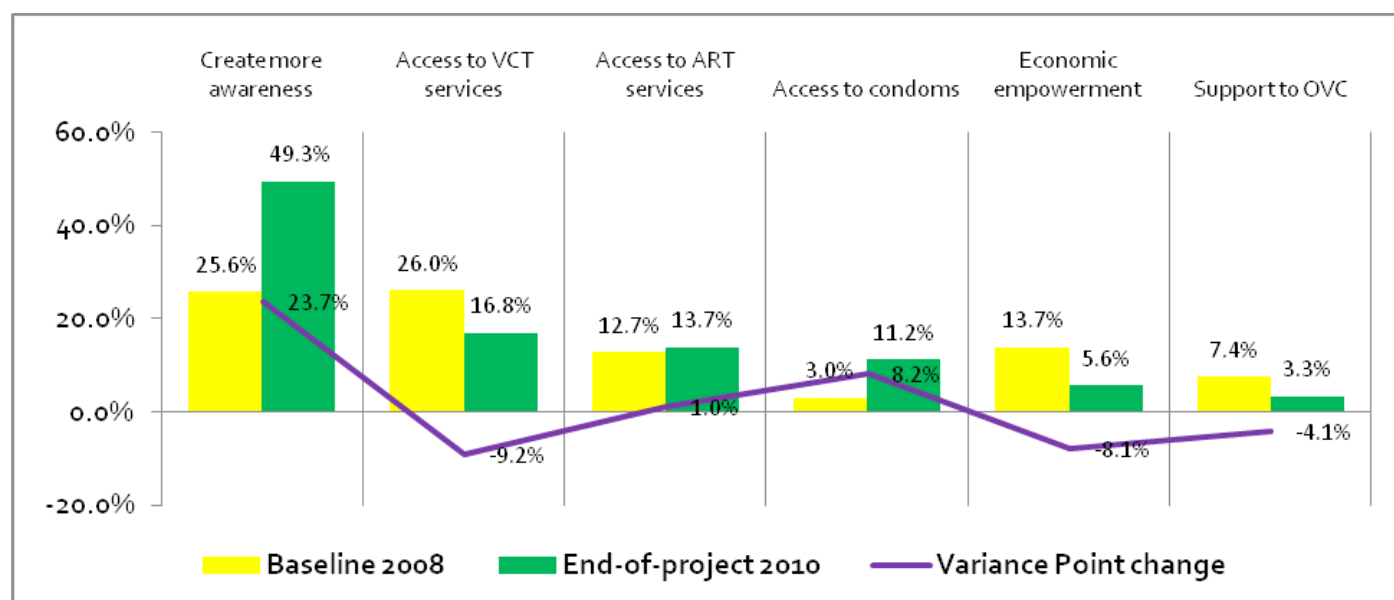
While AFARD's commitment to CSF was to promote positive behaviour change through BCCE so that in the long run HIV/AIDS incidence rate is reduced and at the same time enabling fisher community to mitigate the would-be devastating effects of the scourge, the beneficiary community of Panyimur too had their own expectations from FiCAP. Consideration was taken of these concerns for three reasons. First, for FiCAP to be relevant, it had to respond to the needs of the beneficiaries. Second, such relevance can best be described by the beneficiaries as they own and voice what worked and not (primary evaluators). Finally, this consideration was also for sustainability purpose given that rallying the people to work hand in hand with the PECs in furthering FiCAP goals would require that they see the project as not just their own but also responsive to their needs.

### 3.5.2 Expectations met

Community needs were identified during the baseline survey (and the subsequent follow-up strategy design meetings). Figure 10 below shows that by and large, in the primary focus of FiCAP (awareness creation), 24% point advantage was scored in meeting community expectations. Likewise, positive gains were made in the provision of condoms and support to ART services by the PTCs.

The cases for decline had varied reasons. For instance, the decline in VCT services by 9% in meeting community expectation was by and large a result of the high unmet demand given that outreaches were supported only by contingency funds. For economic empowerment and OVC support, the respective 8% and 4% declines emanated from the limited scope of the call for proposal that saw prevention only from BCCE perspective. Besides, the limited economic enhancement through the nascent PTC credit schemes had limited benefit coverage (to only the few PTC members).

Figure 10: FiCAP's responsiveness to community envisaged changes



# PART 4: PEER EDUCATORS-CUM-COUNSELORS' CAPACITY ASSESSMENT

## 4.1 Justification for and the focus of the capacity assessment

FiCAP was designed to span for only 2 years. This duration, basing on AFARD's experience in HIV/AIDS work among fishing communities along L. Albert, warrants a gradual exit plan. However, such an exit, AFARD believes, requires a competent local institution capable of carrying the mantle of HIV/AIDS prevention together with community care and support. It is for this reason that while assessing the extent to which FiCAP changed fisher folks' lifestyles, a prudent strategy was also adopted to assess how competent the PECs as local change agents were in continuing with nurturing the seeds FiCAP sowed.

In order to ascertain PEC's competency two critical aspects were explored, namely:

- (i) The general level of knowledge of the PECs on the basic facts about HIV/AIDS. This judgment was based on the fact that as educators, PEC's were required to be more aware of the critical contents of what they are expected to transmit to the community. Data for this assessment was collected through individual interviews of the PECs.
- (ii) The level of organization that the PECs have in facilitating the coordination of their operations. Answers to this issue were sought through the participatory evaluation meetings that assessed the organization, management and sustainability of the PTCs.

Below we present the findings of PECs level of awareness and their organizational ability.

## 4.2 Status of knowledge of basic facts about HIV/AIDS

Table 12 below shows that overall the training of PECs as the local frontline change agents leveraged them to acquire and internalize better practice knowledge of the basic facts about HIV/AIDS. With 27% more PECs correctly defining HIV/AIDS as a virus (3 points above that of the community score), PECs generally have more knowledge of HIV/AIDS transmission, symptoms, prevention, and mitigation measures such as positive living and support services.

Where the scores are marginal compared to that of the community members, the PECs in the evaluation meeting noted that even among themselves as peers there are differences in educational status as well as practical religious and social beliefs. As such, although the PEC training requires them to adhere to the basic scientific truth, a few of the PECs are still attached to their belief. A case in point was one youth PEC from Wathparwoth (not named here) is noted to still be carrying some myths about HIV/AIDS.

Table 12: Better knowledge and practices for HIV/AIDS education (%)

Issues around HIV/AIDS	Baseline 2008	End of project 2010	Variance <sup>1</sup>	Variance (Vs community score) <sup>2</sup>
Heard of HIV/AIDS	93.0	100.0	7.0	0.0
Know HIV/AIDS as a virus	69.8	96.7	26.9	2.5
Know at least 5 ways of HIV/AIDS transmission	50.5	93.3	42.8	13.0
Know at least 5 symptoms of HIV/AIDS	75.3	95.0	19.7	5.6
Know at least 5 ways of HIV/AIDS prevention	55.7	93.3	37.6	7.6
Know at least 5 ways of positive living by PLWA	44.9	95.0	50.1	15.3
Know at least 5 essential mitigation services	39.6	93.3	53.7	8.6
Ever heard about condoms	81.3	98.3	17.0	10.9
Knows that condom is also a family planning tool	17.0	34.8	17.8	5.8
Heard of VCT services	80.9	100.0	19.1	1.7
Tested sero-status	30.0	95.0	65.0	21.9
Know about ART services	71.2	98.3	27.1	1.2
Know that ARV is taken for life	25.6	85.0	59.4	9.8
Know of prevention of mother-to-child transmission	39.4	98.3	58.9	15.9

*\*Note: Parenthesis shows were the PECs have low scores than community members.*

### 4.3 Organizational ability

The entry of FiCAP in the 5 epicenter fishing villages was to ensure that a local institution and system was set in place to fill the vacuum of service delivery the community members had suffered all along. Thus, the PECs were established as frontline service providers. They were identified by their respective communities. They represented all social categories of the fisher folks. Indeed, their training and the subsequent refresher courses had enhanced their capacity to deliver quality services to their communities – education, counseling, referral, and coordination of community networking.

Yet, the PECs per se were incapable of sustaining service delivery in the area for two basic reasons. First, without project motivation, many PECs will remain uncommitted to their work. Second, secluded and packaged as 'PECs only' affair, many community members will take a hands off approach and look at PECs more like a special interest (or at worst an AFARD) team. These gaps called for the need to institute a community wide system. Thus, the Post Test Clubs (PTCs) were born to ensure collective responsibilities and local ownership. Both PECs and non-PECs became members of the PTCs whose aims are to continue with HIV/AIDS prevention as well as mitigating the effects of HIV/AIDS starting with member PLWA.

At the time of the evaluation, the 5 PTCs had 385 members (159 males 226 females) with elected leadership. They had accumulated UGX 20,130,600 that they were revolving as loan fund. The proceeds from the loans are used to support 69 PLWA to ensure ART adherence regardless of the distance to service points. Some PLWAs are provided with financial support to access ART services from Arua referral hospital (>100Kms away).

However, while the PTCs provide fertile anchors for coordination and ownership, they are faced with basic organizational development challenges namely:

- (a) Leadership and governance is still not shared. Many members feel that the PECs must continue to lead the PTCs. In some, participatory governance is weak as the executives hardly consult with members on matters that require consensus.

<sup>1</sup> Variance is computed from the same 2008 baseline status since at that time both the PECs and other community members were without external intervention and thus were assessed using the same criteria. During implementation, the PECs were then trained as educators and thus herein they are assessed on 5 key variables.

<sup>2</sup> This PECs and Community variance comparison is conducted to test how better off PECs are as compared to those they have been educating.

- (b) The commitment of the PTCs to support PLWA (and also OVCs later) requires adequate resources. The current resource base of the PTCs is narrow and unable to assist the increasing number of PLWA. All PTCs largely depend on membership contributions. It is only Angumu that receives some financial support from their Beach Management Committee (average UGX 50,000) every 2 months. Not assisted with carrying the heavy burden, members of the PTCs will become demoralized and this may result into fatigue and membership withdrawal.
- (c) Further, the loan schemes that the PTCs are operating are being run on trust but in an ad hoc manner. No clear, written regulations are in place. Borrower's tracking is weak and the general reporting is wanting. Such gaps can provide opportunities for fraud and hence the collapse of the schemes.

In all, while there are in place local institutions, at nascent stages, that can champion continued benefits from FiCAP, it is important that the members rearticulate their direction and commitments in a way that everyone is bound to pursuing a shared dream of reducing both the incidence and effects of HIV/AIDS among the fisher communities in these areas.

# PART 5: LESSONS, CHALLENGES, AND WAY FORWARD

## 5.1 Lessons Learnt

The brainstorming sessions during the participatory evaluation meetings showed both positive lessons (to be replicated) and negative lessons (warranting immediate redress) as below.

### Positive Lessons learnt

- In HIV/AIDS programming, education should be provided together with testing and counseling services. This is because once people are educated they evaluate their past lifestyles and gradually demand to know their HIV status. Those who turn HIV positive and have decided to declare their status equally requires due attention which is better met by Post Test Club (PTCs) as sustainable community care and support systems for PLWAs/OVCs. However, it requires economic empowerment of the PTC members.
- To change people's behavior for better health, it is cost-effective and sustainable to work with local change agents who know their communities because they are able to customize messages, follow up individuals, counter resistance and easily mobilize support. However, they require adequate training, periodic backstopping and IEC materials to deliver effectively.
- HIV/AIDS is not a health issue only. It is closely linked with the economic (dis)empowerment of the people and can better be approached from a multi-pronged approach that integrates prevention and mitigation measures. For instance, economic empowerment catalyses community care and support systems for PLWA and OVCs.
- Behavior change communication can impact better when a multi-channel approach that is built on local area sensitive practices are used.
- To leave a sustainable impact, building local capacity of community based change agents is important. These agents need both skills and tools with which to deliver services.
- It takes time for people to openly declare their HIV 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 further spread.
- The provision of VCT gives meaning to HIV/AIDS education and it presents the critical point for closing the loop between new infection prevention and mitigation prevention programming.
- Working in harmony with all stakeholders promotes the effective execution of the various roles each of them has in HIV/AIDS prevention and mitigation.
- Regular reviews provide a basis for accountability, design of new strategies, and mobilization of support from various stakeholders.

### Negative Lessons learnt

- Banking on government services delivery is very risky as there is limited predictability of when and in what quantity such services will be provided. It is therefore important right from the design stage to create a system that can either make government services effective or that which will complement on the weak government efforts.
- Ignoring the vital positions and symbolic powers local leaders play in any community creates a roadblock to project implementation. Involve them in manners that rhyme with their status so that they can lend in their support to the acceptance of their communities.

- Closing the peer groups to only age category excludes many people who are better targeted by their social affiliations like religion, business, etc. Always target peer groups using broad social categorisations that are considered vital in the community.
- One-off skills training are not adequate for enhancing the capacity of local actors to provide comprehensive services. In designing skills capacity building of local actors, provide for post-training follow-ups as well as refresher courses that deepen their practical skills.
- ABC strategy prioritized reduction of HIV infection from sex-related modes of transmission overshadows other potentially grave means of HIV transmission. Always customize messages to existing practices highlighting at risk factors for a more balanced campaign.

## 5.2 Persisting challenges

The following were noted as roadblocks to deepening impacts.

- The project duration was too short for effective positive behavior change especially in fishing communities with a multitude of cultures and fluid population.
- The PECs still had some knowledge gaps, this hampers their ability to deliver comprehensive knowledge in the community.
- The newly created PTCs, young as they are, suffer from governance, leadership, and resource mobilization challenges that may affect their growth, cohesion and scope of service delivery in the future.
- An inadequate supply of condoms from central government to the district health sector has made access to condoms intermittent, and as such, the efficacy of condom use in promoting prevention continues to be limited.
- Likewise, VCT outreach by government health facilities are too inadequate to meet the high demand the community members have after receiving BCC education messages.
- Livelihood insecurity has caught many parents between 'two hard rocks' - they can neither support, nor stop their children from promiscuous acts which meet their needs in the short-run at the expense of their future. For instance, many girls resort to 'sex-for-money' while boys take up to mixing with older fishermen during fishing from which they learn high-risk life styles.

## 5.3 Way forward

Inasmuch as the delivery of BCCE customized to local situations through the PECs and with multi-communication channels increased, awareness gaps remain visible in the detail comprehension of basic facts about HIV/AIDS. For instance, issues related to transmission by mother-to-child transmission and open wound contact, prevention by use of screened blood, access to medical services from quack personnel, and HIV status testing, and positive living through timely seeking of counselling and treatment of opportunistic infections requires grounding. Most worrying is also the gradual change in safer sexual practices; something that can be attributed to the short project timing as well as the inadequacy of government-centred condom supplies.

It is therefore important that for FiCAP to deepen the gains it has made in the various fishing communities the following are done:

- a) The PECs should be refreshed on basic facts as well as critical education and counselling strategies.
- b) FiCAP continues to secure and provide condoms to the PECs for peer-based distribution-with- education.
- c) The various PTCs should be strengthened as locally owned and managed structures for continued service delivery.

## Annex 1: Project outreach fishing villages

Parishes	Epicenter Fishing village	Satellite landing sites/villages
Nyakagei	1. Kayonga	a. Awulu b. Nyamutagana A c. Nyamutagana B
	2. Angumu	a. Rwanga b. Adundo c. Nyaloi
Ganda	3. Wathparwoth	a. Abok b. Munywa c. Bonguloya d. Ugal
Boro	4. Wangkadu	a. Portbell b. Ganda c. Kaligonzi
	5. Mututu	a. Jakok b. Mbaguru

## Annex 2: Project Assets

Date	Details	Location	Units	Source of funding
<b>Computers</b>				
2008	Toshiba Laptop	CDM'S Office	1	CSF
<b>Equipments</b>				
2008	Tigmax Generator+Stabiliser	Panyimur	5	CSF
2008	Sonny Digital Camera	CDM's Office	1	CSF
2008	Digital VHS/DVD	Panyimur/Office	6	CSF
2008	Samsung "21" TV Set	Panyimur/Office	6	CSF
2008	Public Address System	Panyimur	10	CSF

## Annex 3: Social categories reached by awareness creation seminars

Parishes	Epicenter fishing villages	10 -14 years			15-24 years			25+ years		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Nyakagei	Kayonga	1,321	1,267	2,588	1,138	798	1,936	1,010	789	1,799
	Angumu	1,096	1,234	2,330	1,090	1,007	2,097	1,212	1,092	2,304
Ganda	athparwoth	1,109	1,098	2,207	1,097	1,231	2,328	987	1,241	2,228
Boro	Wangkadu	1,123	1,098	2,221	1,212	1,123	2,335	790	973	1,763
	Mututu	1,211	1,029	2,240	1,132	1,109	2,241	1,119	1,009	2,128
<b>TOTAL REACHED</b>		<b>5,860</b>	<b>5,726</b>	<b>11,586</b>	<b>5,669</b>	<b>5,268</b>	<b>10,937</b>	<b>5,118</b>	<b>5,104</b>	<b>10,222</b>



## Annex 4: Social categories reached by PECs

Parishes	Epicenter fishing village	10-14 years			15-24 years			25+years		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Peer education										
Nyakagei	Kayonga	1,321	1,267	2,588	1,138	798	1,936	1,010	1,213	2,223
	Angumu	1,096	1,234	2,330	1,890	1,456	2,097	1,212	1,092	2,304
Ganda	Wathparwoth	1,109	1,971	3,088	1,190	1,231	2,328	1,321	1,241	2,562
Boro	Wangkadu	1,123	1,968	3,091	1,212	1,123	2,335	1,384	973	2,357
	Mututu	1,211	1,029	2,240	1,132	1,109	2,241	1,119	1,009	2,128
Peer counselling										
Nyakagei	Kayonga	300	437	737	512	432	944	132	654	786
	Angumu	314	321	634	452	432	884	780	480	1,260
Ganda	Wathparwoth	679	567	678	546	676	567	987	789	1,776
Boro	Wangkadu	456	432	567	343	432	456	589	790	1,379
	Mututu	567	345	912	445	980	651	879	637	1,516
TOTAL REACHED		2,316	2,099	3,529	2,298	2,982	3,513	3,367	3,350	6,717

## Annex 5: People reached with condom promotion

Peer group	Fishing Village					
	Kayonga	Angumu	Wathparwoth	Wangkadu	Mututu	Totals
Male youth	21	22	16	20	16	95
Female youth	11	17	13	15	12	68
Single women	13	15	18	13	14	73
Lither	22	18	22	17	17	96
Married women	20	17	15	22	22	96
Married male	11	18	12	17	19	77
<b>TOTAL REACHED</b>	<b>98</b>	<b>107</b>	<b>96</b>	<b>104</b>	<b>100</b>	<b>505</b>

## Annex 6: VCT outreach

Fishing village	Number of people tested			HIV Positive		
	Male	Female	Total	M	F	Total
Mututu	156	282	438	4	5	9
Wangkadu	146	250	396	8	14	22
Wathparwoth	152	176	328	5	11	16
Angumu	134	205	339	6	11	17
Kayonga	140	226	366	4	9	15
<b>Total</b>	<b>728</b>	<b>1,139</b>	<b>1,867</b>	<b>27</b>	<b>50</b>	<b>79</b>
<b>% share</b>	<b>39</b>	<b>61</b>	<b>100</b>	<b>34</b>	<b>66</b>	<b>100</b>





Fisher Community Anti-AIDS Project (FICAP)

# PROJECT COMPLETION REPORT

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