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Factors influencing knowledge levels regarding identifying ways of preventing sexual transmission of HIV, rejecting major misconceptions and the correct steps on condom use in Uganda

Research Report

Civil Society Fund

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List of acronyms/abbreviations

ACP:	AIDS Control Programme
AIDS:	Acquired Immune Deficiency Syndrome
ANC:	Antenatal Care
BCC:	Behaviour Change Communication
BS:	Bio Statistician
CBO:	Community Based Organisations
CD:	Compact Disc
CI:	Co- Investigator
CSF:	Civil Society Fund
CSL:	Capacity Systems Link Limited
CSOs:	Civil Society Organisations
DC:	Data Clerks
FGD:	Focus Group Discussions
FS:	Field Supervisor
HCT:	HIV Counselling and Testing
HH:	Households
HIV:	Human Immune Deficiency Virus
HSSIP:	Health Sector Strategic and Investment Plan
IEC:	Information, Education and Communication
IRB:	Internal Review Board
KII:	Key Informant Interview
LC:	Local Councils
LI:	Lead Investigator
LQAS:	Lot Quality Assurance Sampling
MEA:	Monitoring and Evaluation Agency
MoH:	Ministry of Health
MUSPH:	Makerere University School of Public Health
NDP:	National Development Plan
PLHIV:	People Living with HIV/AIDS
PMTCT:	Prevention of Mother to Child Transmission of HIV
RA:	Research Assistant
SDA:	Seventh Day Adventist
SMC:	Safe Male Circumcision

SRH:	Sexual and Reproductive Health
STD:	Sexually Transmitted Diseases
STI:	Sexually Transmitted Infection
TMA:	Technical Management Agent
UAC:	Uganda AIDS Commission
UAIS:	Uganda AIDS Indicator Survey
UDHS:	Uganda Demographic Health Survey
UNCST:	Uganda National Council for Science and Technology
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children Fund
WHO:	World Health Organisation

Operational definitions

The key terms of this study are knowledge of HIV transmission, misconceptions, comprehensive knowledge, youth, community factors, and service factors.

Community factors refers to the cultural and social beliefs, perceptions and support systems which deter and or facilitate access to correct information and formation of misconceptions on ways of preventing sexual transmission of HIV such as peer influence, availability of HIV prevention activities in the community, and beliefs that condoms are permeable or contaminated or used by prostitutes and that abstinence from sex lessens sexual potency.

Comprehensive knowledge refers to knowledge of reducing HIV- risk by consistent use of condoms and being faithful to one uninfected sexual partner who has no other partners, and includes rejection of misconceptions of mosquito bites and sharing food with a person who has AIDS as modes of HIV transmissions.

Knowledge of HIV transmission is the ability of individuals to identify the correct ways of transmitting HIV and preventing the risk of HIV infection.

Misconceptions are individual and community beliefs such as HIV- infected people always appear ill, and that the virus can be transmitted through mosquito or other insect bites, sharing food with someone who is infected and through witchcraft or other supernatural means.

Service factors refers to the institutional and human resource experiences, which deter and or facilitate provision of correct information and formation of misconceptions on ways of preventing sexual transmission of HIV such as Information Education and Communication (IEC) and infection control supplies, and knowledge and attitudes of service providers and clients on ways of preventing HIV transmission.

Youth refers to the individuals in the age range 15 – 24 years. This definition is adopted from the United Nations Population Fund (UNFPA), United Nations Children Fund (UNICEF) and World Health Organisation (WHO) definition of adolescents in the context of sexual reproductive health (SRH). In this study the term youth and a young people are used interchangeably.

Executive Summary

Introduction: Despite numerous interventions in behaviour change communication for HIV prevention, comprehensive knowledge about HIV transmission and prevention remains very low. Whereas previous studies such as the 2012 Civil Society Fund Lot Quality Assurance Sampling (CSF-LQAS), the 2011 Uganda AIDS Indicator Survey (UAIS), the 2006 and 2011/06 Uganda Demographic Health Surveys and the 2005/6 Uganda HIV/AIDS Sero-behavioural Survey identify populations with low knowledge on the correct ways of transmission and preventing HIV, they neither explain the factors influencing low levels of comprehensive knowledge nor offer proposals for addressing low comprehensive knowledge among populations aged 15 – 54 years.

Objectives: This study examined factors influencing knowledge levels regarding identifying ways of preventing sexual transmission of HIV, rejecting major misconceptions and the correct steps on condom use in Uganda amongst populations aged 15 – 54 (youth 15-24, men 25-54, females 25-49 years) in the 4 geographical regions, in the districts of Adjumani, Hoima, Kaberamaido, Mubende and Mukono districts. These districts were selected to ensure a geographical regional representation of the findings

Methods: This was a cross-sectional study conducted using a combination of quantitative and qualitative research methods used concurrently involving use of interviewer-administered structured questionnaires (8640 respondents), 20 Focus Group Discussions (FGDs) and 30 Key Informant Interviews (KIIs) assessing the factors influencing knowledge related to HIV and AIDS.

Key findings

Overall assessment of HIV Knowledge:

- Most people (96.4%) are able to correctly mention at least one way through which HIV can be transmitted. The most commonly mentioned was male condoms (71.3%). A large proportion mentioned PMTCT (84.8%)
- Significant proportions also answer positively to HIV transmission ways that are misconceived such as mosquitoes (35.1%), sharing utensils (18.9%) and eating food with an infected person (10.1).
- Across districts and sub-populations, there are glaring knowledge gaps about HIV, steps in HCT and condom use, PMTCT, SMC and amount of information about STI symptoms
- Many still lack information about the specific actions and steps to follow in applying some of the approaches such as condom use, PMTCT, HCT, or SMC. There is only basic information about the approaches.
- The major challenge both with the service providers and general community is the attitude and belief that people know enough about HIV. Consequently many make limited effort to learn more about HIV address deep-seated misconceptions and get sufficient knowledge about tested prevention approaches

Influence of socio-demographic factors on HIV knowledge:

- Disaggregation of knowledge levels by district shows statistically significant differences; Hoima has higher proportion (66%) of participants followed by Kaberamaido (50%) that know at least 2

actions that reduce MTCT; Adjumani scores least (35%) on the correct condom use steps. Hoima showed higher knowledge levels on SMC and STIs (P value< 0.000)

- Statistically significant differences are evident between individual socio demographic and economic factors and knowledge about selected aspects on HIV transmission and prevention.
- A higher proportion of women knows at least 3 correct steps to get HIV test than men and youth but cannot correctly identify at least 2 common STIs. Similarly, they know the actions that reduce MTCT while men score better on steps for condom use, identification of STIs and information about SMC (P<0.000 for all).
- Results from logistic regression show that other Christians mainly the “Born Again” are more likely to have less comprehensive HIV knowledge (OR=0.42, P<0.001) compared to other religious categories.

Influence of community factors on knowledge of HIV:

- Most common beliefs about HIV which depict lack of appropriate understanding of the epidemic are not necessarily cultural but largely individual misconceptions.
- Few people talk about witchcraft and prayer as forms of HIV transmission and treatment respectively. However, there are still limits within traditional cultural and religious norms and values regarding sex which inhibit open discussion of sexual matters because they are sacrosanct.
- From cultural and religious perspectives, condom use is still largely considered to be at variance with the meaning and purpose of coitus and dismissed as an abhorrent practice.
- Partly as a result of the considerable obscurity that clouds condom talk, the initiative to learn how to correctly use condoms remains low.
- Differentials between men, women and young people about various aspects of HIV knowledge and service related information also arise from gendered socialization regarding sexuality, role ascriptions and power relations. Men are expected to succumb last in the event of a calamity as devastating as HIV/AIDS. Seeking HIV services, even information, may be construed a sign that one has succumbed.

Influence of service -related factors on knowledge of HIV

- Health education has suffered considerably and is less prioritized as a service, in addition to conflicting messages relayed by some of the stakeholders and the moralization of the epidemic
- There are challenges related to weak coordination, limited capacity and lack of commitment from different stakeholders charged with HIV service provision. While district staff complain of poor integration of HIV activities at lower levels, CSOs complain of lack of will by civil servants unless an activity offers material or financial gain.
- Service centres for HIV information and care are often distant; scope of service is limited mostly to HCT. Few VHTs are active. Community awareness campaigns are quite rare.
- Due to funding challenges, a number of key CSOs in the study districts had wound up implementation of activities due to CSF project closure. Most external funding for district health programs in general and HIV in particular is limited to static health services and delivery of HIV information as an integrated service.
- Through logistic regression, compared to those who have no access to information, respondents who learnt about HIV from radio and health workers are 6.7 and 5.5 more times respectively, likely to have comprehensive knowledge.

Recommendations for increasing knowledge levels about HIV

Regular sensitization and training in communities: There is need for continuous, regular sensitization of whole communities about HIV. Focus on knowledge is required not simply about HIV services but for people to reject misconceptions and to learn the correct steps to use the services, including condoms. Health education should be prioritized as a critical stand-alone area of attention in the country HIV response and approaches leaning towards its integration into other service programs reconsidered.

Working with local leaders: All leaders, political and technical, should organize community forums to talk about HIV, its dangers, transmission ways, prevention approaches and technologies and places where one can get services. Poorly informed leaders and community service providers such as VHTs need to be equipped with appropriate IEC and models of delivery to be able to disseminate well to others. Organizations carrying out interventions should use local authorities including LCs to do mobilization for HIV programs in order to attract more people attend such programs.

Use effective communication channels and timing: While there is need for more programs on radio to capture wide audiences, and interpersonal channels to reach different audiences to provide more in-depth information, effective ways of IEC should be reconsidered. Messages should be comprehensive in content so as to give opportunity to people to learn all that is required, not simply a mention of HIV transmission ways. There is therefore need to repackage intervention messages.

Innovative use of social and other public events: It is not easy to bring all people together except on particular occasions such as funeral places, places of worship, and spontaneous public gatherings where people of all shades come around. All these are good opportunities for dissemination of HIV information but are seldom used. These need to be used more for dissemination of HIV information.

Better Targeting of HIV IEC efforts: Specific target groups should be considered for well packaged information depending on their knowledge gaps. This study shows that a higher proportion of women know about HCT and PMTCT than men and youth but know little about STIs, correct condom use and SMC. This calls for deliberate targeting of categories that have paucity of information on particular HIV interventions.

Deliberate funding support for sensitization and training: While health workers and a variety of other service providers are expected to deliver appropriate information about HIV, many are constrained due to low motivation and facilitation. Service providers including VHTs and other community based workers require more support to play their roles, to mobilize their communities and fill knowledge gaps on a sustainable basis. This requires deliberate programming specific for HIV education. Funds should be set aside and provided to local governments, CSOs and community structures under a specific program for HIV education, training and capacity building of actors.

CHAPTER ONE: INTRODUCTION

1.1 Background to the study

Uganda continues to bear a heavy burden of HIV/AIDS. For the last ten years, the HIV prevalence and incidence (new HIV infections) have been rising every year. As of end of 2011, the annual new HIV infections were approximately 130,000 while the annual deaths stood around 50,000 cases. Currently, the HIV prevalence among adults in ages 15-54 is estimated at 7.3% (MoH-UAIS 2011). Prevalence rates vary between age groups with women in the age bracket 35 - 39 experiencing the highest prevalence of 12%. The HIV prevalence also varies according to sub regions, with the South central having the highest prevalence of 10.6%, West Nile and Mid-Eastern with the lowest of 4.9% and 4.1% respectively (MoH-UAIS 2011).

Wamucii (2007) notes that the fight against HIV/AIDS has relied heavily on educational programs and on mass media to disseminate information and reduce misinformation. Initial public AIDS awareness campaigns relied upon the assumption that correct information on transmission and prevention of HIV infection would lead to behavioral change. Some major achievements have been accomplished, because awareness of the lethality of AIDS is practically universal Uganda having rates of 90% for women and 91% for men. However, widespread awareness about AIDS has not been accompanied by a significant decline in potentially risky sexual behaviors, particularly among adolescents and young adults. Several studies have documented similar difficulties in bridging the gap between AIDS awareness and preventive behavior in other countries (Caldwell et al 1992; Hulton et al 2000; Rwenge 2000; United Nations 2002; Anarfi 2003; Meekers et al 2003 all as cited in Wamucii 2007).

Despite the effort to enhance knowledge on HIV prevention, comprehensive knowledge remains very low (34% women and 42% men MoH-UAIS 2011) with many misconceptions still within the community. These misconceptions and stigma surrounding HIV may make it difficult to focus on HIV as a 'disease' as opposed to a 'social malady' despite the long period Uganda has been open about HIV/AIDS (Derlega, Yanga and Luo 2006). It is known that unfounded beliefs about casual transmission of HIV heightens fears of HIV/AIDS and in turn re-enforce discriminatory attitudes (Quian et al 2007). For example the belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners. Correct knowledge about false beliefs of possible modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, the belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safer sexual behaviour, while the belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with AIDS. At the programme level, it is important to have continued education to the population to eliminate misconceptions about HIV transmission and reduce stigma.

Although there have been extensive efforts in promoting condom use, young people in Sub-Saharan Africa still engage in risky sexual behaviors and consistent and correct condom use remains relatively low (Bankole et al 2007). A multitude of factors may impede young people's ability to protect themselves by using condoms, including attitudes towards condoms and ineffective use of the method. Tackling misconceptions about condom use and knowing the correct steps remains a challenge for programs and policies aimed at increasing condom use among sexually-active adolescents, and while the evidence continues to grow about how adolescents view condoms, very

little information is available on whether adolescents' knowledge of how to use condoms is correct and whether they actually follow the correct steps while using a condom. The main reasons for the rising trends in new HIV infections include the low levels of comprehensive HIV prevention knowledge and risky sexual behaviour such as inconsistent condom use, infidelity and cross-generation and transactional sex (MoH-STD/ACP, 2011).

1.2 Problem Statement

Results of Lot Quality Assurance Sampling (LQAS) studies conducted by Civil Society Fund (CSF) in ten districts indicated that 41% of men (15-54 years) and 30% of women (15 – 49 years) had comprehensive knowledge about HIV transmission and prevention. The same study also indicates that knowledge on specific ways of preventing HIV transmission is low. On average, 24.8% of women aged 15 – 49 years, 23% of mothers of children aged 0 – 11 months, 30.5% of men aged 15 – 54 years, and 30% of youth aged 15 – 24 years were able to correctly identify ways of preventing sexual transmission of HIV and also reject major misconceptions of HIV. In addition, only 3.5% of youth aged 15 - 24 years knew the correct steps to follow when using the condom (CSF 2012). The LQAS methodology used in the previous study did not explain the factors influencing low levels of knowledge on HIV/AIDS and condom use among the population aged (women 15-49 and men 15-54 years).

Available data from other different national studies such as 2011 Ministry of Health – Uganda AIDs Indicator Survey (MoH-UAIS), the 2011 Uganda Demographic Health Survey (UDHS), 2004/5 Uganda National sero-behavioral survey, only establish knowledge levels but not the factors influencing the knowledge levels. These studies identify gaps but offer no solutions to address the low levels of HIV comprehensive knowledge. In a consultative meeting with CSF, National non-governmental Organizations (NNGOs) and Management Health Sciences (MSH), it was deemed necessary to conduct a diagnostic assessment as a follow on to the LQAS (CSF 2012) that was earlier on conducted.

1.3 Justification/Significance of the Study

Whereas these LQAS studies and previous national surveys such as UAIS (2011), UDHS (2006) and Uganda HIV/AIDS Sero-behavioural Survey (MoH & ORC Macro, 2006) identified populations with low knowledge on the correct ways of transmission and preventing HIV, they neither explained the factors influencing low levels of comprehensive knowledge nor offered proposals for addressing low comprehensive knowledge among populations in the age range 15 – 54 years. This study will help to identify specific factors underlying the low levels of comprehensive knowledge of HIV/AIDS among population aged 15 – 54 years, and inform programming amongst implementing partners of the Civil Society Fund and other agencies, as well as government policy regarding HIV prevention through increasing comprehensive knowledge and correcting misconceptions about HIV/AIDS.

1.4 Objectives of the Study

The general objective of the study was to establish the factors influencing knowledge levels regarding identifying ways of preventing sexual transmission of HIV, rejecting major misconceptions and the correct steps on condom use among youths (15-24), adult men (25-54 years) and women (25-49 years).

The specific objectives included to establish:

- i. The socio- demographic factors influencing knowledge levels on identifying ways of preventing HIV transmission of HIV, rejecting major misconceptions, and the correct steps on how to use a condom among youths (15-24), adult men (25-54 years) and women (25-49 years).
- ii. The community factors influencing knowledge levels on identifying ways of preventing HIV transmission, rejecting major misconceptions and the correct steps on how to use a condom, among youths (15-24), adult men (25-54 years) and women (25-49 years).
- iii. The service provision factors influencing knowledge levels on identifying ways of preventing HIV transmission, rejecting major misconceptions and the correct steps on how to use a condom among youths (15-24), adult men (25-54 years) and women (25-49 years).

1.5 Study hypotheses

The hypotheses of this study are that:

1. There is relationship between the individual socio demographic and economic factors and comprehensive knowledge on the transmission and prevention of HIV and AIDS.
2. There is a relationship between the Community and service factors and comprehensive knowledge on HIV transmission and prevention.

1.6 Scope of the Study

This study was conducted in 5 of the 10 districts where CSF had earlier conducted an LQAS namely; Adjumani, Hoima, Kaberamaido, Mubende and Mukono among youths (15-24), adult men (25-54 years) and women (25-49 years). The districts were selected to ensure a geographical regional representation of the findings. In each district, two supervision areas drawn from the CSF LQAS survey were covered. The rural and urban sub counties were represented in the sample.

Among the socio- demographic factors included in the analysis are gender and age differences, locality of residence, marital status, income status, level of education, religious affiliation, access to media and knowledge of HIV status. The community factors included socio-cultural beliefs about HIV transmission and prevention, cultural norms regarding sex and condom use, and systems for socialization regarding sexuality and relationships. Some of the key service-related influences included issues of availability of HIV prevention information and services, content of HIV prevention Information, Education, and Communication (IEC) messages and the modes of delivery used in IEC/Behavior Change Communication (BCC) campaigns.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This chapter presents a brief review of existing literature and gaps in relation to factors influencing knowledge levels regarding identifying ways of preventing sexual transmission of HIV, rejecting major misconceptions and the correct steps on condom use in Uganda. In addition, it has conceptual framework detailing the study variables.

2.1 The HIV/AIDS Prevention Landscape in Uganda

Available evidence suggests that HIV/AIDS continues to pose the greatest public health and economic challenge to Uganda, threatening the attainment of the Millennium Development Goals (MDGs). There is evidence to suggest that the HIV prevention response is failing to keep pace with the epidemic. The annual number of new infections continues to outstrip Uganda's ability to enroll those in need into care and treatment programs (UAC 2011). The hitherto heralded success in decreasing prevalence of HIV from a peak of 18% in 1992 to a low of 6.1% in 2002 through prevention interventions and visionary leadership (Asimwe-Okiror et al 1997; Kirungi et al 2006) has been eroded by the high rising cases of new infections. With over 124,000 new HIV infections every year, the need to scale up HIV prevention in Uganda is not debatable. For instance, in the fiscal year 2010/2011 alone, there were 128,980 new HIV infections in Uganda (UAC 2012).

Various strategies have been developed to try and bring down the rate of new infections. For instance, the current National HIV Prevention Strategy recommends implementation of combination HIV prevention comprising of an integrated package of biomedical, behavioral and structural interventions. This is premised on the understanding that medical interventions alone are not enough to influence behavior. It is argued that community level engagement is essential to addressing socio-economic and socio-cultural drivers of the epidemic. However, Ministry of Health's estimation and projections of the number of new HIV infections reveals a rise in new infections between 2007 and 2010, namely, from 115,775 new infections in 2007 to 128,980 in 2010 (UAC 2012). This has happened despite the country's focus on "accelerating the prevention of sexual transmission of HIV through established as well as new and innovative strategies".

Through Behaviour Change Communication (BCC) campaigns, various agencies including but not limited to STAR-E, STAR-EC, STAR-SW, Northern Uganda Malaria, AIDS&HIV and TB program (NUMAT, Health Communication Partnership (HCP), Communication for Development Foundation (CDFU), Uganda network of AIDS Service Organizations (UNASO), and Young, Empowered and Healthy (YEAH) have been implementing educational and behavioral interventions in order to increase knowledge of HIV/AIDS as well as reduce misconceptions about HIV transmission in the general population. Similarly, evidence from districts suggest that sensitization about HIV/AIDS has remained a top priority for the districts, Civil Society Organizations (CSOs) and other district-based partners. Educational interventions focused on raising awareness, in particular, about modes of HIV transmission and prevention are widespread. All these point to the fact that increasing comprehensive knowledge of HIV/AIDS is among the country's major target outcomes for prevention interventions. However, at the moment, no study has explored the factors behind the high rate of new infections and the prevailing low levels of comprehensive knowledge about HIV transmission and prevention. This proposed study will, among other things, explore the factors that inform

individuals' abilities to identify certain ways of preventing sexual transmission of HIV compared to others.

2.2 Knowledge on HIV prevention and transmission

Knowledge of HIV/AIDS is an important cornerstone in the prevention of sexual transmission of HIV and other sexually transmitted infections (STIs). Although it has been argued that knowledge alone is not adequate to lead to behavior change, knowledge of modes of HIV transmission and prevention can be a significant step leading to behavior change. HIV prevention experts have considered possession of knowledge as one of the most important steps in the prevention of the transmission of HIV/AIDS.

Studies done by key HIV implementing partners in Uganda (STAR-EC 2010; NUMAT 2010) suggest that knowledge of HIV prevention methods is high. STAR-EC, found that the proportion of adults who knew all the three major ways of HIV prevention had increased from 59% in 2009 to 64% in 2010. In the same study, it was found that 97% of participants could mention at least one major HIV prevention method. Knowledge of single HIV prevention methods was higher (83% mentioned abstinence only, 84% mentioned condom use only, and 85% mentioned being faithful only). Similarly, in the study conducted by the Northern Uganda Malaria, AIDS&HIV and TB Program (NUMAT), it was found that the proportion of adults who could mention the three major ways of HIV prevention (abstinence, being faithful, and condom use) had increased from 48% in 2008 to 55% in 2010. Despite the high knowledge levels, occurrence of new infections has remained high. Findings from the Modes of Transmission study (Wabwire-Mangeni et al 2009) showed that married couples and individuals in stable, long-term sexual relationships contributed up to 43% of new infections. Further, the percentage of adults (15-49 years) who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months and used a condom at last higher risk sex (male: 57.4%, female: 34.9%) was lower than the target (male: 66%, female: 58%) for end of 2010/11 (UAC 2012).

Several interventions have been implemented in Uganda including the GO RED for fidelity campaign, anti-cross generation sex campaigns, campaigns against sex with non-marital, non-cohabiting partners, educational programs in the country encouraged individuals to know their own and their partners HIV sero-status, but all these have not led to universal adoption of HIV prevention measures. However, the proportion of adults with comprehensive knowledge of HIV/AIDS has remained low. Several studies have concluded that the percentage of adults (15-49 years) and young people (15-24 years) who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission is not yet universal. For instance, the country's target is to increase comprehensive knowledge to 63% among adult males, 52% among adult females, 64% among young males and 52% among young females by end of 2010/2011. This would be a rise from the low 42% among adult males, 31.3% among adult female, 38.2% among young male and 31.9% among young female recorded in 2006/2007 (UHSBS 2004/05). These findings call for a need to assess the factors that influencing knowledge levels regarding identifying ways of preventing sexual transmission of HIV, rejecting major misconceptions and the correct steps on condom use in Uganda amongst populations aged 15 – 54 (men 15-54, females 15-49 years).

2.3 Rejection of Misconceptions about HIV transmission

Reports from several studies suggest that the proportion of Ugandans who reject major misconceptions about HIV/AIDS has improved over time. In the study by NUMAT (2010), the

proportion of adults who rejected all the major misconceptions about HIV/AIDS remained almost stable between 2008 and 2010, at 47% in 2008 and 48% in 2010. The belief that HIV could be spread through mosquito bites was still prevalent. In another study by STAR-E (2010), a USAID-funded project, more than 80% of respondents rejected witchcraft, touching an infected person and sharing toilets with an infected person as ways through which HIV can be transmitted. However, the misconception about mosquito bites causing HIV transmission was still high at 46.8% among women and 56.8% among youth (STAR-E 2010).

Findings from the HCP-YEAH Mid-term Evaluation Report (2011) show that 83% of men and 79 percent of women understand that people cannot get infected with HIV by sharing food with a person who has AIDS, 88% of men and 82% of women know that people cannot get HIV due to witchcraft or supernatural means, 73% of men and 66% of women know that people cannot get HIV from mosquito bites. Also, 88% of men and 84% of women understand that an HIV positive man cannot be cured by having sex with a virgin, 86% of men and 79% of women know that HIV/AIDS cannot be cured through prayer/religious healing, and 94% of men and 89% of women know that traditional healers cannot cure HIV/AIDS. The proportion of adults and young people rejecting major misconceptions was higher in the HCP-YEAH study than in the NUMAT study but comparable to proportions reported by STAR-E (2010). In a recent study conducted by STAR-EC in nine districts in East Central Uganda in 2010, the proportion of participants who were able to reject major HIV/AIDS misconceptions (witchcraft, mosquito bites and sharing food with a person living with HIV) increased slightly from 48.3% in 2009 to 57.1.

In 2010, Mayega et al. conducted a sero-behavioral survey to document levels of HIV knowledge and patterns of misconceptions among 3,718 University students in six Universities in Uganda. Study findings suggest that overall awareness about the existence of HIV/AIDS among University students is high (97%). However, prevalence of comprehensive knowledge about HIV/AIDS was 71%, indicating that a significant proportion of students (29%) were not adequately aware of specific issues regarding HIV/AIDS.

Taken together, these findings suggest that while a greater proportion of Ugandans reject major misconceptions and have got favorable attitudes towards people living with HIV, misconceptions about HIV/AIDS are still prevalent, calling for a need to investigate and establish the factors that influence knowledge levels regarding identifying ways of preventing sexual transmission of HIV, rejecting major misconceptions and the correct steps on condom use in Uganda. This will greatly provide insights for designing interventions that improve levels of comprehensive knowledge of HIV/AIDS transmission and prevention among sexually active Ugandans.

2.4 Factors Associated with adoption of certain HIV prevention measures

Studies have established that men and women who are exposed to behavior change communication messages about HIV/AIDS and other STIs are likely to have higher knowledge on condoms for disease prevention than those not exposed to the media messages (MoH, UAIS 2011; UNAIDS/UNICEF/WHO 2002). Studies have also established that knowledge on increased adoption of condoms is associated with exposure to BCC including the radio soap opera. The different BCC channels are aimed at increasing knowledge of HIV/AIDS, changing attitudes, and encouraging HIV prevention behaviors. Knowledge on incorrect beliefs about HIV/AIDS is also very important as it helps to eliminate popular misconceptions. Some of which include the idea that all HIV-positive people appear ill and the belief

that the virus can be transmitted through mosquito bites, by sharing food with someone who is infected, or by witchcraft or other supernatural means (MoH-UAIS 2011, UNAIDS/UNICEF/WHO 2002).

Further, studies (Mahalakshmy et al 2011) have showed that accurate information and better health knowledge are important in bringing about behavioral change. According to Mahalakshmy et al 2011, a positive correlation was reported between the knowledge of HIV transmission and risk reduction behavior. When social influences are taken into account, they are most often measured at the individual-level with variables such as respondent's age, ethnicity, religion, and socio-economic status. Education status is another factor that scholars have noted to be associated with knowledge on HIV prevention and transmission. Studies have showed that educational status is positively associated with the knowledge. Similarly residence is also noted to be associated with knowledge; in the same study, it was observed that a higher proportion of urban subjects (48%) had studied up to 10th class as compared to those from rural area (32%) (Caldwell et al 1997; Maticka-Tyndale et al 2005; Mahalakshmy et al 2011).

Individual factors have also been found to be directly associated with knowledge on HIV prevention and transmission. Some of the factors include condom self-efficacy, pressure to engage in sex, communication with family members, and rejection of myths about HIV transmission. It is therefore important to address issues related to the myths and misconceptions other than limiting interventions to providing only factual information about transmission of HIV (Tenkorang et al 2011).

In addition, mothers of children 0-11 months are expected to access comprehensive information on HIV transmission and prevention during the Antenatal Care (ANC) visits. Since 95% of pregnant women seek ANC from a skilled health service provider at least once (UBOS and MEASURE DHS 2011), it is expected that most of them would have comprehensive knowledge on HIV transmission and prevention. However, CSF (2012) studies indicate low comprehensive knowledge on HIV transmission and prevention among mothers of children aged 0-11 months. MoH-UAIS (2011) also found that 35% of women and 44% of men in the age group 15-49 did not know the two key ways by which transmission of HIV from mother to child can be prevented, namely exclusive breast feeding and taking antiretroviral drugs (nevirapine) during pregnancy. This suggests that either HIV education is not adequately incorporated in ANC services or it is provided inconsistently or in a way that is difficult for the public to understand. There is therefore need to re-examine the packaging and delivery approaches of Sexual and Reproductive Health (SRH) and HIV/AIDS services provided to different population groups as well as service factors influencing comprehensive knowledge of HIV transmission and prevention. Overall, available evidence suggests that although studies (the demographic and health surveys, AIDS indicator survey) have showed that comprehensive knowledge of HIV/AIDS transmission and prevention is low, there remains little information about the factors that have led to the low knowledge levels exhibited in the wake of widespread campaigns and promotion of various modes of prevention of sexually transmitted HIV.

Given the strong community orientation together with the socio-cultural and economic conditions prevailing in most sub-Saharan African (SSA) countries including Uganda, knowledge levels are not only for the individual but also for the community. Studies conducted in Namibia revealed that, at the school and community levels only the socio-economic status of the school was significant in determining individuals' knowledge and behavior among both female and male students. However,

in the same study, sponsorship of the school by a religious group and the availability of condoms at community clinics had significant effects on reported condom use for males, as opposed to females, including HIV prevention messages in community festivals significantly contributed to reported condom use. Similarly, studies done in Kenya showed that pressure from peers and community members to engage in sex, together with the consequences of not doing so, have been shown to motivate Kenyan youth to engage in early sexual activity (Tenkorang and Tyndale 2012).

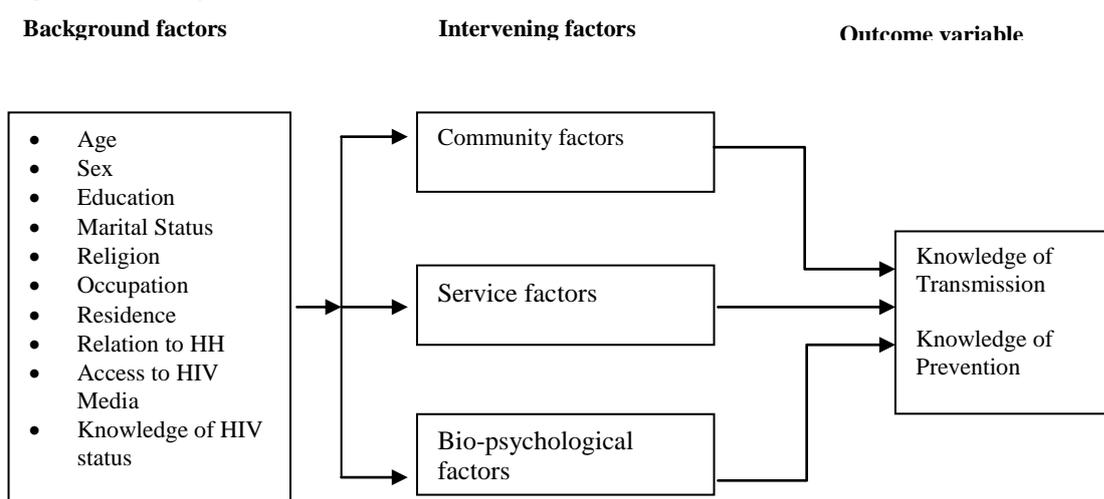
Stephenson (2009) in his study on Community influences on young people's sexual behavior in 3 African countries concluded that programmes aimed at increasing knowledge should focus on community-level influences as an intervention point for behavioral change. He contends that such interventions should recognize specific cultural settings and the different pathways through which the community can shape the sexual behaviors of young men and women.

Stephenson (2009) further discusses that living in a community in which women married later, had their first birth later, and initiated sex at an older age was associated with greater knowledge of HIV/AIDS, particularly among young women. Communities in which women began sexual activity, marriage and childbearing later were more likely to be those communities where there are also more opportunities for women to accrue social capital through education and employment. Such communities afforded women more opportunities to access education, health services and information. For males, economic opportunities were important in shaping their access to information and educational resources. Similarly communities that have greater exposure to media have greater knowledge of HIV/AIDS.

Iralu et al (2010) assessed the impact of socioeconomic factors and the use of traditional healing on HIV disease progression in a rural American Indian community. The study identified recent alcohol abuse, incarceration, and use of traditional medicine as important social factors affecting HIV disease management among American Indians. Winscott et al 2010 analyzed rates, geographic distribution, and time to treatment of chlamydia, gonorrhoea, and early syphilis among American Indians residing in Arizona compared with those of non-Hispanic white people. The results of this study have implications for the design of STI prevention and education programs to promote expeditious screening, diagnosis, and treatment in the American Indian population. In another study conducted in Namibia it was found that having two or more sexual partners, a behaviour that was common in the study sites due to cultural norms, posed a strong risk of HIV transmission but for which their society saw as normal.

2.5 Conceptual Framework

Figure 1: Conceptual framework



The framework adopted (see Figure 1) asserts that the selected background factors influence individual knowledge about HIV transmission and prevention. The background factors presumed to influence individual knowledge on HIV transmission and prevention include sex, age, education, marital status, religion, ethnicity, occupation, residence, relation to residents of the household, access to HIV media services, and knowledge of HIV status. The framework further contends that social, service and bio-psychological factors such as customs, beliefs, lifestyle, family and peer pressures, community education, knowledge and attitude of service providers, availability of HIV prevention supplies and services in local facilities, HIV infection, fear, maturation, intelligence, curiosity, motivation and carelessness influence individual knowledge on HIV transmission and prevention.

The specific outcome variables assessed include:

- i) Knowledge of unprotected sexual intercourse with an infected person, sharing non-sterile sharp instruments, perinatal infection, and unsafe blood transfusions as modes of HIV transmission; and
- ii) Knowledge of abstinence from sex, sexual fidelity, consistent and correct condom use, Sexually Transmitted Infections (STI) screening and treatment, use of protective gloves, and the correct steps and benefits of HIV Counselling and Testing (HCT), Prevention of Mother-to Child Transmission (PMTCT) and Safe Male Circumcision (SMC) as methods for preventing HIV infection.

Under the intervening factors, the key aspects examined are availability and packaging of HIV education services, the strategies used to provide health education to the different communities, the society value of HIV education services, and the basis for the different misconceptions on HIV/AIDS.

CHAPTER THREE: METHODODOLOGY

3.0 Introduction

This section describes the overall study design, study areas and population, sample size, sampling strategy, data collection methods and instruments, data collection procedures and ethical considerations, data analysis approaches, quality control measures and study limitations.

3.1 Overall Study Design

A cross sectional survey design utilizing both qualitative and quantitative methods of data collection was adopted in the execution of this study. Quantitative methods involved use of interviewer administered structured questionnaires to a sample of 840 respondents which was around 101.4 responses rate to assess the factors that influence levels of comprehensive knowledge among youths (15-24), adult men (25-54 years) and women (25-49 years) on HIV prevention. The qualitative methods, on the other hand, involved use of focus group discussions (FGDs) and key informant interviews with various stakeholders both at facilities and within communities. This helped to provide a deeper understanding of the issues and explanations on why comprehensive knowledge on HIV prevention has remained too low despite the numerous and widespread HIV prevention interventions.

3.2 Study Areas

This study was conducted in five (5) out of the 10 districts that participated in CSF's LQAS study carried out early this year (2012), namely Adjumani, Kaberamaido, Hoima, Mubende and Mukono. These districts were selected to ensure a geographical regional representation of the findings. In each district, the study was conducted in the same supervision areas where the LQAS study was carried out. Each supervision area formed a cluster from which villages to be visited were randomly selected. This study was also stratified along the urban rural divide. One urban supervision area and one rural supervision area were selected for visiting. In situations where there was more than one supervision area with urban sub-counties in a given district, simple random sampling techniques (the lottery method/ using raffles) were used to pick one supervision area to include in this study. Selection of the rural supervision area to visit also followed simple random sampling techniques (see Annex A.1for supervision areas that were selected for visiting).

3.3 Study Population

The study population comprised youths (15-24), and adult men and women in the reproductive age brackets (females 25-49 and males 25-54 years) within the five selected districts. These participated in both the quantitative and qualitative components of the study. For the qualitative component, the study also covered District Health Officers, District HIV Focal Persons, health facility service providers/ in-charges, community-based caregivers/volunteers, religious leaders, programme managers of CSOs providing HIV prevention services, school heads, local councils, community development officers, and leaders of youth and women groups in the selected districts.

3.4 Sample size determination and distribution for the quantitative component

To ensure adequate representation of the general population in the sample, statistically appropriate sizes for each sample were determined. The total population of the districts visited met the minimum requirement for the use of the Kish (1995) formulae. The sample was therefore determined using the formulae below.

$$n = deff. \frac{Z^2 PQ}{e^2} . r$$

Where

n	required sample size
z	is the 95% Confidence interval, Z=1.96,
e	is the permissible error = 5%
p	Proportion of the population with comprehensive knowledge about HIV (CSF 2012 LQAS showed that it was 34%)
q	1-p (1.00-0.34) =0.66
deff	Design effect =2
r	Anticipated response rate 80%

The plan was to use confidence level of 95%, and statistical power of 80% with a margin of error of 0.05, which would provide a minimum sample size of 828 respondents to be distributed disproportionately among the five districts. However, in order to ensure a uniform number of study participants distributed across supervision areas, villages, and population categories, the total number reached 840 respondents that were included and successfully interviewed, implying a response rate of over 101.4%.

3.5 Sampling Procedure

A three-stage sampling approach was used to select participants for quantitative component of this diagnostic study. In the 1st stage of sampling, both random and non-random sampling approaches were used to select the supervision areas to visit

The 2nd stage of sampling comprised selection of 4 villages/cells from each selected supervision area using systematic sampling techniques. Given that each supervision area on average had 19 villages/cells, a skip interval of 5 was followed to select the 4 villages/cells to be visited.

The village was considered as the primary sampling unit [PSU] because it was easy to generate comprehensive sampling frames. Within a PSU, a total of 21 households were randomly selected using a systematic random sampling technique. Each selected PSU contributed 21 households to the overall sample because beyond 21 households, there would be limited value-addition.

Further stratification was done at the village level to ensure that representation of the various age groups namely youth 15-24 years (both male and female), men 25-54 years and women 25-49 years are attained. The sample for each village was disproportionately allocated between 3 categories. Using the list of the 21 households selected, local leaders were asked to help identify households on the list with youth aged 15-24 years; these would constitute the first 7 households to be specifically visited to conduct interviews with *youth 15-24 years (both male and female)*, the remaining households would then be divided into two to target 7 adult men and 7 women. In households with more than one eligible person, the KISH Table of random numbers was used to select the person to interview.

3.6 Selection of Participants for the Qualitative Component

Qualitative data was collected through focus group discussions (FGDs) and key informant interviews (KIIs) with selected participants from within the same administrative units where structured interviews were administered. Participants for the group discussions and in-depth interviews were purposively selected.

3.6.1 Focus Group Discussions (FGDs)

To ensure that the views obtained through FGDs are representative of the target population and that various discourses regarding comprehensive knowledge on HIV prevention are explored, discussions were held with various categories of people classified based on age, gender and social status. The categories considered for FGDs included male youth aged 15 – 17, female youth aged 15 – 17, male youth aged 18 – 24, female youth aged 18 – 24, men aged 25 – 35, women aged 25-35, Men aged 36 – 54, women aged 36-49, mothers aged less than 25 year of children 0 – 11 months and mothers aged more than 24 of children 0 – 11 months. The intent was to make sure different categories (young or old) express their view freely.

Alternating FGDs were conducted in the sampled supervision areas, namely two discussions per category earmarked for the FGD were conducted making a total of 20 FGDs in the five selected districts. Each FGD comprised between 8-10 participants. The selection of FGD participants was guided by the community leaders who would identify the eligible participants per targeted category. Two (2) members of the study team facilitated FGDs, one moderating the discussion and another to taking notes and managing the recording of the FGD proceedings.

3.6.2 Key Informants interviews

Among the key informants were leaders of youth groups, women groups, PLHIV/ post-test clubs, Boda Boda (motor cycle riders)Fisher folk/Bar maids/transporters groups, Local Council leaders, religious leaders, health facility based service providers /in-charges, heads of schools –both Primary and Secondary within the sampled sub-counties, community-based caregivers, Community Development Workers, District Health Officers/Secretaries for Health, District HIV Focal Persons and Managers of CSOs providing HIV prevention services in the sampled districts. A total of 30 key informant interviews were conducted, targeting at least 2 of each of the categories listed above.

The selection of key informants was purposively done with the assistance of District HIV/AIDS focal persons, CSO extension workers, and community leaders. Two persons per category were earmarked to be covered. Similar to the FGDs, KIIs were also obtained in an alternating manner in each district.

3.7 Instruments

Three types of instruments were used to collect data, namely survey questionnaires, FGD guides and KII guides. The same questionnaire was administered to all the three categories. The interview guide for KII consisted of unstructured questions that sought information to substantiate social and service factors for low levels of knowledge on HIV transmission and prevention in the focus group discussion sessions.

3.8 Quality control

3.8.1 Selection and composition of the research team

To ensure that quality data is collected Socio-Economic Data Center (SEDC) recruited and trained a team of graduate research assistants (RAs) with experience of conducting household based surveys among men and women on issues of HIV/AIDS. Care was taken to recruit research assistants fluent in the local languages of the selected study sites (areas).

3.8.2 Field interviewer training

Training of interviewers consisted of a combination of classroom training and practical experience. During the training, the questionnaire sections, questions, and instructions were discussed in detail. Additional specialized training was provided on the specific duties of appointed supervisors, team leaders and overall coordinator.

3.8.3 Pretesting and Piloting

The data collection tools were pre-tested by each interviewer – with at least two interviews conducted by each of them. The pre-test was done both in English and the respective local languages from selected villages in Wakiso district outside the study area and information gathered assessed for utility, ambiguity and congruence of themes and items. Results of the pre-test were used to inform decisions as to which items to remove, add, improve or re-construct in the questionnaire.

3.8.4 Ethical Considerations

Ethical clearance was sought from Research and Ethics Committee of MildMay Uganda and approval from Uganda National Council for Science and Technology (UNCST). The study design and questionnaire was presented to the committee for review prior to data collection. All necessary steps to ensure compliance to proper ethical procedures such as obtaining informed consent, ensuring confidentiality were taken. At the household, informed consent (obtained verbally) prior to interviews was always sought. Survey respondents (Research participants) were informed of all risks associated with the study and protections in the process of administering the consent.

To ensure confidentiality, all interviews were conducted within the confines of selected persons' home in an identified private place to allow for discussing sensitive topics. In addition, verbal consent was sought with heads of households specifically men when their spouses (wives) had been selected for the study in order to allay any fears and misinterpretations which may arise from isolating the respondent from other household members. In households where respondents in the age bracket 15-17 were selected through the KISH method, also further consent and permission had to be first sought from their parents/guardians before their own consent. The purpose was to make sure parents/guardians would later not take offense since some of the questions to be asked to the young people were related to matters of sexual behavior and condom use.

3.9 Data Analysis

3.9.1 Quantitative data analysis

The data was analyzed using Stata 12 (StataCorp LP) and for better presentation, graphics were done in MS Excel 2007. The Stat Transfer software was used to transfer data from EpiData to Stata.

Initially, descriptive analysis of the data were performed to provide an insight on the counts, means, variances, frequencies and percent distributions of participant characteristics. Later, inferential analyses of data collected were performed to measure association and determinants between respondent's characteristics and knowledge levels.

In this survey, the probability of committing a type-I error was fixed at 5%. Consequently, only differences with p values of 0.05 or less were considered as statistically significant. Finally, the analysis provided a yardstick for suggesting models that explain the determinants of knowledge levels. The summary analysis plan is also annexed in A1.

3.9.2 Qualitative data analysis

Qualitative notes from key informant interviews and focus group discussions were first transcribed and typed into a *Microsoft office, Word 2007* computer program. The notes were transcribed verbatim to ensure they capture the complete responses of the study participants. The notes were then typed into an analysis grid (matrix) to enable easy reading and comparison of responses from different respondent groups. Thematic analysis was used to categorize the data and to establish patterns that would help answer the research questions. Themes and sub-themes relevant to the objectives of the study were identified to enable qualitative coding.

Themes and sub-themes (shown in Annex A.1) were cross-analyzed across the responses of the different target groups for FGDs. The text segments with similar codes and meaning or referring to related issues were then grouped together for interpretation and subsequent presentation and argumentation. In addition, whole texts for use as direct quotations were identified and marked. These stages were followed by looking for patterns, meanings, trends and tendencies in the data; drawing comparisons between study groups, and locations; following up unique or deviant cases, and draw conclusions to answer study objectives and research questions.

CHAPTER FOUR: CHARACTERISTICS OF SURVEY RESPONDENTS

Key Findings

- There were slightly more male (51.1%) participants than female ones (48.9%). Majority of participants were married/living with a sexual partner (63.9%) and a significant proportion either single with no sexual partner (15.5%) or with a regular partner (12.7%).
- Nearly all the survey participants had attained some form of formal education although majority never completed primary school level (63.7%).
- Half of the participants were Roman Catholics followed by Protestants at 28.7%. The rest belonged to other Christian dominations or were Muslims.
- Based on summation of assets owned, slightly more than a half (53.3%) of respondents can be described as being propertied. The other significant proportion is poor (29.6%). Majority were informally employed and farming was identified as the main source of income.
- Majority (80.5%) owned a radio in their household and a mobile phone (76.9%) as tools for communication. Similarly, radio was by far reported as their main source of information (83.3%).

4.0 Introduction

This chapter provides description of the selected demographic and socioeconomic characteristics of the study participants/respondents. This background information helps in the interpretation of findings presented later in the report and provides an indication of the representativeness of the survey. The chapter describes basic socio-demographic characteristics such as age, marital status, religion education and type of residence. It also provides more information on media exposure, employment, occupation, and wealth status.

4.1 Socio-demographic composition of survey sample

Survey participants were targeted in three major age categories that is, youth aged 15-24 years, men (25-54) and women aged 25-49 years. Selection of participants in those categories was based on stratification resulting in nearly equal distribution of respondents for each age group.

Table 1: Basic characteristics of respondents

Variable	Freq	Percent
	(Total= 840)	(%)
Sex		
Male	429	51.1
Female	411	48.9
Age (Groups)		
Youth 15-24	280	33.3
Men 25-54	281	33.5
Women 25-49	279	33.2
Level of Education		
No education	53	6.3
Primary	510	60.7
Secondary+	277	33.0
Religion		
Catholic	428	51.0
Protestant	241	28.7
Muslim	74	8.8
Other Christians	97	11.5
Marital Status		

Variable	Freq	Percent
	(Total= 840)	(%)
Single/no partner	130	15.5
Single/has regular partner	107	12.7
Married/cohabiting/lives with a sexual partner	537	63.9
Widowed/divorced/separated	66	7.9
Fathered a /gave birth to child in last 5 years		
Yes	506	60.2
No	334	39.8
Type of residence		
Urban	219	26.1
Rural	621	73.9

Economic Status of Survey Participants

Based on the summation of assets owned as recorded per this study, slightly more than a half (53.3%) of the surveyed participants can be described as being upper class. The other significant proportion is poor (29.6%) and the least fall in the middle class. Majority of the participants report to be informally employed and slightly more than a half identified farming as their main source of income.

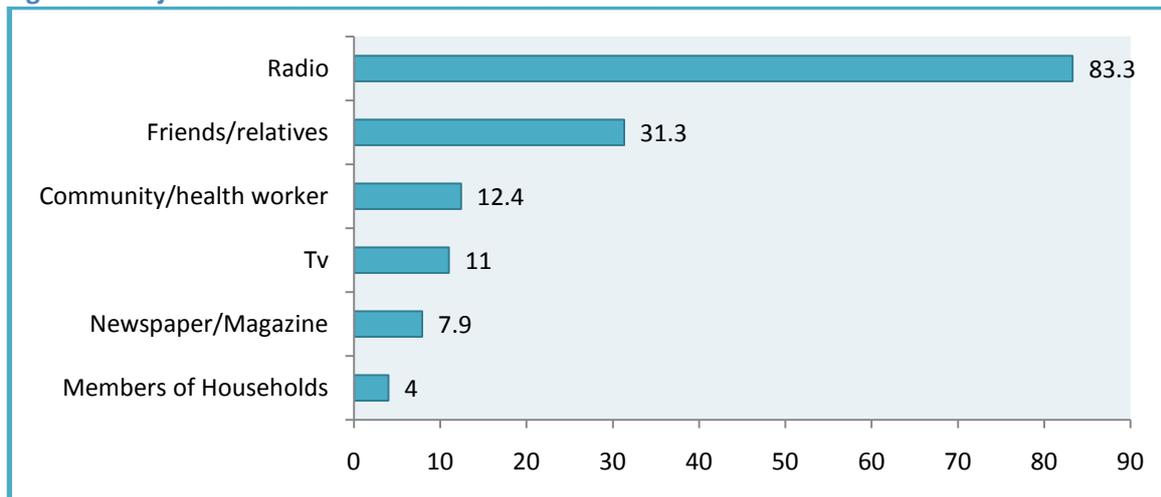
Table 2: Other characteristics of respondents (Economic Status)

Indicator	Freq	Percent
	(Total=840)	(%)
Main Occupation		
Nothing	49	5.8
Informal employment	533	63.5
Formal employment	50	6.0
Housewife	61	7.3
Others	147	17.5
Main source of income		
None	49	5.8
Trading	168	20.0
Remittances	59	7.0
Farming	439	52.3
Salaried employee	45	5.4
Others	61	7.3
Economic status (Based on Assets owned)		
Poor	249	29.6
Middle	143	17.0
upper	448	53.3

Exposure to mass Media

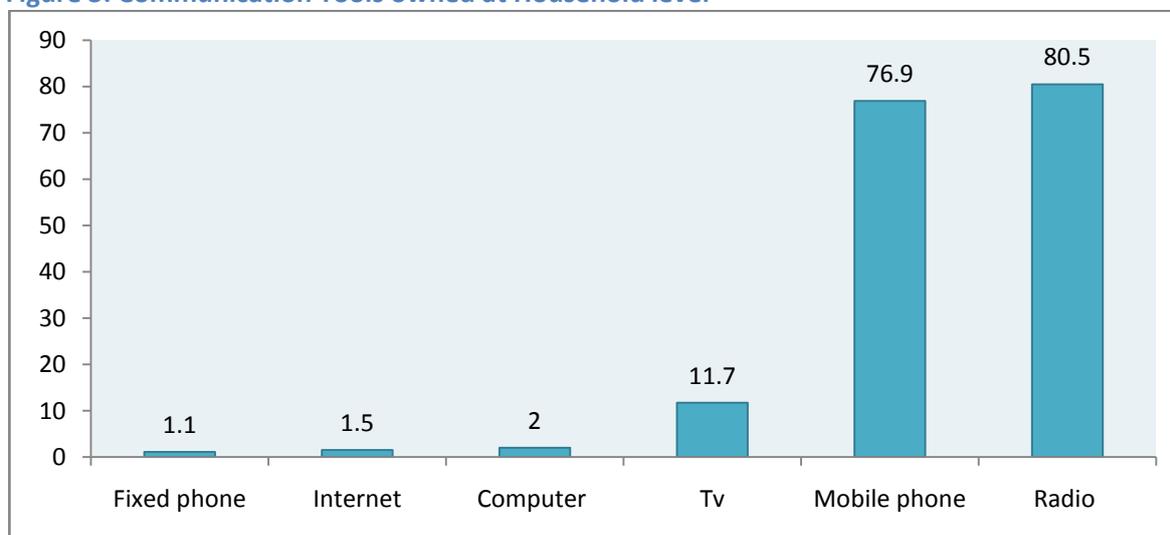
Majority of the survey participants revealed that their household have a radio (80.5%) and a mobile phone (76.9%) as tools for communication. A few (11.7%) own a television set and very few own a fixed phone, computer or internet facility.

Figure 2: Major Sources of information in households



Related to the result above, radio is by far reported by majority (83.3%) as their main source of information. Radio is followed by friends and relatives (31.3%), and community health workers (12.4%) as the other main sources of information.

Figure 3: Communication Tools owned at Household level



Television, billboards, magazines and newspapers are the least mentioned as sources of information by the survey participants.

4.2 Description of participants for focus group discussions

Focus group discussions were held with various categories of people classified based on age, gender and social status. The categories considered for FGDs include male youth aged 15 – 17, female youth aged 15 – 17, male youth aged 18 – 24, female youth aged 18 – 24, men aged 25 – 35, women aged 25-35, Men aged 36 – 54, women aged 36-54, mothers aged less than 25 of children 0 – 11 months and mothers aged more than 24 of children 0 – 11 months. Alternating FGDs were conducted in the sampled supervision areas, namely two discussions per category earmarked for the FGD were conducted making a total of 20 FGDs in the five selected districts. Each FGD comprised between 8-10 participants.

Table 3: Distribution of FGDs

S/N	Target Groups	District	District	Sessions Total
1.	Male youth aged 15 – 17	Mukono –urban SA	Adjumani – rural SA	2
2.	Female youth aged 15 – 17	Hoima – urban SA	Mubende- rural SA	2
3.	Male youth aged 18 – 24	Kaberamaido – urban SA	Hoima – rural SA	2
4.	Female youth aged 18 – 24	Adjumani – urban SA	Mukono – rural SA	2
5.	Men aged 25 – 35	Mubende – urban SA	Kaberamaido –rural SA	2
6.	Women aged 25-35	Adjumani urban SA	Hoima rural SA	2
7.	Men aged 36 – 54	Mukono-urban SA	Hoima- rural SA	2
8.	Women aged 36-54	Mubende urban SA	Mukono rural SA	2
9.	Mothers aged less than 25 of children 0 – 11 months	Hoima – urban SA	Mubende – rural SA	2
10.	Mothers aged more than 24 of children 0 – 11 months	Kaberamaido – urban SA	Adjumani – rural SA	2
	Total			20

4.2 Description of Key informants

Discussions were also held with a number of Key informants. Among the key informants successfully interviewed are leaders of Youth Groups, Women Groups, PLHIV/ Post-test clubs, Boda Boda/Fisher folk/Bar maids/Transporters groups, Local Council leaders, Religious Leaders, Health facility based service providers /In-charges, Heads of schools –both Primary and Secondary within the sampled sub-counties, Community-based caregivers, Community Development Workers, District Health Officers/Secretaries for Health, District HIV Focal Persons and Managers of CSOs providing HIV prevention services in the sampled districts. Two persons per category were covered.

Table 4: Distribution of Key Informant Interviews

S/N	Target Respondents	Districts
1.	Leaders of a Youth Groups	Adjumani, Mukono
2.	Leaders of a Women Groups	Kaberamaido, Hoima
3.	Leaders of PLHIV/ Post-test clubs,	Mubende, Hoima
4.	Leaders of Boda Boda, Fisher folk, Bar maids, Transporters	Mukono, Adjumani
5.	Leader of a Local Council	Kaberamaido, Mubende
6.	Religious Leaders	Adjumani, Mukono
7.	Health facility based service providers /In-charges	Kaberamaido, Hoima
8.	Heads of schools – Primary	Mubende, Hoima
9.	Heads of schools – Secondary	Mukono, Adjumani
10.	Community-based caregivers	Kaberamaido, Mubende
11.	Community Development Workers	Adjumani, Mukono
12.	District Health Officers	Kaberamaido, Hoima
13.	District HIV Focal Persons	Mubende, Hoima
14.	Managers of a CSO providing HIV prevention services	Mukono, Adjumani
15.	Secretaries for Health	Kaberamaido, Mubende

CHAPTER FIVE: OVERALL ASSESSMENT OF KNOWLEDGE OF HIV, CONDOM USE AND SYMPTOMS OF STIs

Key Findings

- Most people (96.4%) are able to correctly mention at least one way through which HIV can be transmitted. The most commonly mentioned was male condoms (71.3%). A large proportion mentioned PMTCT (84.8%)
- Significant proportions also answer positively to HIV transmission ways that are misconceived such as mosquitoes (35.1%), sharing utensils (18.9%) and eating food with an infected person (10.1).
- Across districts and sub-populations, there are glaring knowledge gaps about HIV, steps in HCT and condom use, PMTCT, SMC and amount of information about STI symptoms
- Many still lack information about the specific actions and steps to follow in applying some of the approaches such as condom use, PMTCT, HCT, or SMC. There is only basic information about the approaches.
- The major challenge both with the service providers and general community is the attitude and belief that people know enough about HIV. Consequently many make limited effort to learn more about HIV address deep-seated misconceptions and get sufficient knowledge about tested prevention approaches
- Except for mothers attending ANC and client PLHIV at ART sites, interpersonal communication about HIV is inadequate.

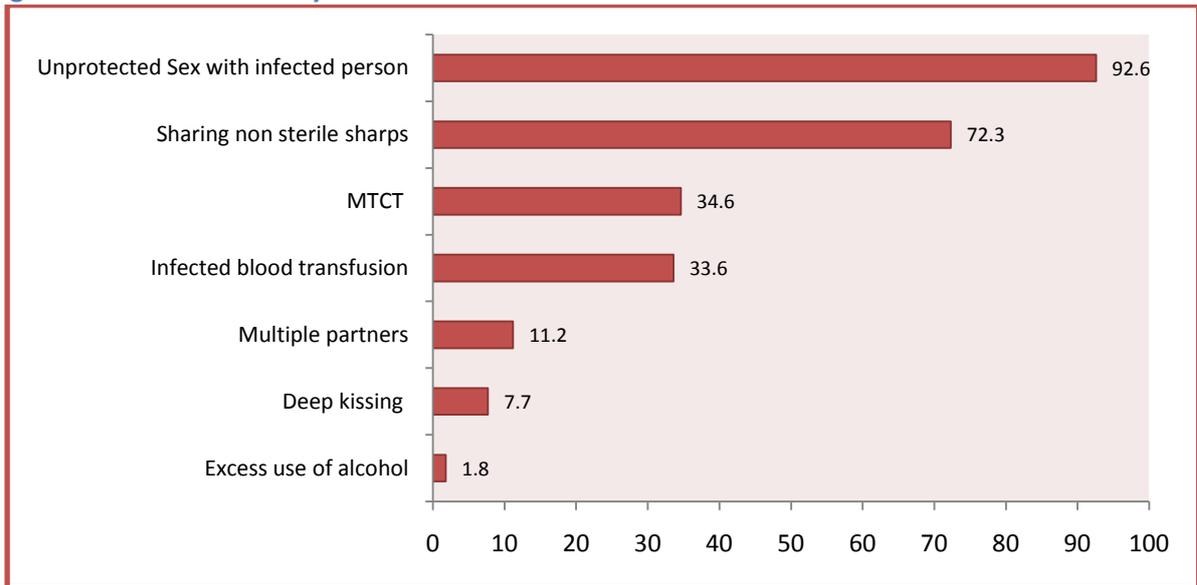
5.0 Introduction

This chapter presents the findings of the study on overall assessment of knowledge levels about HIV transmission including specific knowledge on sexual transmission and ways of HIV prevention, MTCT, HCT, symptoms of STIs and Safe Male Circumcision as HIV prevention measure. Common misconceptions about HIV transmission are also reported.

5.1 Knowledge levels on identifying ways of HIV transmission

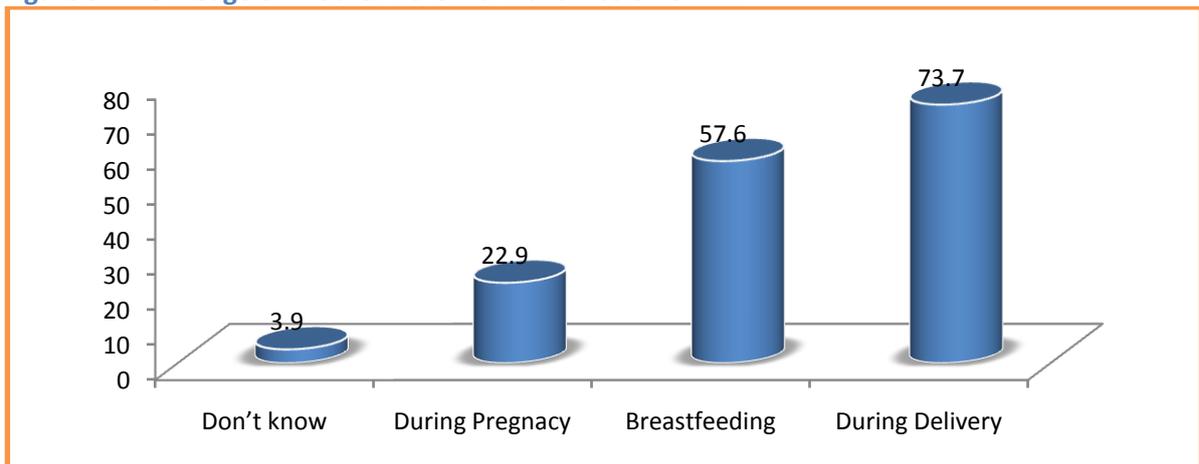
The most mentioned way of HIV infection by majority of respondents is *unprotected sex with an infected person* (92.6%), followed by *sharing non sterile sharp objects* (72.3%), *blood transfusion* (33.6%), *MTCT* (34.6%) and *having multiple partners* (11.2%). A few participants (7.7%) believe deep kissing is one of the ways through which one can be infected with HIV. Less than a percentage point (others 0.2%) consider sneezing as way in which one may get infected with HIV. Therefore, most people are able to correctly mention ways through which HIV can be transmitted. Discussions with various age categories reflected a fair understanding of HIV transmission ways which suggests that the population has had substantial amount of exposure to HIV information.

Figure 4: Awareness of ways of HIV transmission



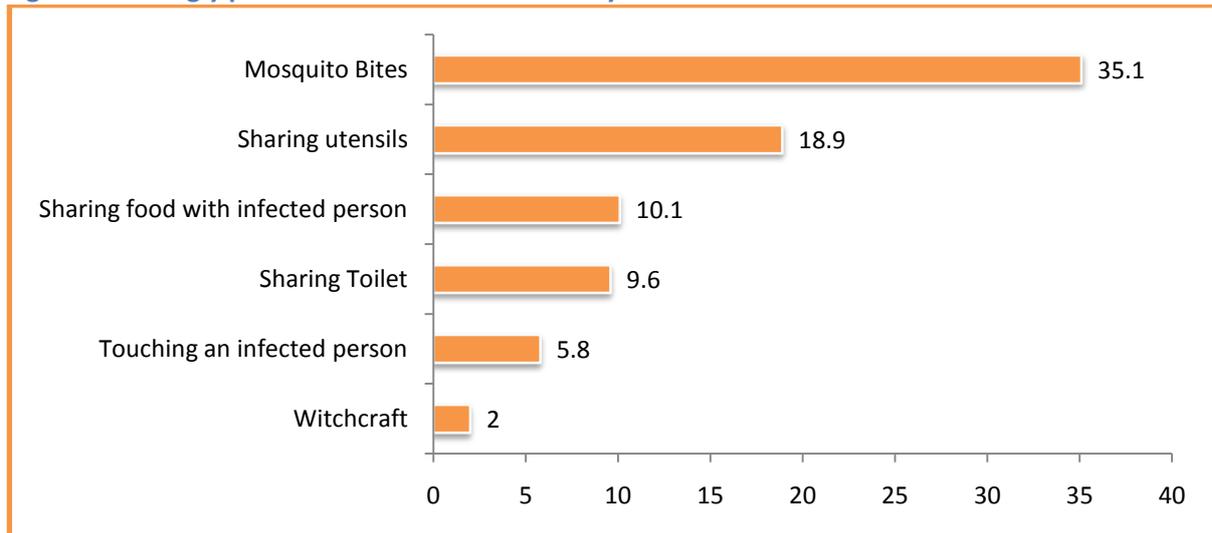
Knowledge levels on MTCT varies among populations. Majority (73.7%) are aware that MTCT mainly occurs during delivery. A significant proportion (57.6%) know that MTCT occurs during breastfeeding, while comparatively a few (22.9%) know that MTCT can/occurs during pregnancy. There is a very small proportion of participants that has no knowledge of when MTCT can or occurs. The level of knowledge of MTCT is evidently inadequate especially with regard to prenatal risks of HIV transmission (less than a quarter have knowledge) and, to a considerable extent, postnatal exposure to HIV risk (slightly above half of respondents).

Figure 5: Knowledge of Mother-To-Child Transmission of HIV



To further ascertain correct knowledge on HIV transmission and misconceptions, survey participants were asked to answer yes or no to a set of other responses (Figure 6). The population with misconceptions related to HIV transmission is quite considerable. Particularly, over one third (35.1%) still think one can be infected with HIV through mosquito bites. Another 19% and 10% think that HIV can be transmitted by sharing utensils and food [and toilet] respectively, with an infected person.

Figure 6: Wrongly perceived HIV transmission ways



Focus group discussions with different groups of the population yielded similar and even more misconceptions. Below are extracts of misconceptions that can be related to individual and group perceptions about HIV;

‘Yes it is true mosquitoes can spread the disease because they suck blood from one person and then bites another person injecting the virus in them. No no no – it is not possible. If that was the case, by now you will be seeing graves only’ (FGD Mothers, Adjumani)

‘R8 Yes mosquitoes can spread AIDS. I don’t agree because mosquitoes have no desire for sex. I think mosquitoes can do it because it will suck on blood and then go and suck another person. It will first suck away the old blood and then suck me also’ (FGD youth,18-24, Kaberamaido)

It is not only mosquitoes that are wrongly perceived by some people as potential transmitters of HIV; some community people also include sharing of food with persons living with HIV (PLHIV) and touching such person.

‘R1, If blood remains in the food which you are eating with an infected person and you also have wounds in your mouth then it can be transmitted. Touching can also spread the HIV Virus if you have wounds in your hands’ (FGD Mothers, 24 years and above, Kaberamaido)

Some of the people holding misconceptions are quick to justify their points of opinion by giving scenarios where persons living with HIV can maliciously plan to spread the infection.

‘Sharing clothes with an infected person; Sharing food with a person who is an infected person causes HIV; Others say eating food prepared by an HIV infected person can cause you HIV because he can inject her/his blood in that food; Others are not accepting that some people are HIV positive but rather were bewitched’ (FGD men and women, 36-49 years, Hoima).

The sentiments above are important because they have implications for the quality of care that community people holding such misconceptions will extend to PLHIV or those they suspect to carry the virus. Similarly, these negative portrayals about PLHIV also are a sign that community people are doubtful of the extent to which PLHIV accept to live positively with the virus.

Other community people have all kinds of arguments about possible HIV transmission ways that are incorrect. Most of the arguments centre on cases where people may come into contact with body fluids of PLHIV

“I think it is possible especially if one shares a sitting toilet with a person who is infected With a sitting toilet, a person who is already infected with HIV can urinate on it and when another person sits on it afterwards the virus can easily enter his body through that urine” (FGD Male youths, Mukono)

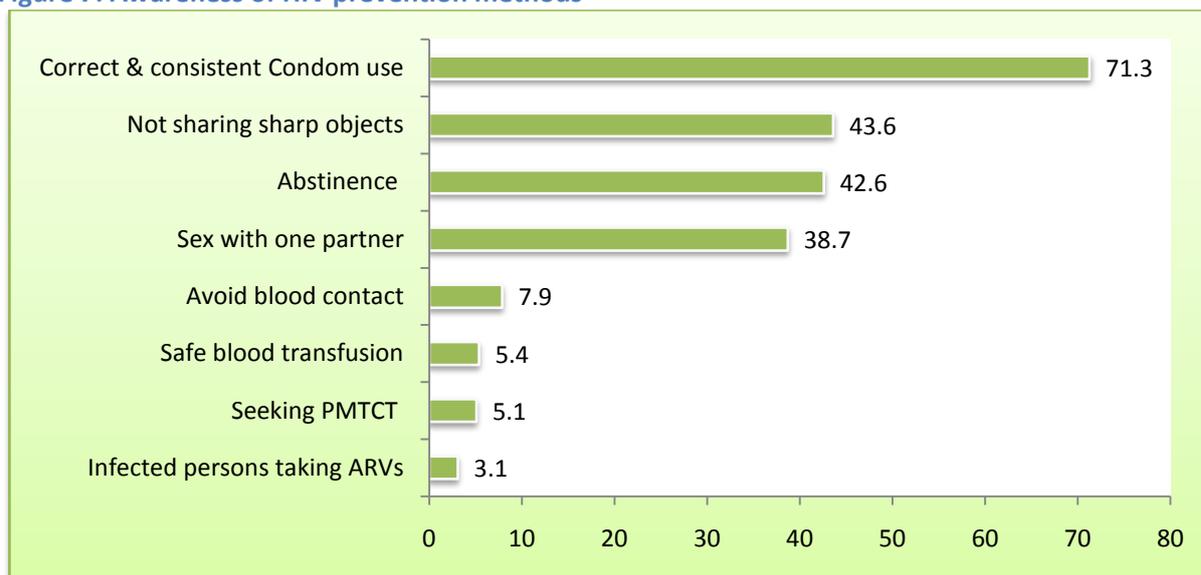
The misconceptions are not only said on known but some go a head to practice the fear from the misconception

“I have a brother who is HIV positive, he put on my t-shirt and it took me a month without putting it on fearing that I might get HIV” (FGD male youth 18-28 years, Hoima)

5.2 Knowledge levels on identifying ways of HIV prevention

In relation to identifying prevention methods of HIV, correct and consistent condom use is the most known (71.3%). This is followed by not sharing sharp objects (43.6%), abstinence (42.6%) and having sex with only one partner (38.7%). Other HIV prevention ways known include regular check up (11.1%), avoiding contact with blood (7.9%) and safe blood transfusion (5.1%). Notably however, seeking PMTCT is known by a few people having been mentioned by only 5.1% of the participants. This is very low compared to the country efforts by both government and civil society to move PMTCT services closer to the people.

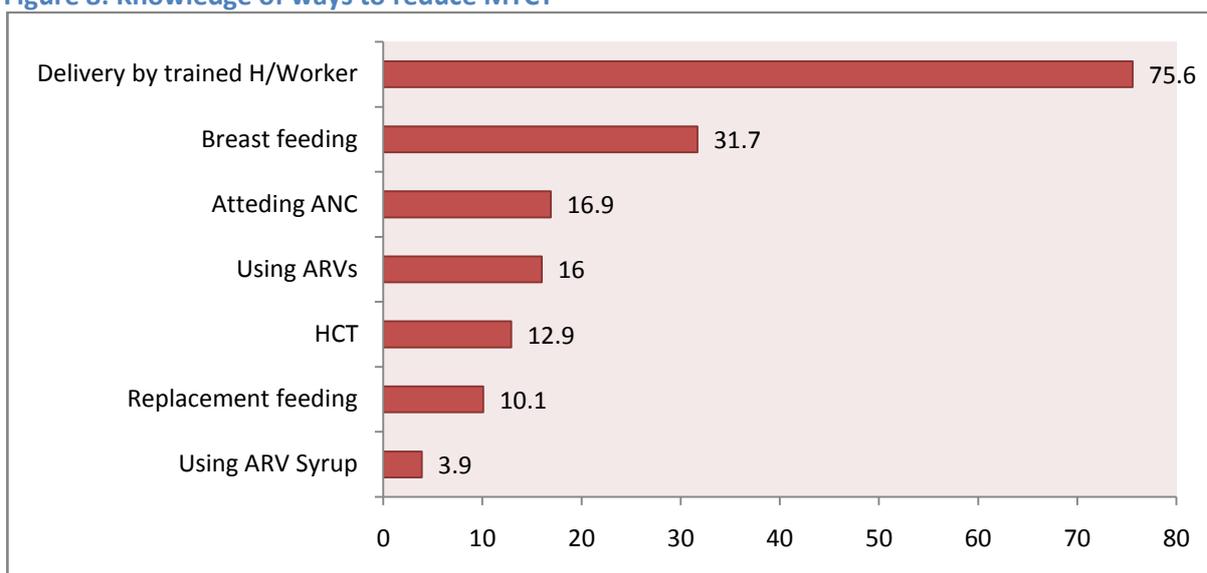
Figure 7: Awareness of HIV prevention methods



5.3 Knowledge of Prevention of Mother To Child Transmission (PMTCT)

Despite a small proportion mentioning PMTCT as an HIV prevention method, majority think that mother to child transmission can actually be reduced (84.8%); with only 7.7% who think the MTCT risk cannot be reduced while 7.5% simply have no idea nor opinion on MTCT. However, knowledge of actual ways of reducing MTCT is basic. About three quarters know that delivery by a trained health worker as a way to reduce MTCT, and nearly a third know exclusive breast feeding for first six months (31.7%). A small proportion know attending ANC, using ARVs and HCT as ways of reducing MTCT. Very few respondents mentioned delivery by Ceaserean -section, vitamin and deworming tablets and using ARV syrup as ways of reducing MTCT.

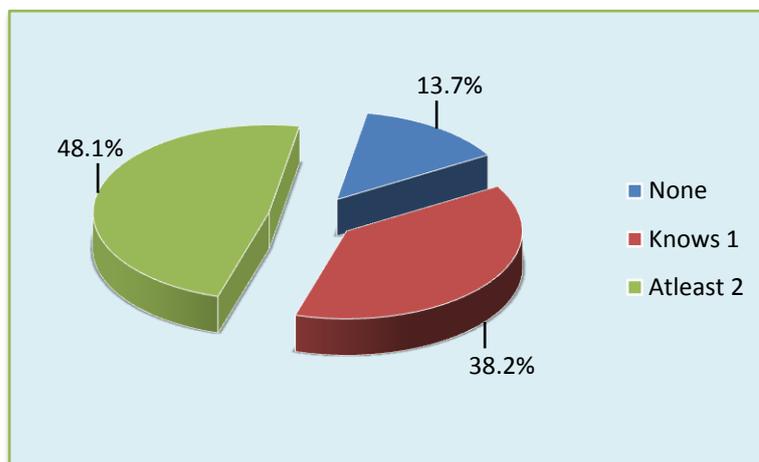
Figure 8: Knowledge of ways to reduce MTCT



Further disaggregation of data shows glaring gaps in knowledge levels about PMTCT as an HIV prevention method.

Figure 9: Knowledge of at least 2 actions that reduce mother to child transmission of HIV

Slightly less than half of the respondents demonstrate comprehensive knowledge of PMTCT. These can at least mention correctly two actions that reduce MTCT, 38.2% can only mention one and 13.7% are not aware of any action that can reduce MTCT.

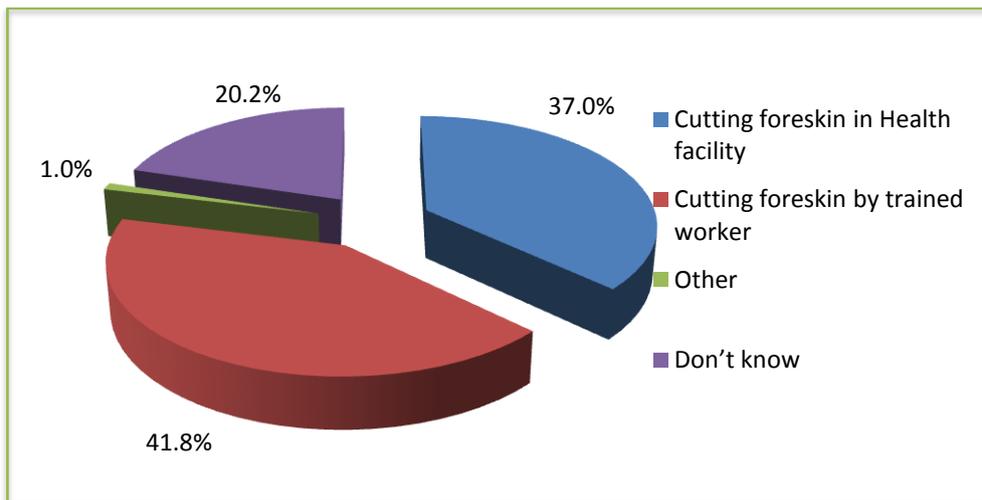


5.4 Knowledge of Safe Male Circumcision

Nearly 80% of the participants correctly know SMC by defining it as a procedure of either cutting the foreskin in a health facility or by a trained worker. Nearly 90% identify hospitals and government health centers as providers of the service. Only 2.5% mention private clinics. Two out of every ten participants do not know any provider of SMC services.

Specifically, about 4 in every 10 participants know SMC as procedure carried out by a trained worker and slightly fewer consider SMC as a procedure carried out in a health facility. About one fifth have no knowledge what exactly SMC means.

Figure 10: Knowledge of Safe Male Circumcision

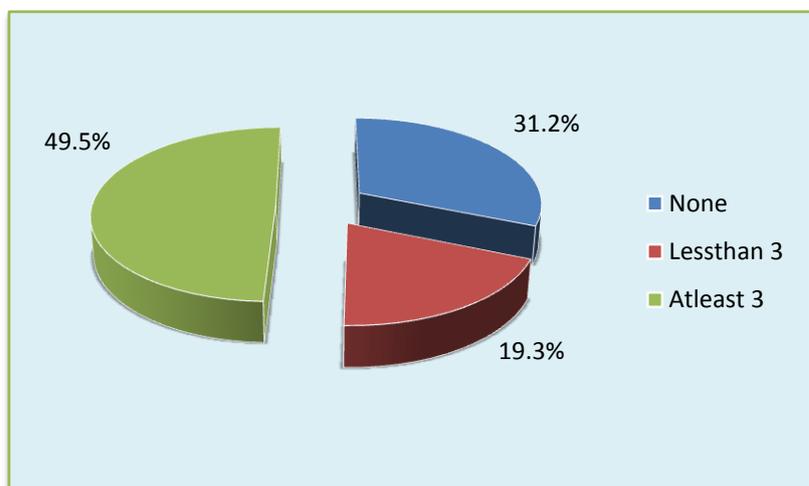


From the survey, majority of people know some advantages of SMC mainly the fact that it reduces HIV risk in men. This was mentioned by nearly 90% of the participants. Hygiene is the second most perceived advantage of SMC, mentioned by 40% of the survey participants. About one in every ten participants consider that SMC increases sex enjoyment and also reduces risk of HIV in women. A few (3%) believe that SMC makes a man stronger. However, a small proportion also finds SMC as having disadvantages, with excess bleeding being mostly noted by 20% of the participants. A notable 7% identifies increasing HIV infection as a disadvantage of SMC, while 5% note that SMC encourages unprotected sex. Other SMC disadvantages revealed include likelihood of increased promiscuity (1.9%) and that SMC reduces sex enjoyment (1.9%). It can generally be concluded that SMC is appreciated and perceived as a good practice by most people in communities.

5.5 Knowledge of HIV Counselling and Testing (HCT)

Figure 11: Knowledge of at least 3 correct steps to get HIV test

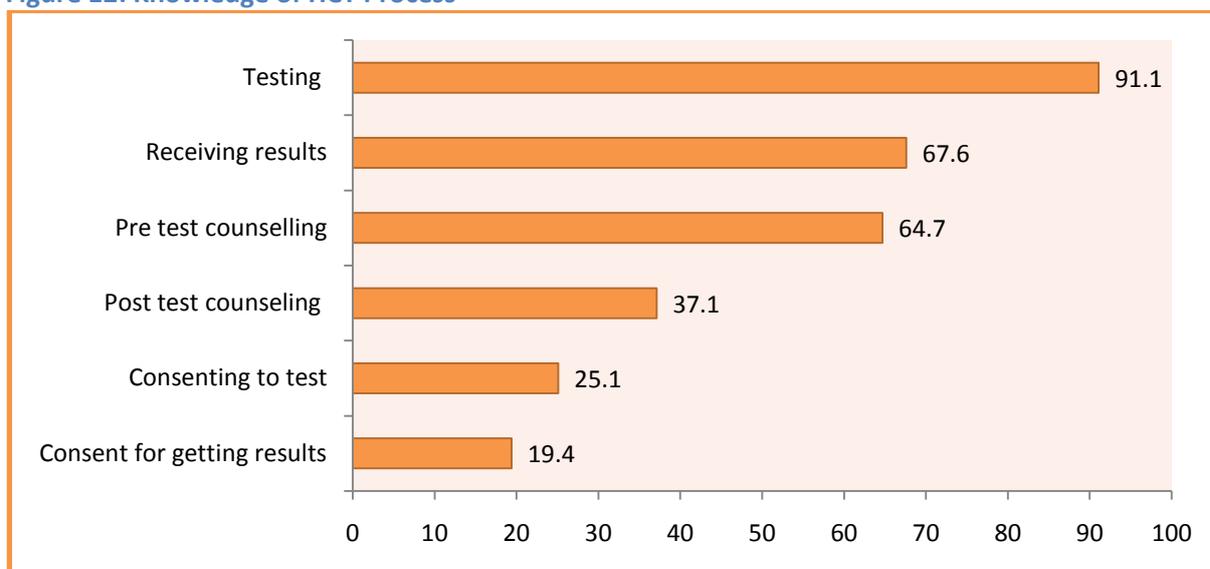
From the survey, nearly half of the participants know at least 3 correct steps to get HIV test while about one fifth identify less than 3. However, almost three in every ten have no knowledge of steps involved in HCT.



When participants were probed to describe the HCT process, testing was mentioned most (91.1%), followed by receiving test results (67.6%), pre-test counseling (64.7%) and few included post test (37.1%) counseling. Considerably smaller proportions mention consenting to test and consenting to

get results (19-25%). Very few (less than 5%) mention follow up and support and referrals as part of the HCT process. However, overall, most of people have considerable knowledge on HCT and many (70%) claim to know their HIV status.

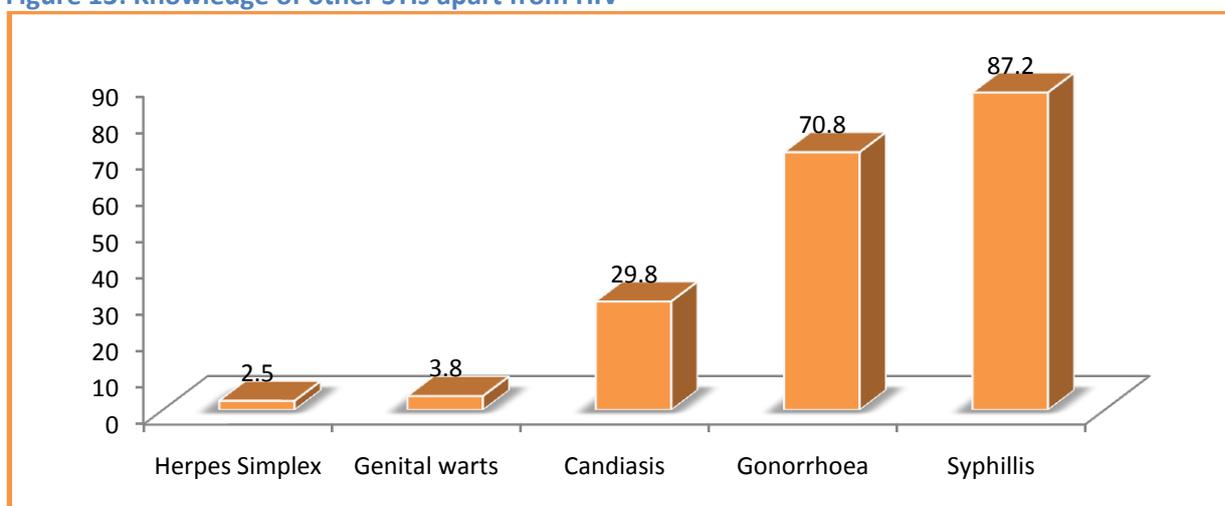
Figure 12: Knowledge of HCT Process



5.6 Knowledge of other Sexually Transmitted Infections apart from HIV

Nearly two thirds (65.7%) of the survey participants correctly identified at least 2 common STIs, about a quarter identified only one. However, a notable 10% couldn't identify any STI. Syphilis and Gonorrhoea are the most identified STIs known, followed by candidiasis, mentioned by nearly 30% of the survey participants. Knowledge of genital warts, herpes simplex and chancroid as STIs is very low; these were mentioned by less than 4% of the survey participants.

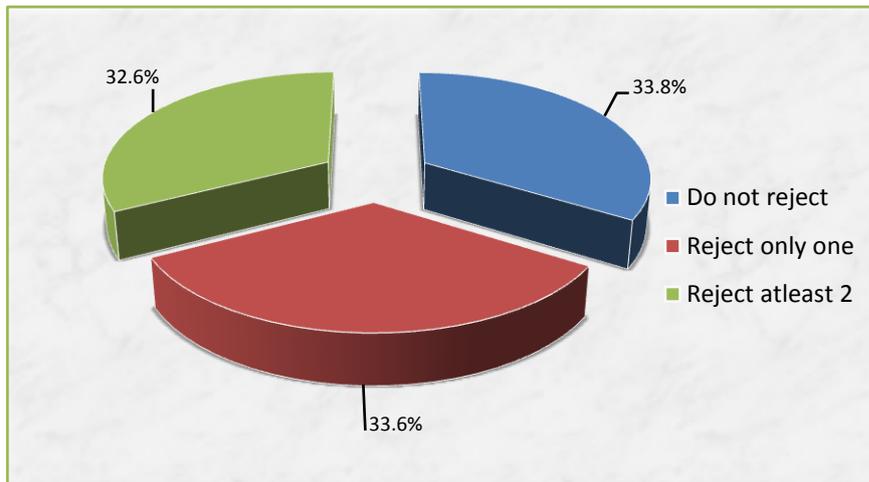
Figure 13: Knowledge of other STIs apart from HIV



5.7 Knowledge levels on rejecting misconceptions related to HIV transmission

Knowledge levels based on ability to reject misconceptions related to HIV transmission is generally low. Overall, only 31.5% of the survey participants mentioned at least 1 correct and rejected at least 2 misconceptions related to HIV transmission.

Figure 14: Proportion Rejecting Misconception of about HIV Infection



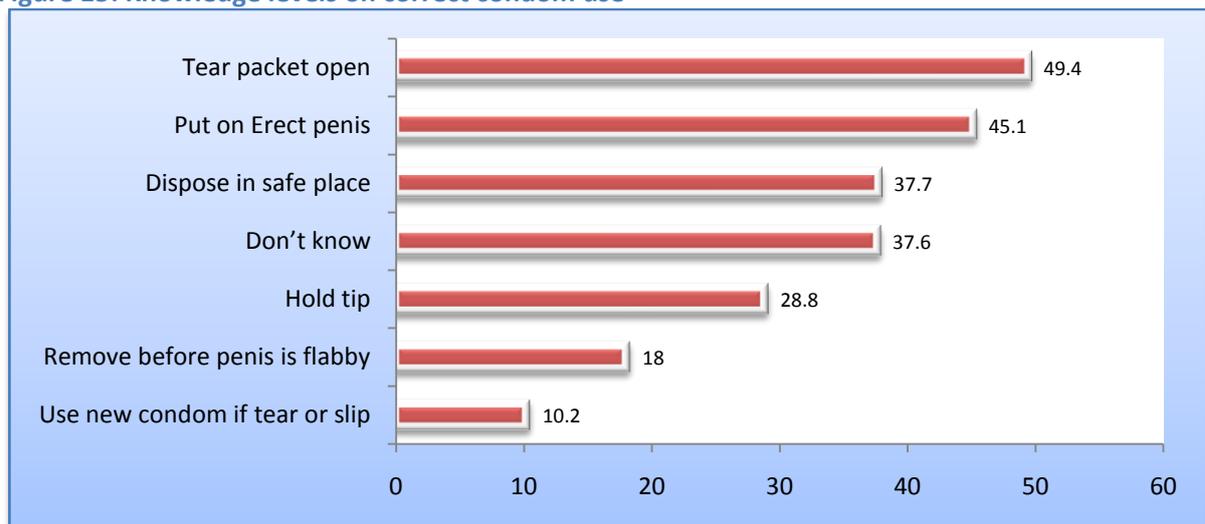
Further disaggregation of data shows that only 32.6% respondents are able to correctly reject at least 2 misconceptions. About a third cannot reject any of the misconceptions while a similar proportion can only reject one misconception.

5.8 Knowledge levels on the correct steps on how to use a condom

Based on the survey, overall, 45.7% of the population knows at least 3 correct steps of how to use a condom. A considerable proportion (39%) do not know any of the correct steps on how to use a condom while the rest can only recall less than 3 correct steps.

On correct steps of using a condom, the most known steps include *tearing packet open* and *putting on erect penis* (45-49%). These are followed by *disposing in safe place* (37.7%) and *holding tip* (28.8%). Less than 20% know that one is supposed to remove the condom before the penis is flabby, not to tear tip when removing and checking the air in the packet before use.

Figure 15: Knowledge levels on correct condom use



Only 10% know that one has to use a new condom if it tears or slips during sex and only a few know that one has to check fluid in the condom packet before use. Overall, it is evident that knowledge levels on correct use of condoms is also relatively low.

CHAPTER SIX: INFLUENCE OF SOCIO-DEMOGRAPHIC FACTORS ON KNOWLEDGE OF HIV

Key Findings

- Disaggregation of knowledge levels by district shows statistically significant differences; Hoima has higher proportion (66%) of participants followed by Kaberamaido (50%) that know at least 2 actions that reduce MTCT; Adjumani scores least (35%) on the correct condom use steps. Hoima showed higher knowledge levels on SMC and STIs (P value< 0.000)
- Statistically significant differences are evident between individual socio demographic and economic factors and knowledge about selected aspects on HIV transmission and prevention.
- A higher proportion of women knows at least 3 correct steps to get HIV test than men and youth but cannot correctly identify at least 2 common STIs. Similarly, they know the actions that reduce MTCT while men score better on steps for condom use, identification of STIs and information about SMC (P<0.000 for all).
- Results from logistic regression show that other Christians mainly the “Born Again” are more likely to have less comprehensive HIV knowledge (OR=0.42, P<0.001) compared to other religious categories.

6.0 Introduction

This chapter presents the findings and analysis of the socio-demographic factors which account for the levels of correct knowledge and misconceptions about HIV. Both qualitative and quantitative data are presented in a triangulated fashion.

6.1 Knowledge levels of HIV by district, age, gender and marital status

Disaggregation of knowledge levels by district shows statistically significant differences (P values <0.05). Overall, participants in Kaberamaido showed a higher knowledge of misconceptions related to HIV transmission than other districts. Over 40% of participants in Kaberamaido reject at least 2 misconceptions compared to less than 35% in the other districts (P value< 0.002). Adjumani scores the least in ability to reject at least 2 misconceptions (24%). The proportion is also higher in Kaberamaido than other districts of those that reject at least 2 misconceptions (P value< 0.002). Only Adjumani has a higher proportion of respondents (65%) with such knowledge on HIV test. Mukono scored least on this knowledge indicator (35%).

Table 5: HIV Knowledge levels by district, age, gender and marital status

Factor	Number	Knowledge item						
		Mentioned at least 1 correct transmission way and reject at least 2 misconceptions	Reject at least 2 misconceptions about HIV infection	Know at least 3 correct steps to get HIV test	Know at least 2 actions that reduce MTCT	Know at least 3 correct steps to use condoms	Correctly know SMC	Correctly identify at least 2 common STIs
Adjumani	168	23.8	25.6	64.9	48.2	35.1	50.6	63.7
Hoima	168	25.6	25.6	48.8	65.5	49.4	94	90.5
Kaberamaido	168	42.3	42.9	58.9	50	64.3	83.9	50
Mubende	168	32.1	35.1	40.5	28	38.7	75.6	60.7
Mukono	168	33.9	33.9	34.5	48.8	41.1	89.9	63.7
Total	840	31.5	32.6	49.5	48.1	45.7	78.8	65.7
P value		0.002	0.002	0.002	0.000	0.000	0.000	0.000

Factor	Number	Knowledge item						
		Mentioned at least 1 correct transmission way and reject at least 2 misconceptions	Reject at least 2 misconceptions about HIV infection	Know at least 3 correct steps to get HIV test	Know at least 2 actions that reduce MTCT	Know at least 3 correct steps to use condoms	Correctly know SMC	Correctly identify at least 2 common STIs
Age group								
Youth (15-24)	280	33.6	35.4	41.8	45.0	42.5	77.5	54.3
Men (25-54)	281	29.9	30.2	51.6	47.0	60.9	82.2	75.8
Women (25-49)	279	31.2	32.3	55.2	52.3	33.7	76.7	67.0
Total	840	31.5	32.6	49.5	48.1	45.7	78.8	65.7
P value		0.636	0.210	0.000	0.090	0.000	0.226	0.000
Gender								
Male	429	30.5	31.9	44.5	44.1	59.7	84.4	69.5
Female	411	32.6	33.3	54.7	52.3	31.1	73.0	61.8
Total	840	31.5	32.6	49.5	48.1	45.7	78.8	65.7
P value		0.519	0.767	0.000	0.026	0.000	0.000	0.045
Marital status								
Single, no partner	130	32.3	35.4	28.5	38.5	36.9	78.5	56.2
Single, regular partner	107	32.7	32.7	43.9	45.8	50.5	85.0	59.8
Married	537	31.7	32.6	55.7	51.6	46.6	77.7	69.6
widowed, divorced or separated	66	27.3	27.3	50.0	42.4	48.5	78.8	62.1
Total	840	31.5	32.6	49.5	48.1	45.7	78.8	65.7
P value		0.882	0.962	0.000	0.000	0.025	0.402	0.009

Similarly, only Hoima has a higher proportion (66%) of participants followed by Kaberamaido (50%) that know at least 2 actions that reduce MTCT. Mubende scored least on this knowledge level measure (28%). Kaberamaido again has the highest proportion (64%) of participants who know at least 3 correct steps on how to use condoms, followed by Hoima (49%), Mukono (41%) and Mubende (39%), while Adjumani scores least (35%) on the correct condom use steps. Hoima showed higher knowledge levels on SMC and STIs (P value <0.000). It was followed by Mukono on both measures. Kaberamaido only scored the least (50%) on STI knowledge level measure.

Age is a strong influencing factor in relation to specific knowledge levels of getting an HIV test, correct use of condoms and knowledge of common STIs (P -value <0.000). Compared to other categorical groups in this survey, more adult women aged 25-49 know at least 3 correct steps to get HIV test than men (25-54 years) and youth aged 15-24years. Of the three population categories in the survey, the youth show the least knowledge levels on the three aspects, that is, process of getting an HIV test, steps in correct use of condoms and knowledge of common STIs. However, there is a slight difference by age group on comprehensive knowledge levels as measured by mentioning 1 correct way of HIV transmission and reject at least 2 misconceptions. However the difference is not statistically significant (P value < 0.636).

In relation to knowledge on correct use of condoms, a bigger proportion (61%) of men know at least 3 correct steps of how to use a condom compared to women group and the youth age groups. Proportion of women with such knowledge is significantly small in comparison with the other age groups. The effect of age on knowledge levels on condom use is highly significant (P value < 0.000). Knowledge of common STIs strongly vary by age groups; more men aged 25-54 correctly identify at least 2 common STIs than women and the youth. The proportion of youth with this knowledge is the smallest of all the three age groups.

There are statistically significant differences in knowledge levels by gender in relation to specific knowledge aspects (P values < 0.05). A higher proportion of women than men know at least 3 correct steps to get an HIV test and the actions that reduce MTCT while men score better on steps for condom use, identification of STIs and SMC. However, there is no significant difference by gender on comprehensive HIV knowledge as indicated by proportions who know one correct mode and rejecting at least 2 misconceptions related to HIV transmission (P value < 0.519). This difference in knowledge on the above specific aspects of knowledge is evidently due to the fact that the different HIV prevention measures largely target specific gender categories.

Survey data shows that knowledge levels of specific HIV prevention strategies significantly vary (P < 0.05) by marital status. More married/cohabiting respondents (56%) and the separated (50%) know at least 3 correct steps to get HIV test, compared to the single (28-43%). The trend is the same on the knowledge of STIs. In relation to knowledge on condom use, more respondents that are single with a regular partner (51%) know at least 3 correct steps on how to use condoms, than those that are single with no partner (37%). However, married/... respondents (47%) and the separated (49%) closely follow the single with regular partner on correct knowledge of condom use. On knowledge of PMCT, more married respondents (52%) know at least 2 actions that reduce mother to child transmission of HIV compared to the singles and separated (42%). The singles have the smallest proportion of members with knowledge on MTCT (39%). Similar to other individual variables, there is no statistical significant difference on comprehensive knowledge levels measured by rejecting misconceptions related to HIV transmission based on marital status (P value < 0.882).

6.5 Knowledge levels of HIV by Level of Education, religion, economic status and locality

Based on the survey, Knowledge levels increase with the level of education in relation to specific measures of HIV prevention. More respondents with secondary education and above, have more knowledge on HIV prevention strategies of HCT, condom use, SMC and knowledge on STIs (P < 0.05). For instance, nearly 60% with secondary education and above know at least 2 actions that reduce mother to child transmission compared to only 28% that have no education at all. The difference is similar on knowledge of correct steps to use a condom and on STIs. Generally, correct knowledge of SMC is high (70% and above) irrespective of education level; however it is higher among those with secondary education and above. However, similar to other demographic characteristics, there is no statistically significant difference in levels of comprehensive knowledge by education level.

Table 6: HIV Knowledge levels by education, religion, economic status and locality

Factor	Number	Knowledge item						
		Mentioned at least 1 correct and reject at least 2 misconceptions	Reject at least 2 misconceptions about HIV infection	Know at least 3 correct steps to get HIV test	Know at least 2 actions that reduce MTCT	Know at least 3 correct steps to use condoms	Correctly know SMC	Correctly identify at least 2 common STIs
None	53	32.1	34.0	43.4	28.3	24.5	71.7	52.8
Primary	510	33.5	35.1	45.9	45.1	37.3	73.7	60.4
Secondary +	277	27.8	27.8	57.4	57.4	65.3	89.5	78.0
Total	840	31.5	32.6	49.5	48.1	45.7	78.8	65.7
P value		0.254	0.176	0.016	0.000	0.000	0.000	0.000
Religion								
Catholic	428	32.7	34.3	51.9	45.8	42.1	69.2	62.4
Protestant	241	29.9	30.3	47.3	53.5	53.5	90.0	70.1
Muslim	74	35.1	35.1	41.9	58.1	44.6	93.2	74.3
Other Xtians	97	27.8	28.9	50.5	37.1	43.3	82.5	62.9
Total	840	31.5	32.6	49.5	48.1	45.7	78.8	65.7
P value		0.650	0.049	0.183	0.012	0.029	0.000	0.175
Economic status								
Low	249	26.5	27.7	42.6	39.4	36.9	73.5	63.1
Middle	143	32.2	32.9	49.0	49.7	41.3	76.9	61.5
High	448	34.2	35.3	53.6	52.5	52.0	82.4	68.5
Total	840	31.5	32.6	49.5	48.1	45.7	78.8	65.7
P value		0.113	0.299	0.042	0.002	0.001	0.019	0.017
Locality								
Urban	219	30.1	30.6	52.5	50.2	45.7	79.9	75.3
Rural	621	32.0	33.3	48.5	47.2	45.7	78.4	62.3
Total	840	31.5	32.6	49.5	48.1	45.7	78.8	65.7
P value		0.613	0.543	0.082	0.666	0.414	0.701	0.001

Like most demographic characteristics, religion is a strong influencing factor on specific knowledge levels related to MTCT, condom use and SMC ($P < 0.05$). More participants (58%) of Muslim affiliation know at least 2 actions that reduce mother to child transmission compared to the rest of religious affiliations. Protestants follow closely, while other Christians contribute (37%) the least proportion on knowledge of PMTCT. On the other hand, more Protestants (53%) know at least 3 correct steps on how to use a condom, compared to other religions (42-44%). Correct knowledge on SMC is generally high across all religions, though proportion of Muslim (93%) and Protestants (90%) is bigger than other religious groups.

However, similar to most demographic characteristics, there is no statistically significant difference ($P < 0.650$) by religious affiliation in comprehensive knowledge levels based on the measure of mentioning 1 correct and rejecting at least 2 misconceptions related to HIV transmission. There is also some observable difference ($P < 0.049$) by religion when data is disaggregated to consider respondents that reject at least 2 misconceptions without necessarily mentioning a correct HIV transmission way.

Economic status (based on asset ownership) influences knowledge levels on specific HIV prevention measures ($p < 0.05$). The lower the economic status the more evident are lower levels of knowledge on selected HIV prevention measures. More respondents termed as rich in the study have higher knowledge levels on MTCT, HCT, correct condom use and SMC. The group termed as poor for the study has the smallest proportion of participants with high knowledge on selected HIV prevention measures. The differences are statistically significant. However, whereas there is a difference in knowledge levels on mentioning at least 1 correct and rejecting at least 2 misconceptions related to HIV transmission, this difference is not statistically significant ($p < 0.113$).

Knowledge levels by locality of usual residence, either in urban or rural, is largely not a statistically significant factor despite some slight differences in proportion of participants on certain measures. The only significant difference is on knowledge to correctly identify at least 2 common STIs, 75.3% for urban and 62.3% for rural respectively ($P < 0.005$).

6.10 Other individual differences influencing information and knowledge levels

6.10.1 Fathered a child in the last 5 years

The study also revealed some difference in comprehensive knowledge levels depending on whether one has had a child in the last 5 years or not, but the difference was not statistically significant. However, there is a significant difference on knowledge levels of PMTCT depending on whether one had had a child in the last 5 years or not ($P < 0.000$). Half of participants that had had a child in the last 5 years knew at least 2 actions that reduce MTCT, compared to those that had not had a child during the same period.

6.10.2 Knowledge of HIV Status and its influence on knowledge of HIV

Another factor that appears to influence knowledge levels is HIV status. Respondents that know their HIV status are more knowledgeable on correct condom use, than their counterparts who do not know their HIV status. Nearly 50% of those that know their HIV status also know at least 3 correct steps on how to use condoms compared to the 36% that don't know their HIV status. This difference is statistically significant ($P < 0.005$). This is clearly related to exposure to relevant IEC, including counseling.

6.10.3 Attitude and belief 'I know enough'

A number of discussants point out that the attitude and belief of some people that they know enough about HIV, is contributing to low levels of comprehensive HIV knowledge. Such people think they know enough and don't make any effort to learn more about HIV, or they do not bother attending HIV sensitization activities. It is reported that some people also view HIV as any other disease now days, and therefore do not see the need to know much about it other than the basic. For some, HIV is incurable and whoever gets it has to die, they believe whether you know less or more about it, once you get it, you will still die

"Here we take HIV to be like any other disease like malaria, headache, so people are reluctant...some people say HIV is not the only cause of death, so people are no longer threatened by HIV, they don't go for HIV test or go for more information about it [HIV]" FGD with male youth 18-28 years, Hoima

"Abandi bagamba, sirimu teita bisaru, ekaija kwita abantu" [HIV does not affect swamps, but rather people, therefore if it came to kill people, they will die]" FGD Female Youth, Hoima

6.10.4 Available service and low demand paradox

While it is assumed people will respond positively when a service affecting their lives is provided, this study found the reverse. It is indeed ironical that there are HIV/AIDS related messages channeled through schools, community outreaches, health centre, print and electric media yet knowledge levels about the HIV are still low. It emerged from the interviews and discussions that people no longer attach much importance to HIV/AIDS as much as other diseases. This explanation came out throughout all the study districts.

“In this school we have PIASCY which is aiming at building life skills through trainings and is done by teachers. In the community, there has been HIV testing and counseling for example recently there was an organized counseling and testing session at the church where your car is parked. There is also health education at health centres where most people do not go, these sessions are attended mostly by women who go there for antenatal or immunization. People are very reluctant to get information about HIV”. (KII Head teacher, Busanga Ps village Bururu sub county Hoima district)

There are various reasons given for people not attending the BCC message. The most common one was the feeling that they now no enough on HIV as echoed in this statement

‘It is hard to tell but I think people have learnt that HIV is no longer a big threat like when it had come and also people think they know a lot about HIV which is not the case’. (KII DHO’s office Adjumani district)

Another important factor for the low knowledge levels can be traced from peoples’ feelings about the quality of HIV services provided at the various delivery points. The concerns about quality are well captured in the voices of the people who use the services as provided below:

“Services are available but they take a lot of time, if you visit TASO and you see how people are lining up, it is too much.there are good services but the health staff are few. Services are good because they give us what we want. ... in the villages services are poor because people walk long distances to health centres, there is need to reach the poor instead of going to the referral hospital.” (FGD Women Aged 18-24 with Children of 0-11months)

NGOs providing HIV/AIDS also shared concerns about the quality of services provided at the health facilities in the study districts

“Here the health centres are not well equipped which makes HIV care and treatment hard by service providers. So we have structures to reach everyone but the health facilities are not equipped well and arte located some distances away from the local communities. There not enough health workers in counseling, what is available is group counseling but one on one counseling is missing because health workers have no time, they are overwhelmed by work. We had volunteers but they were not sustained, health workers are not fully trained to offer HIV services” (KII NACWOLA Hoima)

CHAPTER SEVEN: INFLUENCE OF COMMUNITY FACTORS ON KNOWLEDGE OF HIV

Key Findings

- Most common beliefs about HIV which depict lack of appropriate understanding of the epidemic are not necessarily cultural but largely individual misconceptions.
- Few people talk about witchcraft and prayer as forms of HIV transmission and treatment respectively
- However, there are still limits within traditional cultural and religious norms and values regarding sex which inhibit open discussion of sexual matters because they are sacrosanct.
- From cultural and religious perspectives, condom use is still largely considered to be at variance with the meaning and purpose of coitus and dismissed as an abhorrent practice.
- Partly as a result of the considerable obscurity that clouds condom talk, the initiative to learn how to correctly use condoms remains low.
- Differentials between men, women and young people about various aspects of HIV knowledge and service related information also arise from gendered socialization regarding sexuality, role ascriptions and power relations. Men are expected to succumb last in the event of a calamity as devastating as HIV/AIDS. Seeking HIV services, even information, may be construed a sign that one has succumbed.

7.0 Introduction

This chapter presents the findings and analysis of the community factors which account for the levels of correct knowledge and misconceptions about HIV. Both qualitative and quantitative data are presented in a triangulated fashion.

7.1 Socio-cultural beliefs about HIV transmission and prevention

Based on the study, beliefs about HIV transmission and prevention are not necessarily cultural but more of misconceptions. From discussions and in-depth interviews with key informants it is evident that generally socio-cultural beliefs in relation to HIV transmission and prevention are nearly nonexistent unlike during the early years of the epidemic. Most of the respondents refuse that HIV is not transmitted by bewitching. However there are cases of some FGD participants mentioning witchcraft and prayer as forms of transmission and treatment respectively, these are disregarded on all occasions by the rest of discussants. Below are extracts misconceptions that can be related socio-cultural environment;

“Sharing clothes with an infected person; Sharing food with a person who is infected person causes HIV; Others say eating food prepared by an HIV infected person can cause you HIV because he can inject her/his blood in that food; Others are not accepting that some people are HIV positive but rather were bewitched” FGD men and women (36-49). Hoima

Some people believe that getting infected can be selective. A participant in one of the FGDs expressed her self saying;

“Other people say even if you protect yourself, HIV can get you, HIV chooses someones’ body, because others can sleep with infected people and they don’t get it, yet others sleep with them and they get it” FGD Mothers (18-24), Hoima

Whereas in the quantitative data only 2 percent believed that HIV can be contracted from using witchcraft, those who believe in it have cases on which they refer to support their argument

“I was told of a woman there in Kikooza with HIV. There was this man who used to laugh at her because she was HIV positive. So the woman smoked a pipe for the man to love her and

the man fell for the very woman he used to abuse. The man ended up getting HIV. He went looking for the virus and he got it” FGD Male youths, Mukono

Several incorrect methods of avoiding or getting healed were also mentioned during the discussions
“People say that when a woman is HIV positive and she goes into periods, the HIV Virus keep getting out of the body through blood and eventually she gets healed...HIV can be prevented when there are discordant couples...Some people say that during sexual intercourse you can use withdraw method and if the man is sick, he will not infect the woman....Some people say that if you have sex with a woman who has a lot of sexual fluids and she has HIV she won’t infect you” FGD Mothers (18-24), Hoima

There also continues to be a belief that prayer can heal someone with HIV/AIDS. A participant in a discussion narrated;

“There is a woman who said she had HIV but she went to church, the pastor prayed for her and she got healed, that now she has no HIV. She went to test and she was negative” FGD Mothers (18-24), Hoima

7.2 Cultural norms regarding sex and condom use

Whereas there has been generally a positive shift in cultural norms regarding sex and condom use in most communities, in some communities open discussion of sexual issues in relation to HIV and condom use remain a no-go area in open gatherings. This has limited passing on fully all the required HIV knowledge in such communities, hence low comprehensive HIV knowledge. In relation to condom use, it largely still remains in the hands of the men according to discussions with participants. Women make limited effort to know about condoms or risk to be termed prostitutes. Further, the attitude towards condoms remains largely negative. A number of discussants mentioned that their partners don’t like the condoms, both men and women. Some note that condom use is against their norm of having children. Naturally, few people make an effort to know more about something they don’t like. Below are extracts from discussions on this issue;

“It is a taboo to touch [talk] on sexual related things for example saying that condoms should be used for prevention. The culture among the Madhi is such that sex issues cannot be discussed openly, consequently few parents can do that” K I with Reverend-CoU, Adjumani

“Some parents and caregivers shy away from giving children timely information about HIV, they think it is not culturally right” KI-Head master, primary school, Hoima

There are also persistent beliefs about condoms getting stuck in a woman’s womb. While such perceptions could pass as individual misconceptions, they are quite widespread and have become formulaic pronouncements almost in many communities.

“Ladies are the ones who usually reject condom use because they think that it will enter into them and kill them. It has happened twice in this village a woman after operation from hospital a condom was found in her” FGD MALE (18-24) Kaberamaido

“Some women just do not want to hear about condoms saying they are hot, or it burns you during sexual act...Other women have fear that it can remain in the stomach and you die if not taken to the hospital” FGD of men and women (25-35years) Kaberamaido

Persistent and perhaps gaining in importance at community level are anti-condom campaigns by sections of the religious community who consider condom use as an abhorrent practice deliberately intended to bring moral degeneration. Some new faiths have also emerged, reinforcing the strong anti-condom stance of the mainstream churches.

“There is a religion here which agitates for producing many children, not using phones, not educating children and not going for medical treatment, so its believers can’t know how to use a condom....some people are against family planning so they do not use condoms....Catholics also discourage use of condoms” FGD with men and women (36-49years) Hoima

From discussions, women continue to be reluctant to use condoms basing on moral grounds as a key informant noted;

“Some women still believe that men should not use condoms with them when having sex. They believe that condoms are for prostitutes. Besides, some have never used them before. This attitude may not help men to learn condom application” KI-Manager Straight Talk Foundation, Adjumani

Condom promotion activities have also been limited in certain target communities, thus affecting community condom knowledge levels

“I think it is also because we do not reach everywhere, schools do not allow us to demonstrate” KI-Manager Straight Talk Foundation, Adjumani

It was also revealed that Men have remained with the locus of control over condom use in most relationships

“A woman cannot decide for a man to use a condom...the men decide who to use the condom on.... I have to ask permission from my husband because I can’t decide for my husband to use condom on me and unless he asks me to go for it, I will not go for it” FGD Mothers Adjumani

“It’s the men and male youth who have access to condoms because women fear asking for them or buying them because of fear of losing dignity in society” FGD with male youth 18-28 years, Hoima.

The challenge however is that, the men who have control over condom use, man seem to have a negative attitude towards them

“but how shall we produce [if we use condoms]?...The youth say when they use condoms they don’t get to climax....Most people think if you use a condom then you are sleeping with a condom not a woman” FGD Male (18-24) Kaberamaido

7.4 Community perceptions related to HIV information

In relation to participants perceptions related to HIV in their community, majority (80%) note that their community is interested in any new HIV information and education. This also corresponds with the finding that most (73%) community members show up at sessions for learning about HIV whenever such sessions are organized. However, slightly over 50% of the survey participants disagreed with the statement that there are local initiatives within community giving HIV information to community members. Evidently, there is limited sensitization about HIV prevention in communities.

Over 70% of the participants report that HIV and sex talk is neither a taboo in the community nor offensive to their cultural values. This is contrary to the findings from group and key informant discussions which show that open discussions in relation to condoms use and sex are limited. The difference in result could be in the depth of discussion. Discussions could be generally done but not in-depth as pointed out by the qualitative data.

Table 7: Community perceptions related to HIV information

Statement (N=840)	Agree (%)	Disagree (%)	DNK (%)
This community is interested in any new information and education about HIV/AIDS	80.6	14.5	4.9
There are local initiatives within this community for giving information and education about HIV/AIDS to our members	41.3	53.2	5.5
Most community members show up at sessions for learning about HIV/AIDS whenever such activities are arranged	73.1	22.6	4.3
People doing HIV/AIDS sensitization programs/ activities simply have their own personal benefits	19.8	67.4	12.9
Talking about HIV/AIDS especially in relation to sex is considered taboo in this community	20.8	72.6	6.5
Most people consider HIV talk to be offensive to their cultural values	18.9	75.7	5.4

In terms of condom promotion, only 32% share the view that there are deliberate activities to promote condom use in their communities. A notable 40% has the view that people in their communities do not like using condoms even with non regular partners. Related to treatment of STIs and HIV, most of the respondents agree that STIs apart from HIV can be treated and one gets healed. Based on the study, only a few people (5%) still believe that HIV can be treated and individuals get healed. In a sense, therefore, most communities are simply inadequately served with appropriate IEC about HIV and condoms promotion initiatives.

Table 8: Other Community perceptions related to HIV information

Statement (N=840)	Agree (%)	Disagree (%)	DNK (%)
In this community, there are deliberate activities to promote condom use	32.1	57.3	10.6
Within this community there is enough and suitable information on condoms	27.9	61.1	11.1
People in this community do not like using condoms even with non-regular partners	39.6	29.6	30.7
STIs apart from HIV can be treated and individuals get healed	87.1	4.2	8.7
HIV can be treated and individuals get healed	5.4	91.4	3.2
In this community there are people that can bewitch others to acquire HIV	3.2	92.0	4.8

Disaggregation of data by district shows reveals significant differences ($p < 0.000$) in community perception about HIV information and programs. Adjumani and Hoima show higher presence of local initiatives at community level for giving information on HIV with slightly over 50% of their participants noting existence of such efforts. Mukono follows, with 45% of its respondents admitting such efforts. Kaberamaido and Mubende show least in presence of community level initiatives. Results followed similar sequence in relation to community members attending sessions organized to learn about HIV.

There are also glaring differences in relation to the view that talking about HIV/AIDS especially in relation to sex is considered taboo. More participants in Kaberamaido, Mukono and Adjumani hold the view that talking about HIV/AIDS especially in relation to sex was considered taboo, than participants in Hoima and Mubende. The response result followed similar sequence for the perception that most people consider HIV talk to be offensive to their cultural values.

Table 9: Community perceptions related to HIV information by district

Statement	Adjumani (N=168)	Hoima (N=168)	Kaberamaido (N=168)	Mubende (N=168)	Mukono (N=168)	All N=840	P value
There are local initiatives within this community for giving information about HIV/AIDS to our members	56.5	50.0	26.8	27.4	45.8	41.3	.000
Talking about HIV especially in relation to sex is considered taboo	24.4	8.3	29.2	17.9	24.4	20.8	.000
Most people consider HIV talk to be offensive to their cultural values	23.8	7.1	31.5	12.5	19.6	18.9	.000
In this community, there are deliberate activities to promote condom use	27.4	50.0	16.7	30.4	36.3	32.1	.000
Within this community there is enough and suitable information on condoms	28.0	53.6	14.9	19.6	23.2	27.9	.000

In relation to condom promotion, Hoima shows a better climate than other study districts. For instance, over 50% of its survey respondents note presence of deliberate activities to promote condom use compared to 30% and below in the other districts. The response result is similar in relation to presence of suitable information on condoms at community level. Evidently some districts have a cultural climate that is more acceptable to HIV information, condom promotion and sex talk than other districts.

An attempt is made to analyse the influence of community perceptions on knowledge levels about HIV transmission and selected HIV prevention services. Only a few indicators as shown in the table below show observable differentials. However the statistically significant effect could be due to proportion of participants that answered “don’t know” to the statements presented to them.

Table 10: Community perceptions about HIV services and Knowledge levels

Knowledge item	Most community members show up at sessions for HIV (% N=840)			All N=840	Significance P value
	Agree	Disagree	Don't know		
Know At least 2 actions that reduce MTCT	49.0	47.4	36.1	48.1	.003
Correctly know SMC	80.8	76.8	55.6	78.8	.001
	Talking about HIV/AIDS especially in relation to sex is taboo (% N=840)				
Know At least 2 actions that reduce MTCT	44.6	50.8	29.1	48.1	.000
Know at least 3 correct steps on how to use condoms	44.0	48.9	16.4	45.7	.000
	Most people consider HIV talk offensive to their culture (% N=840)				
Know At least 2 actions that reduce MTCT	45.3	50.0	31.1	48.1	.007
	This community is interested in any new information about HIV (% N=840)				

Know at least 3 correct steps on how to use condoms	47.1	44.3	26.8	45.7	.004
In this community, there are deliberate activities for condom use (% N=840)					
Know at least 3 correct steps on how to use condoms	51.9	47.0	20.2	45.7	.000
Within this community there is enough information on condom (% N=840)					
Know at least 3 correct steps on how to use condoms	53.0	47.4	18.3	45.7	.000
People in this community do not like using condoms (% N=840)					
Correctly know SMC	82.3	85.9	67.4	78.8	.000

7.4 Community interest in HIV sensitization activities

While the quantitative data shows considerable community interest to learn about HIV, there is a general consensus among both community group discussants and key informants that a considerable number of people are less interested in obtaining HIV information, and therefore despite the little efforts in the community, some people are not bothered. It is noted that those that make the effort to make attend such sessions either don't take what is said seriously or are more interested in material gains than the information being passed. In the end, people have not learnt all the information about HIV. The trend is also attributed to the fact that people have over the years have come to think that HIV is no longer a big threat like before and a majority think they know a lot about the epidemic, which is may not be the case.

"People who have been sensitized but do not take the sensitizations seriously" FGD men and women (36-49years) Hoima

"People are no longer interested in sensitization campaigns, about HIV. When they are invited, they ask if there are sodas, if not they don't go" FGD Mothers (18-24years), Hoima

"All I can say is that we still have attitude issues, people imagine HIV information is only for positive people" Project coordinator NACWOLHA Hoima Branch

"People do not come as much because they are interested in material gains...these were refugees here who were used to handouts and money...when we organize health education talks their concentration is divided when payments at the end will be announced or not, this ultimately makes them fail to listen attentively hence missing what information is being given" KI-Manager Straight Talk Foundation, Adjumani

7.5 Gender issues, mainly low male participation

It is pointed out by respondents that the limited participation of men in most community activities is affecting knowledge on HIV at that level. Men are expected to be resilient and fight on. This affects their attendance to HIV services and consequently their knowledge of many aspects related to the epidemic. A number of discussants note that men constitute the majority of people that hold misconceptions related to HIV because they never want to go for testing, unlike the women. To succumb to external support would be to accept defeat. The situation is compared to community development programmes, where men take long to be involved. One of the discussants describes men as having 'complicated hearts'.

"...men always say HIV came to kill human beings not animals, so whatever we do, we have to die."... it is because they [men] rarely attend such campaigns against HIV unless they are sick" FGD male youth 18-28 years, Hoima

7.6 Ineffective communication channels at community level

The way HIV information is communicated in the community is pointed out as a factor for the low knowledge levels. Respondents report that information circulation channels used do not reach majority of the people at grass root and in the end few people turn up for sensitization sessions. The low turn up for such activities is also attributed to poor mobilization techniques. In addition, the use of print media by most actors is described as being ineffective as many people cannot read or even afford media like newspapers. Whereas radio is praised by many as the most effective way of communicating to a large audience of people, it has its disadvantages. Survey participants highlight that not all people can afford radio and the timing of the program needs to be taken into consideration, they also caution on the language as well as the issue of feedback and response. It should be noted that radios are mostly in the hands of the men and at times move with them. This directly affects women's use of the radio as a source of information.

"radios do not reach people because few people have radios .and those who have sometimes do not have dry cells or are not on radio all the time. So when they are called for sensitization meetings, there is low turn because some miss the radio announcements" KI-Head master, primary school, Hoima

"Many listen to FM radio programs especially if programs are in the evenings. The problem again is the airtime one needs to buy time to airing the talk shows on the part of sponsor and also on the part of the listener since they have to call in to seek clarifications. KI- Head teacher, Adjumani

"Some people do not have radios and some that have do not understand the language being used to disseminate information. Again to call back requires one to have airtime which most of us cannot afford" KI-Boda Boda riders association leaders- Adjumani

"Even the radio programs do not feature health education so much....There is also limited use of mobile cinemas about HIV yet this would attract big crowds" Clinical Officer Pekele HCIII, Adjumani

The study further reveals the lack of consistency in flow of information flow, due lack of proper programs to plan for information circulation in various parts of the communities. For instance respondents note that at times information comes in when it is least expected or a wrong hour or timing such as harvesting season. In such a case, people do not attend such meetings in big numbers.

7.7 Irregular community sensitization and low coverage with IEC initiatives

Low knowledge levels were also attributed to irregular sensitization and limited coverage. Group discussion participants noted that a lot of sensitization is carried out towards or on [World] AIDS day and a few conducted during the year. Discussants noted that when information is given, lot of time passes before another package of information is disseminated, memory lapse likely to be.

Related to above, it was revealed that there is a gap in sensitizing the community in terms of geographical coverage. Participants noted that there are people in rural areas where health workers cannot reach to disseminate HIV information, and therefore such people don't get the chance to learn more about the disease.

7.8 Weak partnerships and low community capacities

Glaring low comprehensive HIV knowledge levels are also attributed to poor coordination, limited capacity and lack of commitments from different stakeholders at the community level. Whereas the

government officials complain of poor integration of HIV/AIDs activated at lower local government, CSO representatives report lack of will by some of the local government officials. They report that these never want to take part in activities unless they expect material or financial gain.

“There is a tendency to think HIV is a problem under Health. Other directorates are less involved especially at the sub county level such as sub county extension workers could be brought on board hence should be empowered to give information whenever they interact with the community” KI CDO, Adjumani

“There is no will dedicated to fight HIV because sometimes stakeholders do not attend important meetings in planning for HIV activities, you will only see the mayor all the time but no counselors” KI- Project coordinator NACWOLHA Hoima Branch

“I think one of the reasons is that some leaders mind-less information dissemination/sharing...key people who are targeted for information during seminars do not roll out the information. Currently people refuse voluntary services hence community talks on HIV sensitization do not attract many people because they expect some form of direct material benefit like money or sodas” KI with Reverend-CoU, Adjumani

In addition, whereas there may be commitment to use local structures and resources to increase awareness, the capacity at such level has not allowed doing so. CSO key informants highlight the lack of people in the community who would help to pass on information to fellow people in their areas. It is further reported that elders and community leaders who should give information are not knowledgeable themselves and tend to give half-baked information, yet majority of people are shy on giving sex related information. This has rendered peer to peer education at community level limited yet it would be an important opportunity for sharing information.

CHAPTER EIGHT: INFLUENCE OF SERVICE -RELATED FACTORS ON KNOWLEDGE OF HIV

Key Findings

- Health education has suffered considerably and is less prioritized as a service, in addition to conflicting messages relayed by some of the stakeholders and the moralization of the epidemic
- There are challenges related to weak coordination, limited capacity and lack of commitment from different stakeholders charged with HIV service provision. While district staff complain of poor integration of HIV activities at lower levels, CSOs complain of lack of will by civil servants unless an activity offers material or financial gain.
- Service centres for HIV information and care are often distant; scope of service is limited mostly to HCT. Few VHTs are active. Community awareness campaigns are quite rare.
- Due to funding challenges, a number of key CSOs in the study districts had wound up implementation of activities due to CSF project closure. Most external funding for district health programs in general and HIV in particular is limited to static health services and delivery of HIV information as an integrated service.
- Through logistic regression, compared to those who have no access to information, respondents who learnt about HIV from radio and health workers are 6.7 and 5.5 more times respectively, likely to have comprehensive knowledge.

8.0 Introduction

This chapter presents the findings and analysis of the service provision-related factors which account for the levels of correct knowledge and misconceptions about HIV. Both qualitative and quantitative data are presented in a triangulated fashion.

8.1 Availability of HIV prevention services

Across the study districts, the district health department together with other HIV/AIDS service organizations (includes local national and international NGOs) are reported to be at the centre of providing HIV prevention information and services playing complementary roles of the district health department. Their services include: ART, PMTCT, radio talk shows for health education on transmission and prevention, safe male circumcision supply and distribution of condoms, HCT and Routine Testing and Counseling treatment and care, support and prevention of HIV among the population in general and special population groups such as children and pregnant mothers. Prominent among the organizations in question are: PREFEA, Baylor College, Straight Talk Foundation, Mulango-Mbarara Joint AIDS Program (MJAP), The AIDS Support Organization (TASO), Walter Reed project, SPEAR World Vision, Action for Research and Development (ACORD), Kyetume Community Based Organization and NACWOLA Hoima branch.

8.1.1 Distance to service points for HIV prevention and care

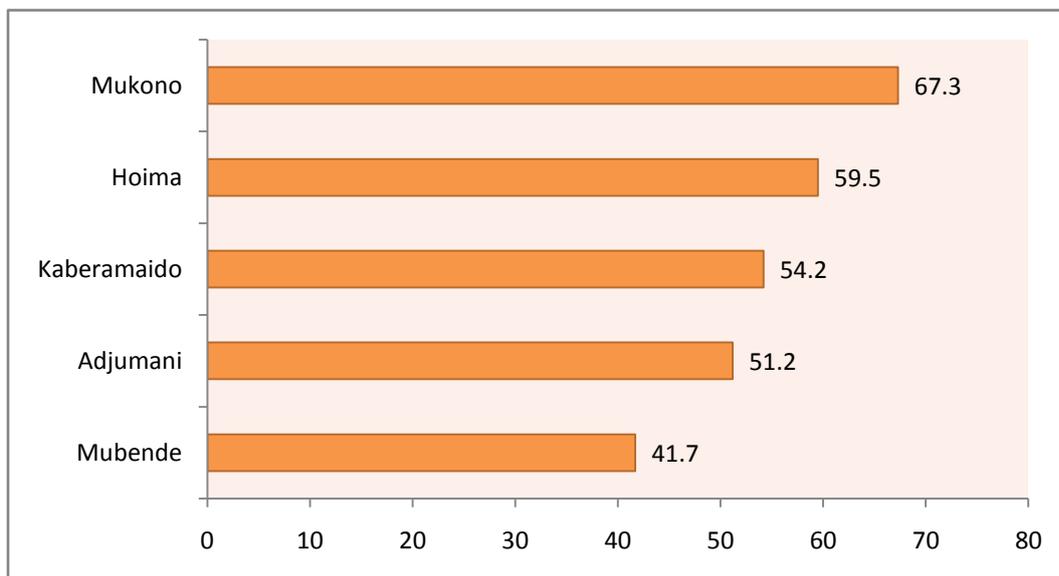
It is reported that HIV service centres are often far away from many people who would be coming for HIV services/programs. In some districts there are hard to reach areas like lake shores because of long distance and bad roads.

“Distance from villages like this one to the health centre is 4kms so even a person will not waste time to travel all that long to get the services like sensitization/education on HIV prevention and transmission” (Local Government official Anyara Sub-county, Amid Parish Kaberameido district)

From the survey, about half (45.2%) of the respondents have a place within their parish/ward where one can access HIV/AIDS related services. Evident is the need for more effort to take HIV related services closer to the people, expressed by 54.8% across all districts.

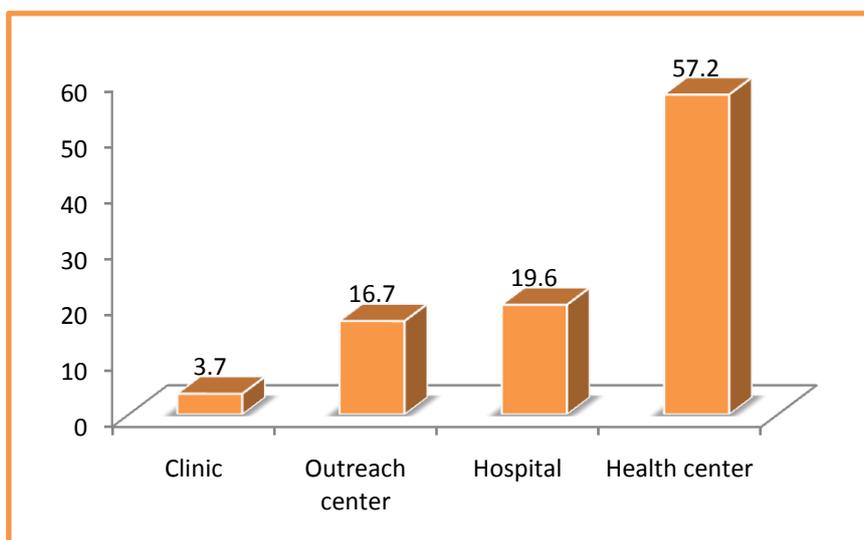
In terms of district differentials in availability of a place within a parish that provides HIV related services, Mukono scores better than the rest of the survey districts with 67% participants noting that they have such a place. Mukono is closely followed by Hoima, Kaberamaido and Adjumani. Mubende scores least.

Figure 16: District differences in availability of HIV services



Overall, whereas 38% of respondents note that condoms are among the services available at HIV service provider points in their parishes, only 27.6% have a place within 2km where they can get free condoms. Over 70% have no access to free condoms. On the brighter side, 92.7% report having a place within 2km where they can buy a condom if they need one. Naturally those who cannot afford to buy condoms have challenges of access, given the poor availability of free condoms. This indeed partly explains why slightly over 30% report having problems getting condoms.

Figure 17: HIV Service provider



Majority (57%) of respondents identify HIV service provider as being a health center, while about 20% mention a hospital or an outreach center. A very small proportion (4%) mention a clinic as the HIV service provider in their community. This denotes that government health facilities are the major providers or center points of

HIV related services in most parts of the country.

7.1.2 Shrinking numbers of HIV service programs

CSOs and donor agencies have been instrumental in the fight against HIV in Uganda and the developing world in general. They have either provided the required resources for implementation or have been involved in direct implementation. However following the world economic meltdown, there is a growing decline in donor funding for development work. The study reveals that a number of important CSOs in the study districts have pulled out/closed shop thus negatively impacting on health programs they have been supporting. According the department of health staff of the study districts and rightly so, these organisations were key players in the provision of information, HCT services, drugs, food support and condom distribution.

In Adjumani for instance PREFA, and other active CBOs such as Madhi Community HIV/ AIDS Initiative (MACI) are reported to have wound up their program support since the end of September (2012). It is Baylor and Straight Talk foundation which are still actively providing HIV/AIDs related services highlighted by health education. In Kaberamaido, Uganda Red Cross Society which is reported to have been at the vanguard of HIV/AIDS programs has gone slow due to funding concerns. In Mukono, similar concerns about declining funding for CSO and CBO activities are also raised as intimated in one of the respondents' voices.

"people are always overwhelmed with whatever they are supposed to do. Resources have been too low because Kyetume is not give adequate resources to address all these areas much as you apply they will not give you, they would say this is what we have, in the district, we used get money for HIV prevention but its no long there, the money which is given on PHC it is very little compared to the community we need to go to you get that?" (KII Kyetume CBO Mukono District)

A CBO official in Mukono lamented about the dwindling numbers of HIV/AIDS fighting organisations and funding for HIV prevention and control as summarised below:

"But what I can say is that some partners had to leave before the battle is won, they say now we have worked with you for 7 years but now we have to go and change because our program area is no longer in your area of operation so you need to swing so fast to another partner which is always a problem and competition is so stiff" (KII Kyetume CBO Mukono District)

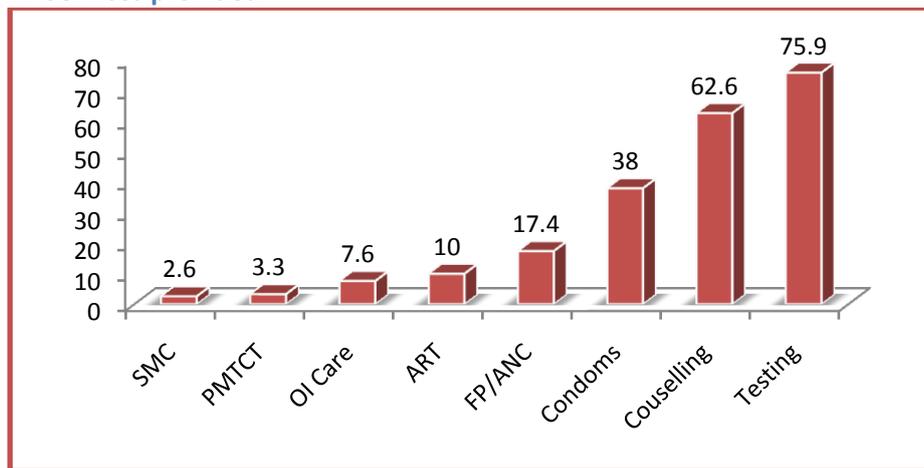
".... the intervention did not last for long only about 3-4 months and it suddenly stopped but that was long ago and these strategies used to be done through radio's programmes in Kumam, Ateso, Langi. Here also through churches, health centres like Kobulu HCIII and during market days where people are many" (VHT member Omoro Village Okile Parish, Kaberamaido district)

"NGOs which are involved in HIV services operate on contracts of 3 years or 5 and upon expiry of their contract period, sustainability of their activities is missing. For example we have an NGO here called AVSI, it had a system of follow ups on clients with good adherence packages but after it phased out nothing was done to follow up these clients, some clients health have since deteriorated. If I can tell you the counseling which I got when I was starting treatment in 2004, it has really moved me well

WHO trained used to train 20 expert clients on HIV counseling to reach out to other PHAs which was a good idea but has since stopped. This is the kind of training I would recommend for our counselors “(KII NACWOLA Hoima Branch)

From the findings, HIV testing and counselling constitutes the most common HIV service offered by service providers (mentioned by 76% and 63% respectively). These are followed by condom promotion/distribution mentioned by nearly 40%. Family planning and antenatal care are the other HIV services, reported by a significant proportion (17%) of community people. ART services and OI care being offered by service providers were mentioned by only 10%, while the least mentioned HIV services available are SMC and STI management.

Figure 18: HIV Services provided



7.1.3 Limited outreach and mobile HIV prevention and other services

With most external funding for district health programs in general and HIV in particular, health facilities have resorted to largely providing health services at static sites. This is attributed to logistical constraints associated with doing outreach HIV services provision such as HCT and health education. In Adjumani for instance, MJAP project before ending its programs in September 2011 was mainly into HIV prevention- and supported HCT outreaches especially in HCIII settings and held meetings with HIV/AIDS committees at various levels during which technical officers who monitor HIV services in health facilities would be equipped with knowledge and skills for providing services and then give feedback and way forward. Thus with these opportunities gone, the coverage of HIV services in the affected districts remains minimal.

“There is also advocacy for faithfulness and abstinence by the church and other NGOs. Of recent a session on HCT was conducted at church by SURE people in Kyamigango village many miles from here where people cannot easily walk to health centres and the turn up was good. If such services are close to them there would be a difference (KII Headteacher, Busanga Ps village Buraru sub county Hoima district)

No doubt, there are likely to be service gaps in the districts where such HIV support programs cease to run. In Adjumani for instance Straight Talk Foundation is credited for the great work in HIV /AIDS transmission and prevention awareness talks especially targeting youth groups and individuals and providing HCT services through health facilities and distribution of literature on HIV and reproductive health issues

Local organisations such as CBOs and other community level structures like PLHIV themselves are equally constrained and only survived through donor/external support for their HIV awareness program activities. In Adjumani for instance MACI was one of the local organizations which pioneered HIV services provision in the district to provide HIV services especially counseling and testing and also people living with HIV groups, providing home care and drama groups. However, by the time of this study MACI was reported to be less active due to limited funding from European Union.

7.1.4 Lack of supplies and sundries at service delivery points

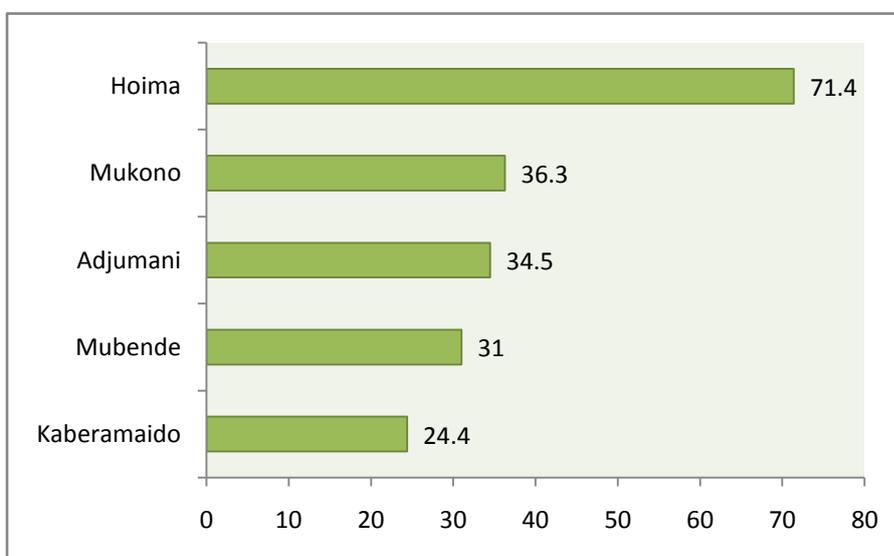
Access factors are also raised as affecting low knowledge levels. It should be noted that HIV/AIDS factual information is a sub set of HIV service package expected by clients who come. However, this study reveals that most health facilities do not provide the expected due to lack of such supplies as testing Kits, ARVs, condoms, food supplements. This results in disappointments and subsequent shunning of HIV/AIDS sensitization drives.

“...In addition to what others have said, am a community counselor but I spend two weeks without condoms for distribution yet people are demanding for them, if am to get them very fast I have to put in my own money to go and pick them from Hoima. So for the time I have no condoms people are not stopping getting involved in sex” (FGD with Males and Females, Kitoba sub-county, Hoima district)

“Now you find those who are already infected, and when they come for training and they are not provided with medicine or material things, they look at it as a wastage of time. So, normally, some of them don’t turn up that negative attitude could also be another issue as to why”. (KII with Sec School head teacher Adjumani district)

Quantitative data also shows glaring gaps in supplies of essential items including condoms affecting availability. Of the 5 survey districts only Hoima scores well on availability of free condoms with a distance of 2km.

Figure 19: District differences in availability of free condoms



Over 70% of respondents in Hoima report having access to free condoms with in 2km compared to Mukono, Adjumani, and Mubende that follow with 30-36% of participants residing in these districts reporting access. Kaberamaido scores the least with only 24% of its survey participants noting to

have a place where they can get to free condoms within 2km.

In relation to availability of condoms to buy within two kilometers, Mukono scores highest with over 90% of its participants noting to have such access.

Figure 20: District differences in availability of condoms to buy

Hoima follows with nearly a similar big proportion (83%) of participants with good access to condoms selling points with 2km. Mubende also has a relatively big proportion of participants with access to condom selling points. Adjumani scores least, followed by Kaberamaido.

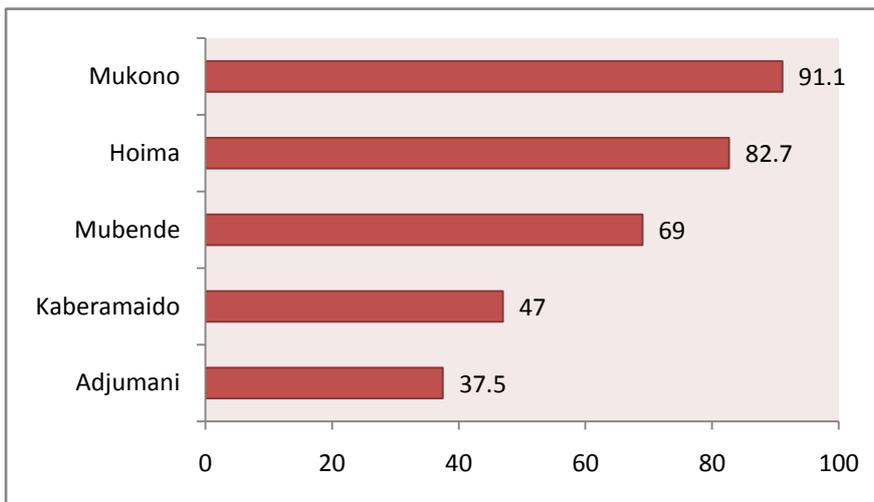


Figure 21: Problems when obtaining condoms

Asked to reveal exactly the challenges they face in obtaining condoms, cost affordability is expressed by about a quarter of respondents. Others point merely to fear to buy condoms and a litany of other personal and social challenges.

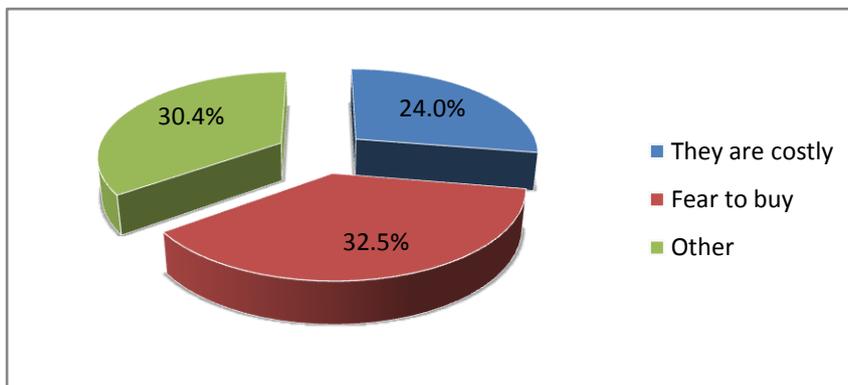
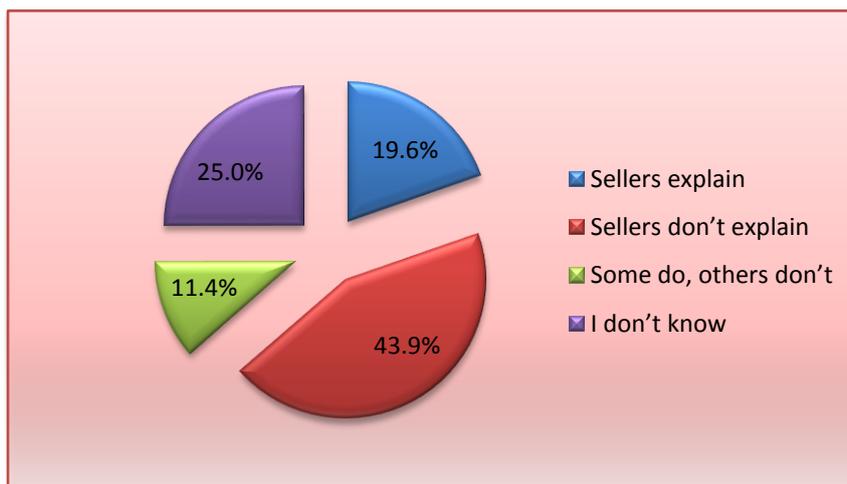


Figure 22: Quality of condom distribution services

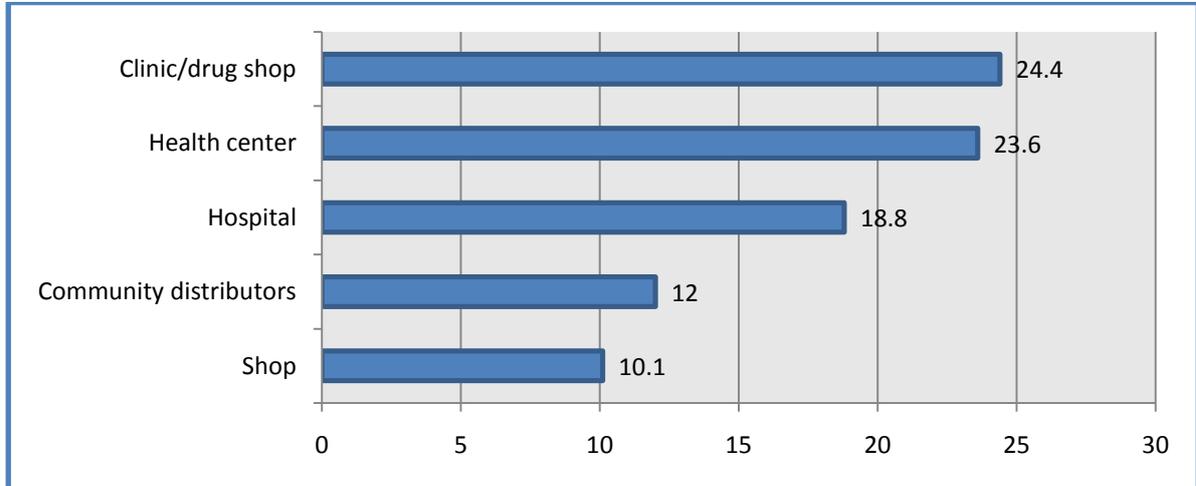
To further underpin the fact that condom promotion is generally poor, over 40% of the participants reported that sellers of condoms never explain to them how to correctly use the condom. Only 20% noted that condom sellers actually explain to them how to



correctly use the condom.

Most people prefer clinics or drug shops and health centers as their source of condoms. Fewer prefer the hospital, community distributor and general mechanize shops. Spouses and friends are the least preferred sources of condoms (1%).

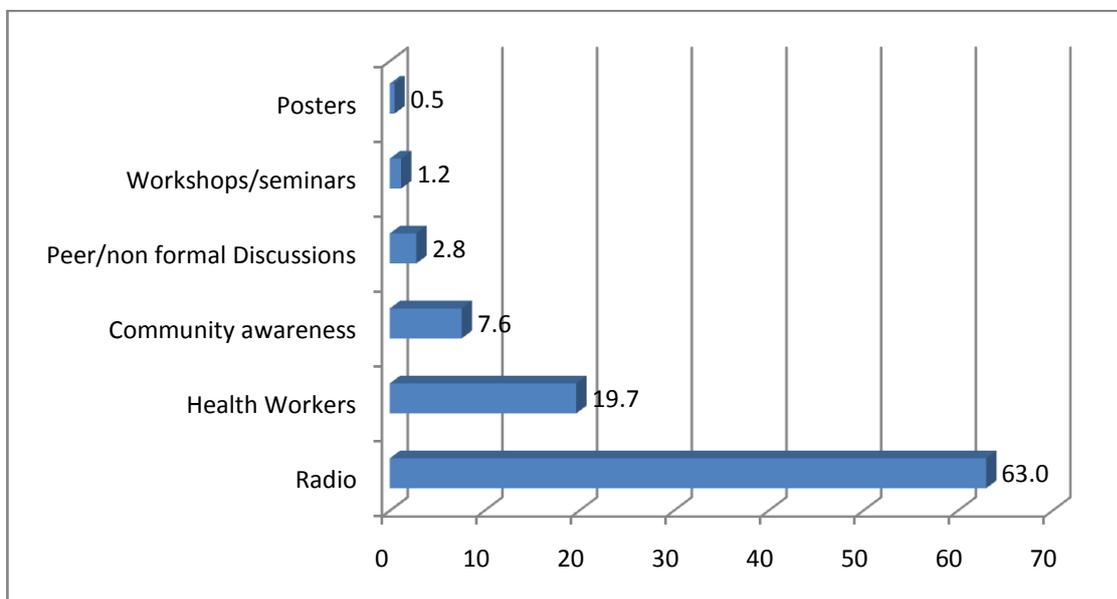
Figure 23: Preferred source of condoms



7.1.5 Narrow range of effective channels for dissemination of HIV information

This study acknowledges the role of HIV/AIDS service providers in the study districts especially regarding HIV/AIDS knowledge dissemination and awareness creation spearheaded by the district health department and partner agencies at all levels. This notwithstanding this study reveals that there are still populations not fully knowledgeable about certain aspects relating to HIV transmission and prevention.

Figure 24: Source Learned from most

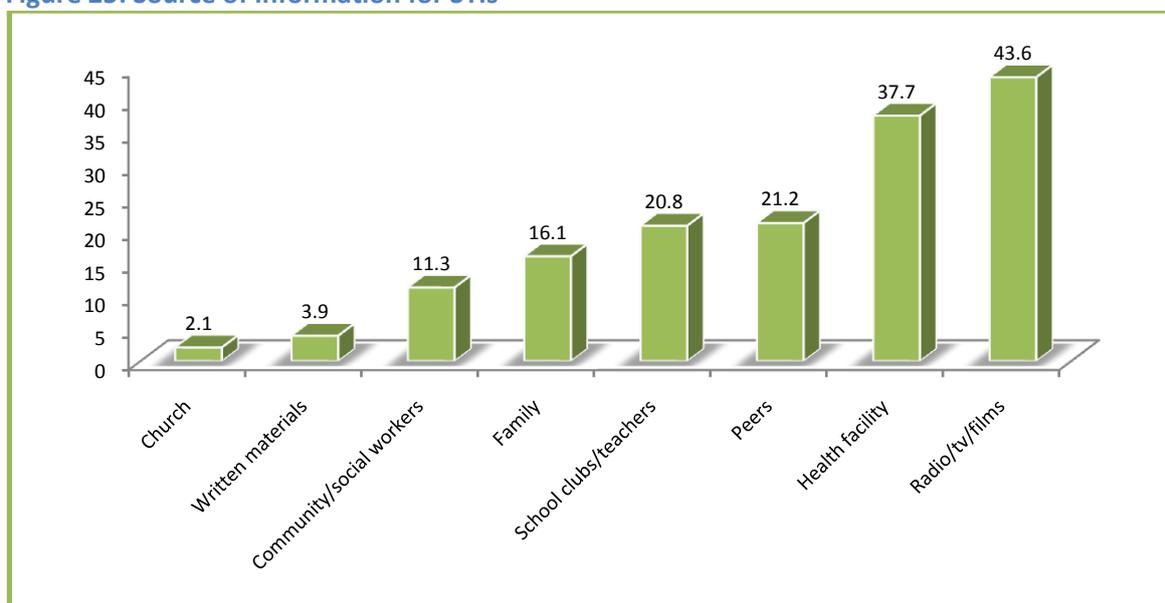


Overall, about half of study participants (51.4%) had accessed some form of HIV information the last 3 months before the study. Radio by far is the source learned from most (63%), followed by health workers noted by 20%, largely at point of service. Community awareness campaigns are quite rarely mentioned (8%). Very few participants identify workshops, seminars and posters as their source of HIV information learned from most.

In terms of sufficiency of HIV information received, nearly 70% of the survey participants that have received such information report that the kind of information received is sufficient to address their learning needs/concerns about HIV. Three in every ten people who attended to HIV related IEC during the last 3 months preceding the survey remains dissatisfied with the information received is also important. This partly explains the glaring gaps in levels of comprehensive knowledge about HIV transmission, prevention and rejection of misconceptions.

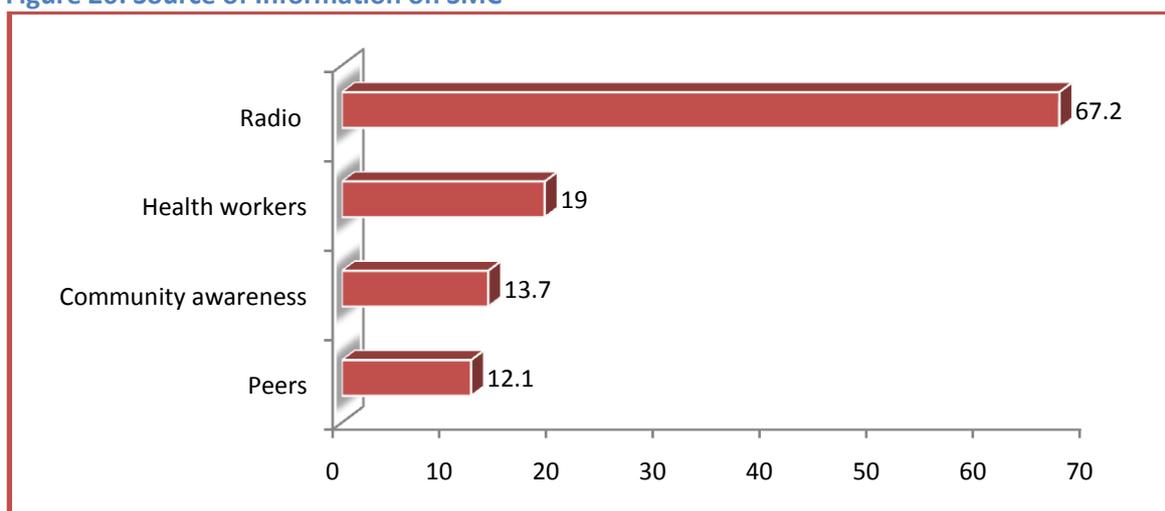
Data was also collected on sources of specific HIV services. For knowledge on STIs, radio and TV are the most mentioned (44%) sources of information for STIs. These are followed closely by health facility that is mentioned by 38% of the participants as source of STI information. Peers, school clubs and teachers follows being mentioned by 20%. The internet, Church and written materials were the least mentioned sources of STI information.

Figure 25: Source of information for STIs



In relation to information on SMC, still radio is identified most as the source of information and learning about SMC, followed by health workers, community awareness and peers in descending order. Workshops and posters are least identified as source of information on SMC.

Figure 26: Source of Information on SMC



To undertake a deeper analysis, the study examines the factors explaining information gaps based on analysis of district level key informant interviews and community based focus group discussions with various population categories and age groups. Some of the emerging issues are presented as follows;

7.1.6 Priority shifts in HIV/AIDS service planning and resource allocations

Little attention to health education compared to curative services was mentioned as one of the factors accounting for the low knowledge levels about HIV. It was noted that rather than spending a good amount of time providing health education at the health centres or out reach points, the health workers instead mind more about how many patients in the line they have been able to attend to either giving HCT/VCT or ARVs. It was explained this scenario is a result of the donor's interests or national priorities which local governments must comply with.

"... in the beginning we used to emphasize prevention as the cardinal principle in the fight against HIV but in the end as we have continued to cope with HIV we are seeing the treatment for HIV infected people is given more priority than prevention.....personally when we were still doing preventing, eeh very vigorously.... there was a time when we used to go schools and communities during that time we could have regular time periods used to engage the young people in schools with video shows and counseling sessions.... This schedule now is no longer there because all the money that is given to HIV at the moment goes to care and support treatment administering ART and trying to support people to adhere to the treatment of ART and possibly the T.B, so what is why we see that prevention as far as it is concerned is little bit and I can say that is marginalized". (KII Kyetume Community Based Organization Mukono district)

7.1.7 Questions about the competence of HIV information providers

With diverse sources of information at the disposal of the population, there is a potential risk of getting information from less informed sources. Consequently those who receive the messages get 'a mixed bag' containing truths and untruths about HIV/AIDS.

Across the study districts for instance it was found that religious leaders are involved to some extent in HIV/AIDS information dissemination. They take off some minutes when they are giving sermons to talk about some aspects of HIV/AIDS. Spending some minutes means a lot of information is left out either deliberately or because they are morally constrained to discuss such topics as condoms and

condom use procedures or they are technically incompetent to talk about such complex and sensitive topics.

“As church we organize youth and married couple conferences separately and during those conferences one the topics/ themes of discussion is health including HIV/AIDS. In particular during the conferences and church teachings we counsel the flock on dangers of unfaithful sexual behaviors and sex outside marriage. We also organize youth camps-where youths gather like for one week and HIV becomes of one of the topics” (Religious leader Adjumani district)

“.....we receive teachings from our churches also does not allow us to use condoms yet health wise we need to use it. Others say we should produce and fill the world”. (FGD with Males 18-24, Omor Village Kaberamaido district)

“..... little sensitization is also a root cause because there are very few people who are trained and even those few are not doing what they are expected of. This leaves the knowledge levels still very low. (KII Local Government official Anyara Sub-county, Amid Parish Kaberameido district)

From the preceding voices of it is evident that HIV/AIDS related information given is limited in terms of depth and topics covered. Therefore for some body whose main source of information about HIV/AIDS is the worship place, his or her knowledge about the disease may leave a lot to be desired.

7.1.8 Health staffing and motivation issues

Closely linked to the foregoing finding, health service providers who are often in-adequate do not get facilitation for doing HIV outreach work. Yet it is on such occasions that VCT and health education are provided to far off communities. Consequently, there is limited geographical reach of health education programs due to low staffing and logistical constraints The implication is that quite a number of the population especially children who have graduated into adulthood remain in darkness or get half baked knowledge on the disease.

“Of course the shortage of health staff is number one factor because health centres receive too many patients and a result they do not have adequate time not only for health education, counseling but also for follow ups” (Key Informant DHOs office Adjumani district)

“Well I don’t have much on the weakness but the most one I can say is limitation on the work force, providers are few and they are even under paid. Sometimes they don’t bother because after all they are not earning much, that’s why you find that if you are sent from Kampala to come and sensitize these people in Mukono you may decide to stop in town or just move in the 4 km radius outside the town than going to kisenyi or as far as Katosi or Ssii because the roads are poor and it’s too far thus the same that is happening”. (KII Sec school Head teacher Mukono district)

7.1.9 Health provider complacency

In view of the fact HIV/AIDS has been in Uganda for about three decades, there has been a lot of awareness activities to the extent that health providers tend to relax in the false belief that everyone knows about the disease fully. This over assumption was evident during interviews with some health workers who seemed to doubt the LQAS study results indicating low HIV knowledge levels in their districts. This shows that some health workers and planners believe everyone knows about HIV/AIDS.

“Awareness generally about HIV/AIDS is high because at least all people in the district have been reached with strong messages on how they can contract HIV/AIDS and how to avoid getting the virus. However, the decision to implement some of the things is personal. For instance, as a district, we can only provide condoms and make them available in health facilities but the discussion to use a condom is personal. One can have a condom in his pocket and decide not to use it” (KII HIV Focal Person Mubende District).

As result there is a tendency to prioritize curative services as opposed to HIV prevention awareness programs in their district plans and resource allocations.

“.....previously we used to reach out reach school with information, education and community kind of skills but now we just do HCT and that HCT we just go to communities where we can meet our clients to treat ...To conduct HCT and we end there” (KII Kyetume Community based organisation Mukono district).

“The district priorities are mainly in condoms promotions, education and sensitization programs but still its impact is very low because it is on a limited scale and the challenges are that the district gets small stock of condoms, limited funding for HIV/AIDS prevention programmes and even very skilled personnel to deal with the HIV/AIDS” (KII Local Council Leader Kaberamaido district).

Consequently the population with full knowledge about HIV/AIDS remains limited

“Again there is not enough mass communication education/sensitization on the ways of HIV prevention and transmission because the knowledge and information the local communities know is little” (VHT member Omoro village, Kaberamaido district).

7.2 Content of HIV prevention IEC messages

7.2.1 Moral values compromise depth of HIV information given

It was noted that there are different providers of HIV information including individuals as popular community leaders or heads of social institutions such as churches. However, due to their personal values as for the case of parents they sieve the information they give to their audiences thus giving incomplete HIV/AIDS information packages. Religious leaders were also cited as an example of those institutions which give/ handle selected topics and leave out others when teaching about HIV/AIDS/AIDS

“Religion, for example Catholics and born again Christians do not believe in condom use. So this has also affected the condom use as a way of HIV/AIDS prevention. Even they go ahead to preach that God wants you to believe in him that the disease will not get/harm you”. (Local Government official Anyara Sub-county, Amid Parish Kaberameido district)

7.2.2 Inconsistent and conflicting messages about HIV/AIDS

Interviews with health workers (professionals) and other community health educators revealed that some HIV/AIDS information providers give information that sometimes contradicts earlier messages about the topic. This may happen out of necessity considering that HIV is dynamic and therefore updates on the disease are critical. However, when health workers are not refreshed based on emerging knowledge aspects about the disease, they may end up misleading or confusing the public. Examples of messages in question cited include safe male circumcision and option B for PMCT. A review of the focus group discussions across the study districts for instance revealed there are divided views about the significance of safe male circumcision in HIV prevention.

The foregoing concerns are supported by the lingering beliefs about HIV as articulated by one of the key informants as outlined in the quote below:

People believe that if one is sick and is on drugs then he can always sleep with a positive person without condoms, without knowing there is re-infection..Some people believe that taking septrin cures HIV..On safe male circumcision, most youth still think you are free from being infected...Others say if safe male circumcision prevents HIV why do Muslims get infected?(KII NACWOLA Hoima district)

7.2.3 Limited Initiation of New and Refresher Sensitization programs

Due to the fact that the target age groups for HIV information are successive in nature it was observed it is important to keep refreshing those who already have received the information and targeting the successor age groups so as to keep the candle burning. Children for instance who grow into adults should be targeted and this can be achieved if there are scheduled sensitization drives otherwise there is a risk of having a generation people information vacuum about the disease considering how dynamic and mutative the HIV virus is.

“People tend to grow and they out-grow the information, you get that? So information need to grow with them. I don’t know whether this is well taken. People need to grow with information – information has to change with a change of time, you get that? That one is not well monitored countrywide. In addition, in schools we used to get and create some family like clubs and give them information regarding the prevention of HIV/AIDS but those clubs when you go back like after two years those clubs and those students have changed, some have grown, others have come” (KII Kyetume CBO Mukono district)

Some added there are no programmes of follow-up to try to find out if the people are learning from what they are taught.

7.3 Modes of delivery used in IEC/BCC campaigns

7.3.1 Overall assessment of service delivery modes

This study further examined the approaches used in disseminating HIV/AIDS related information in a bid to identify the factors for the low knowledge levels among the population. A review of the Key informant interviews revealed no major variations in terms of the approaches used across the districts to reach the population with HIV/AIDS related information. Together with development partners the DHOs office coordinates the trainings provided, sensitization through community and Radio Talk Shows, community dialogues where people gather and discuss HIV related issues. These approaches are tellingly captured in one of the responses during interviews with one official from the health department of one of the study districts: Asked why, with all the HIV/AIDS control and prevention programs, there is still lack of complete knowledge among the people in respect to how HIV is spread, prevention and proper condom use procedures, one key informant revealed;

“This is hard to explain because there have been talk shows organized by different organisations in the communities and on the radio .In schools-PIASCY project is all over, evident in existence of “Taking compounds”. There are IEC materials in Health centres except many of them are in English. There are always health education sessions in health centres though not regular. Also during antenatal clinics, there are health education sessions. PHA groups such as Pekele Women association, PAWA disseminate information through home-visiting and drama shows and also provide advice-referral advice for further management” (KII Health Department Adjumani district)

While the above is given as a sample of the approaches used, the voice of respondent reveals some inherent weaknesses in some of the approaches such as irregular health education sessions, language barrier in view of the language in which the printed IEC materials are written and a lot other weaknesses as will be discussed in subsequent sections.

7.3.2 Radio as a channel in HIV/AIDS information dissemination

It was noted, one of the common channels used for reaching people with information is through radio programs. However, it was also observed that not every one is accessible to radio. Besides, when the programs are being aired everybody and those accessible may not get full information because they lack the money in form of air time to call back and get clarifications on the topics being discussed/presented.

“The media used to reach is also worth examining because very few people have access to print media in the sense that they do not reads or they cannot afford the cost of the newspapers. However many listen to FM radio programs especially if programs are in the evenings. The problem again is the airtime one needs to buy time to airing the talk shows one the part of sponsor and also on the part of the listener since they have to call in to seek clarifications” (Key informant Interview Head Teacher secondary school Adjumani district)

“... to information circulation channels do not reach grassroot people for example radios do not reach people because few people have radios .and those who have sometimes do not have dry cells or are not on radio all the time. So when they are called for sensitization meetings, there is low turn because some miss the radio announcements”. (KII Head teacher, Busanga Ps village Buraru sub county Hoima district)

“All ... it’s a radio,,,, P4, yes, we can say it’s a radio, but what I want to add on is that a radio is common source because it reaches many people but in terms of effectiveness, health centres are better because the health workers explain to you and you ask questions”(FGD Male Youths, Bugahya county Kitoba Sub-county Hoima)

Discussions with men and women combined echoed similar feeling about the radio as a channel through HIV/AIDS information is disseminated.

“Look at the HIV radio adverts which take place on 3 to 5 minutes, whereas the advert may reach out to many people, in the next 5 minutes, the people will have forgotten about the message, but with Drama shows, they may be watched by few people but the message sinks into people’s minds” (FGD Men 36-54 and Women 36-49b years, Bugahya county, Kitoba sub county, Hoima)

“The methods of giving information, these programmes are mostly get from radios and health centres. Some people do not listen to radios, others do not go to health centres due to distance so they end up missing this opportunity of having better understanding on HIV/AIDS prevention and transmission”. (Local Government official Anyara Sub county, Amid Parish Kaberameido district)

7.3.3 Use of change agents in HIV/AIDS information dissemination

The effectiveness of using change agents to relay HIV/AIDS messages also generated considerable discussion during the interviews. It was noted that some organisations train locally recrute people such as PHAs, local leaders including religious leaders. These people are in turn entrusted with dissemination of HIV information to people within their reach or they are serving in way or other. However, it was argued that some of these people end up targeting certain population categories and leaving out others. If it is women they tend to target or talk to fellow women leaving men and

youths. Thus comprehensive coverage of the population is not realized yet resources allocated to the activity may have been meant for everybody to be reached.

“That one, I think they had fairly little money, which would run their programs for a short period of time and even the staffs they had was a small one but skilled and very social and approachable, which made the local to trust and love them and I remember only had a training with them once at Kobulubulu but I did not get enough information on HIV/prevention and transmission because sometime some members of the community ask me some questions on HIV but I cannot answer them because I have little education and information about HIV” (VHT member Omor Village, Kaberamaido district).

“Again sometime this services are limited in coverage size for here it use to be at Ogeria trading centre only and other areas no, also fewer staffs, with limited funds to run large scale initiative and they only targeted youth and women leaving aside men and the old age in the rural communities and these centres that they established are far reach areas for some communities (VHT member Omor Village Kaberamaido district).

To the children some parents and care givers shy away from giving them timely information about HIV (KII Head teacher, Busanga Ps village Buraru sub county Hoima district).

7.3.4 Sensitization through home visits and community meetings

Home to home sensitization and follow-ups was mentioned as one of the modes used in reaching people with HIV and services. However, this, it was argued, requires a lot of time which most health providers let alone persons living with HIV (PLHIV) often do not have. When resources permit, the general feeling seems to be that health providers should undertake adequate mobilization by using public media announcements and then make home visits on particular schedule.

The use of community sensitization meetings is arguably a good opportunity for dissemination of HIV information especially in rural settings. However, some people such as motor cycle transporters felt concerned they are usually not mobilized early enough to attend and, consequently some end up missing the sessions. Others simply do not attend unless assured of monetary compensation for their “lost time”.

“Sensitization of the local people is a till very low, sensitizations on radios, churches are not enough, people are very rigid to change, so to change them they have to be told or sensitized very many times and with emphasis.” (FGD Men and Women, Kitoba village, Hoima)

“Some service providers are not committed to what they are doing for instance some are interested in meeting donors expectations not the impact on the community for example in 2008, we received Africa youth ministries which carried out routine counseling and testing of people, health and games and sports to teach about HIV, Some people who were tested were positive, after that the project ended without referrals no help to those who were found positive, no measures were put in place to sustain their activities and with time people have lost information they got then” (KII Head teacher, Busanga Ps village Buraru sub county Hoima district)

7.3.5 Regularity of health education and depth of information

The issue of non-regular health education and less comprehensive information given was also raised. It was explained that at health facilities health education including HIV knowledge issues is not provided on a daily basis and that when they do it is usually for a short time thus leaving the audience confused or with incomplete knowledge about the disease.

“.....what I can tell you is that, we have heard much about HIV in different forums. We have sensitized people on radios, in their communities and in other gatherings about HIV/AIDS and

I think majority of them are aware about the major ways through which HIV/AIDS can be transmitted from one person to another. Probably the challenge has been the repetitive nature of the same messages on HIV/AIDS for a very long time. I think increasingly, people have become used to the messages and are no longer finding sense in them. Even me I feel I am challenged” (KII HIV Focal Person Mubende district).

In Adjumani for instance, one of the key informants reasoned that the limited schedule, time and depth of information may also explain why proper condom use procedures which require elaborate explanations are rarely given.

“People are taught on HIV/AIDS only at the health centres and then the whole sub county has got only three (3) facilitators who teach people on HIV/AIDS in the parishes. There is no consistency because we receive sensitization programmes irregularly without even prior knowledge” (KII, Women Group Leader Kaberamaido district).

“There is also lack of consistency in information flow, because we do not have proper programs to plan for information circulation in various parts of the country, information comes in at a time it is least expected or a wrong hour or timing like harvesting, people will not attend such a meeting in big numbers”(KII Head Teacher Busanga P/S Hoima district).

“We also have education and behavior change activities such as health education which includes consistent use of condoms, HIV positive living campaigns. However such approaches are low in schools because schools say they have PIASCY, Out of school youth are reached through group discussions but these are limited to specific small numbers due to resource constraints, their sessions are also limited to specific hours like a half day session yet if I have to facilitate to such a group I would need a full day to impart comprehensive knowledge to such a group” (KII NACWOLA Hoima Branch).

7.4 Other Service related factors influencing knowledge levels

The issues outlined hereunder are some of the suggestions (in their direct form) and concerns shared as affecting/explaining the low knowledge levels about HIV and what could be done to step it up;-

- Limited time allocation to HIV health education talks by both health workers at health facilities and CSOs into HIV/AIDS control and prevention.
- Unplanned activities such as trainings and workshops that affect staff availability
- Social problems such failure to attend/come to work because a health worker has lost a relative and is gone for burial or a relative or child is sick
- Conflicting time demands and proper timing for HIV education programs especially for certain population groups as fisher-folks
- Conflicting community meetings for instance political rallies and health education sessions suggesting low coordination
- Language and ethnic diversity which compromises communication effectiveness during health education activities as was the case in Mukono
- Limited availability of print media materials for literate especially the youths to read as the Straight Talk materials make sense
- People do not have capacity to reach source of information because of remoteness, and poverty, they do not have radios, even those with radios sometimes fail to get money to buy cells.
- Many HIV/AIDS facilities have to be opened and fully stock with all information on HIV/AIDS in Ecede parish.

- There is need for proper records of all community members in terms of age gender categories so that any intervention take into account how many people are being targeted and how many are being reached by the intervention.
- In terms of coverage all HIV services target everyone in reproductive age but the problem is in terms of hard to reach areas

7.5 Measuring the influence of service related factors on knowledge levels

7.5.1 Access to HIV related services and its influence on HIV knowledge levels

Availability of a place offering HIV related services has an effect on knowledge levels. More participants that have a place within their parish where they can access HIV related services have higher HIV prevention knowledge than those that lack such a place. More participants of the group that has access know at least 3 correct steps to get HIV test, at least 2 actions to reduce MTCT and correctly identify at least 2 common STIs compared to the proportion that has no access. This difference has a statistically significant influence on knowledge levels ($p < 0.05$).

Table 11: Availability of HIV services and its influence on knowledge levels

Knowledge item	Place in this parish/ward where you can access HIV/AIDS related services (%)		All N=840	Significance P value
	Yes (N=460)	No (N=380)		
Mentioned at least 1 correct and reject at least 2 misconceptions	30.9	32.4	31.5	.655
Know at least 3 correct steps to get HIV test	54.3	43.7	49.5	.007
At least 2 actions that reduce MTCT	50.9	44.7	48.1	.052
Correctly identify at least 2 common of STIs	69.1	61.6	65.7	.054

7.5.2 Access to information on HIV in last 3 months

Access to HIV information in the last 3 months significantly influences knowledge levels on specific measures for HIV prevention ($p < 0.05$). More participants that had got HIV information in the last 3 months are knowledgeable on HCT, MTCT, condoms and STIs than those that have not accessed such information. There is a 10% difference in proportion of participants that are knowledgeable and have accessed HIV information and those that have not. The differences are statistically significant ($p < 0.05$).

Table 12: Access to information on HIV in last 3 months and HIV knowledge levels

Knowledge item	Got HIV information in last 3 months (%)		All N=840	Significance P value
	YES (N=432)	NO (N=408)		
Mentioned at least 1 correct and reject at least 2 misconceptions	33.8	29.7	31.5	.149
Know at least 3 correct steps to get HIV test	55.1	43.6	49.5	.001
At least 2 actions that reduce mother to child transmission of HIV	53.0	42.9	48.1	.002
Know at least 3 correct steps on how to use condoms	53.0	38.0	45.7	.000
Correctly know SMC	83.1	74.1	78.8	.002
Correctly identify at least 2 common of STIs	69.9	61.3	65.7	.008

7.5.3 Availability of condoms and its influence on HIV knowledge levels

Availability of condoms (free or to buy) also has some influence on knowledge levels of HCT and condoms use ($P < 0.000$ for both indicators). More survey participants that noted availability of condoms in their communities within two kilometers /LC1/Ward where one can get a free/buy a condom know at least 3 correct steps to get HIV test (67.7%) and at least 3 correct steps on how to use a condom (58.2%), compared to their counterparts who lack such services (42.6% and 41.0% respectively).

7.5.4 Comparing the effect of selected factors influencing HIV knowledge levels

Comprehensive knowledge on HIV/AIDS outcome variable was regressed with selected key background factors, services factors and community variables.

Table 13: Results from Logistic Regression for factors associated with HIV Knowledge

Variable	Odds Ratio	p-value	95% confidence Interval
District (Reference=Adjumani)			
Hoima	2.69	0.000	1.58 – 4.60
Kaberamaido	4.76	0.000	2.80 – 8.10
Mubende	3.22	0.000	1.95 – 5.33
Mukono	2.80	0.000	1.64 – 4.79
Age (Reference =15 – 24)			
Men (25-54)	0.62	0.031	0.41 – 0.96
Women (15 – 49)	0.17	0.229	0.50 – 1.18
Education Level (Reference=None)			
Primary	0.78	0.422	0.42 – 1.44
Secondary+	0.60	0.132	0.31 – 1.17
Religion (Reference=Catholic)			
Protestant	0.94	0.742	0.64 – 1.37
Muslim	1.07	0.804	0.61 – 1.87
Other Christians	0.42	0.001	0.26 – 0.69
Marital Status (Reference=Single, no partner)			
Single, regular partner	1.10	0.742	0.62 – 1.97
Married	1.33	0.281	0.79 – 2.25
Widowed/divorced/separated	1.16	0.680	0.57 – 2.36
Main Source of Income (Reference=None)			
Trading	1.07	0.856	0.52 – 2.20
Remittances	2.39	0.038	1.05 – 5.46
Farming	1.39	0.349	0.70 – 2.76
Salaried Employee	1.16	0.748	0.46 – 2.92
Others	2.17	0.066	0.95 – 4.94
Place where access HIV services (Reference=Yes)			
No	1.06	0.707	0.78 – 1.44
Got HIV/AIDS services (Reference=Yes)			
No	1.06	0.767	0.72 – 1.57
Got information/sensitization on HIV (Reference=Yes)			
No	5.16	0.002	1.81 – 14.72
Know HIV status (Reference= Yes)			
No	1.27	0.200	0.88 – 1.82

Variable	Odds Ratio	p-value	95% confidence Interval
Community interested in new information (Reference=Agree)			
Disagree	0.66	0.059	0.43 – 1.02
Don't know	0.76	0.461	0.37 – 1.57
Talking HIV/AIDS is a taboo (Reference=Agree)			
Disagree	0.86	0.432	0.58 – 1.26
Don't know	0.80	0.543	0.39 – 1.64
People do HIV/AIDS programs for their benefits (Reference=Agree)			
Disagree	0.92	0.657	0.619 – 1.35
Don't know	0.95	0.852	0.54 - 1.67
Asset ownership (Reference=Limited assets)			
Some assets	1.23	0.366	0.78 – 1.94
More assets	1.03	0.887	0.72 – 1.47
Source learned from (Reference = None)			
Radio	6.88	0.000	2.35 – 20.11
Health workers	5.51	0.000	1.83 – 16.61
Other sources	7.88	0.000	2.48 – 25.05

Findings show that comprehensive knowledge on HIV/AIDS was associated with factors like district where the survey was carried out, the age categories (youth, men and women), religion, sensitization about HIV/AIDS and access to information. Respondents from the district of Hoima, Kaberamaido, Mubende and Mukono had higher odds of being well informed about HIV/AIDS compared to the district of Adjumani. Men in the age category of 25-54 years had reduced odds of having comprehensive knowledge on HIV/AIDS compared to the youth. The results also show that other Christians mainly the “Born Again”, had reduced odds of having comprehensive knowledge about HIV/AIDS compared to the Catholics. Access to information was also found to be a key factor associated with comprehensive knowledge on HIV/AIDS compared to those who had no access information. Respondents who learnt HIV/AIDS from radio or health workers had 6.7 and 5.5 odds respectively of having comprehensive knowledge compared to those without access to information.

Programmes to increase comprehensive knowledge among the population should therefore target men (25 -54 years). There is also need to relay message to the “Born Again Christian”. There is need to target use of radio and health workers to increase comprehensive knowledge on HIV/AIDS.

CHAPTER EIGHT: CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

This section presents a summary of the key issues emerging from the data analysis to explain the factors which have an influence on current low comprehensive knowledge regarding identifying ways of preventing sexual transmission of HIV, rejecting major misconceptions and the correct steps on condom use in Uganda. Arising from this synthesis, a number of conclusions and recommendations for increasing knowledge levels are made.

8.2 Synthesis of major findings and emerging issues

Overall, while most people are able to correctly mention ways through which HIV can be transmitted, significant proportions among them also answered positively to HIV transmission ways that are misconceived. Similarly majority have broad knowledge about HIV prevention approaches and programs including PMTCT, condom use, HCT, SMC and know about STIs but have scanty information about the specific ways and steps to follow in applying any of the approaches. Some of the key issues emerging from the data include the following:-

- Statistically significant differences are evident between individual socio demographic and economic factors and knowledge about selected aspects on the transmission and prevention of HIV. A higher proportion of women knows at least 3 correct steps to get HIV test than men and youth but cannot correctly identify at least 2 common STIs. Similarly, they know the actions that reduce MTCT while men score better on steps for condom use, identification of STIs and SMC. This is largely an issue of exposure, attitude and interest. Even when information may be given to everyone, especially through the media, it depends on who the sensitization message falls to; those who use condoms or seek PMTCT services will pay more interest to particular aspects of the package.
- In general, across sub-populations, there are glaring knowledge gaps about ways of HIV transmission and prevention, steps in HCT and condom use, and amount of information about STI symptoms. These need to be filled. The results from logistic regression show that other Christians mainly the “Born Again” have reduced odds (0.42, $P < 0.001$) of having comprehensive knowledge about HIV/AIDS compared to other religious categories. This is attributable to the deep beliefs, and some of the positions faith leaders convey to their flock about HIV transmission, prevention approaches and related services.
- A major challenge both with the service providers and general community is the attitude and belief that people know enough about HIV; consequently many do not make deliberate effort to learn more about HIV generally, to address deep-seated misconceptions and to get sufficient knowledge about tested prevention approaches including correct steps for condom use. Except for mothers attending ANC, interpersonal communication about HIV has reduced most especially in schools and communities, yet more information is emerging about various aspects related to the epidemic. Fear of widespread complacency and HIV fatigue has also been expressed.

- Although there are few people who talk about witchcraft and prayer as forms of HIV transmission and treatment respectively, most of the common beliefs about HIV which depict lack of appropriate understanding of the epidemic are not necessarily cultural but largely individual misconceptions. This notwithstanding, there are limits within cultural and religious norms and values regarding sex which still inhibit open discussion of sexual matters especially condom use talk. Condom use in particular is still considered to be at variance with the meaning and purpose of coitus from some cultural and religious perspectives and dismissed as an abhorrent practice. This is not helped by fears and misconceptions especially about condoms getting stuck in women's wombs. Partly as a result of the considerable obscurity that clouds condom talk, the initiative to learn how to correctly use condoms remains low.
- Arising from the nature of socialization regarding sexuality, gender roles and decision making, there are persistent gaps and differentials between men, women and young people about various aspects of HIV knowledge and service related information for HIV prevention. Men constitute the majority of people that hold misconceptions related to HIV possibly because many never want to go for testing, do not attend ANC at maternity service points nor seek other HIV services, including treatment. Apart from role ascriptions, men are expected to succumb last in the event of a calamity as devastating as HIV/AIDS.
- Glaring low comprehensive HIV knowledge levels are also attributed to poor coordination, limited capacity and lack of commitment from different stakeholders at the community level charged with service provision. Few VHTs are active in de facto terms and their attrition rate is high. While the community health workers and district staff complain of poor integration of HIV/AIDS activities at lower local government level, CSO representatives complain of lack of will by civil servants unless an activity offers material or financial gain.
- Further, service centres are often distant from many people who need HIV services/programs. Only about half of the participants revealed that they have a place within their parish/ward where one can access HIV/AIDS related services. Even then, the scope of service is limited mostly to HCT. Due to funding challenges, a number of key CSOs in the study districts have pulled out thus negatively impacting on health programs they were supporting.
- For similar reasons, most external funding for district health programs in general and HIV in particular suffers grave cuts; health facilities have resorted to largely providing static health services or delivering HIV information as an integrated service. Thus, apart from inpatients and their caregivers, the women seeking family planning services and ANC, PLHIV seeking care, and women bringing children for immunization, most people are not being served with HIV information. Radio is thus by far the source learned from most, followed by health workers, largely at point of service. Community awareness campaigns are quite rarely mentioned. Through logistic regression, access to information was found to be a key factor associated with comprehensive knowledge on HIV/AIDS compared to those who had no access information. Respondents who learnt HIV/AIDS from radio or health workers had 6.7 and 5.5 odds respectively of having comprehensive knowledge compared to those without

access to information. While this sound promising, not everyone is accessible to radio, nor has the benefit of IEC from health workers.

- Overall, health education has suffered considerably and is less prioritized as a service. Even at the health centres or outreach points, rather than spending a good amount of time providing IEC, presently health workers instead focus more on number of patients/clients in the long cues they have been able to attend to, either giving HCT/VCT or ARVs or other drugs. Other key informants have also reasoned that the limited schedule, time and depth of information may also explain why for instance proper condom use procedures which require elaborate explanations are rarely given.
- There are also grave concerns about the quality of information about HIV disseminated by diverse sources of information at the disposal of the population, and therefore a potential risk of getting information from less informed sources. This is in addition to conflicting messages relayed by some of the stakeholders, the moralization of the epidemic and attendant anti-condom use discourses in the public sphere. With the limited geographical reach of health education programs due to low staffing and logistical constraints, most of the misinformation about HIV cannot be fully rebutted.

8.3 Recommendations for increasing knowledge levels

8.3.1 Regular sensitization and training in communities

There is need for continuous, regular sensitization of whole communities about HIV and not waiting for special days such as World AIDS day, or waiting for patients and caregivers seeking treatment and care at health facilities. There should be more regular sensitization using radio in addition to other tested channels of communication about HIV, with focus on knowledge required not simply about HIV services but for people to reject misconceptions and to learn the correct steps to use the services, including condoms. Health education should be prioritized as a critical stand-alone area of attention in the country HIV response and approaches leaning towards its integration into other service programs reconsidered. More regular sessions in schools and communities as were arranged during the early of the epidemic should be re-invigorated. This way, the mothers and their male spouses that do not attend ANC will be reached, so will everyday people that rarely visit health facilities.

8.3.2 Working with local leaders

All leaders, political and technical, should organize community forums to talk about HIV, its dangers, transmission ways, prevention approaches and technologies and places where one can get services. These are opinion leaders and can easily influence positive attitudes and responses. Poorly informed leaders and community service providers such as VHTs need to be equipped with appropriate IEC and models of IEC delivery to be able to disseminate well to others. Similarly organizations carrying out interventions should use local authorities including LCs to do mobilization for HIV programs in order to attract more people attend such programs.

8.3.3 Use effective communication channels and timing

While there is need for more programs on radio to capture wide audiences, and interpersonal channels to provide more in-depth information, effective ways of IEC should be reconsidered so that, for instance, the talk shows allow concerns of target audiences to be fully addressed. Similarly, the

messages should be comprehensive in content so as to give opportunity to people to learn all that is required, not simply a mention of HIV transmission ways. People should be supported with more detailed information and guidance on how to use some of the approaches and technologies to prevent HIV. There is therefore need to repackage intervention messages. Some have argued, for instance that messages on T-shirts meant to promote condoms should include such words as *use condoms correctly, consistently and if you do not know a condom is only used once*.

8.3.4 Innovative use of social and other public events

It is not easy to bring all people together except on particular occasions such as funeral places, places of worship, and spontaneous public gatherings where people of all shades come around. All these are good opportunities for dissemination of HIV information but are seldom used. For instance, IEC related to HIV and services such as HCT can be provided on worship days and video shows on health education films used. These and others can be innovative ways for passing on other information including condom education.

8.3.5 Better Targeting of HIV IEC efforts

Specific target groups should be considered for well packaged information depending on their knowledge gaps. This study has shown that a higher proportion of women know about HCT and PMTCT than men and youth but know little about STIs, steps for condom use and SMC. This requires deliberate targeting of categories that have paucity of information on particular HIV interventions or aspect. For the case of young people, there is need to emphasize more sex education in schools including demonstrations to older pupils on correct ways of using condoms.

8.3.6 Deliberate funding support for sensitization and training

While health workers and a variety of other service providers are expected to deliver appropriate information about HIV, many are constrained due to low motivation and facilitation. Service providers including VHTs and other community based workers require more support to play their roles, to mobilize their communities and fill knowledge gaps on a sustainable basis. This requires deliberate programming specific for HIV education, not simply expecting that HIV information will be delivered during immunization. Funds should be set aside and provided to local governments, CSOs and community structures under a specific program for HIV education, training and capacity building of actors.

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Annexes

A1: Tables for methodology

Table 14: Supervision Areas visited during this Study

District	Cluster Name	Supervision Areas(Admin Units)
Adjumani	Adjumani T/C	Adjumani T/C
		Pakele
	Dzaipi	Dzaipi
		Arinyapi
Hoima	Hoima Municipality	Hoima Municipality
		Buhanika
	Kitoba	Kitoba
		Kyabigambire
Kaberamaido	Kalaki B	Otuboi
		Anyara
	Kaberamaido A	Kaberamaido T/C
		Kobulubulu
		Ochero
Mubende	Buwekula B	Bagezza T/C
		Kibalinga
	Buwekula A	Kiyuni
		Madudu
		Butologo
Mukono	Mukono T/C	Goma
		Mukono
	Nagojje	Nagojje
		Ntunda

Table 15: Analysis Plan for Quantitative Data

Sub section	Content	Methods
Socio-demographic characteristics	age, sex, rural – urban residence, education, religious affiliation, occupation, marital status, ethnicity, occupation, relationship to HH, access to HIV media and Knowledge of HIV status	<ul style="list-style-type: none"> Univariate analyses which generated frequency tables and other descriptive statistics. Continuous data was analyzed using measures of central tendency (means, median) and variation (Standard deviations, Inter-quartile range). For the bivariate analyses, each explanatory variable was run against the outcome/dependent variable to assess any statistical association. Chi-square test and p-values with a cut-off point of 5% to determine statistical significance. For the categorical variables, proportions were used and where appropriate, graphs such as pie-charts and bar graphs were plotted.
Comprehensive Knowledge	Knowledge of transmission Knowledge of Prevention	
Modeling factors associated to	Outcome: Comprehensive Knowledge on HIV and AIDS,	<ul style="list-style-type: none"> Multiple linear regression/ Multinomial / ordered logistic regression ascertain independent

Sub section	Content	Methods
knowledge of transmission and knowledge of prevention.	Predictors: Socio-demographics, behavioral characteristics, community, service and bio-psychological factors	associations adjusted for actual and potential confounders. <ul style="list-style-type: none"> • Interaction terms were tested and stratified analyses aimed at parsimony in models. • Inclusion of variables in the multivariable models depended on whether they had $p < 0.05$ in the unadjusted models, or were potential confounders.

Table 16: Themes for Analysis of Qualitative Data

Objective	Themes and Sub-themes
Socio- demographic factors influencing knowledge levels on identifying ways of preventing HIV transmission, rejecting major misconceptions and the correct steps on how to use a condom	<ul style="list-style-type: none"> • Age – differences in access to information and knowledge levels between the youth, young adults and adults; • Gender – differences in access to information and knowledge levels between male and female • Level of education – differences in access to information and knowledge levels across people of different education levels • Differences between urban and rural dwellers
Community factors influencing knowledge levels on identifying ways of preventing HIV transmission, rejecting major misconceptions and the correct steps on how to use a condom	<ul style="list-style-type: none"> • Socio-cultural beliefs about HIV transmission and prevention • Cultural norms regarding sex and condom use • Systems for socialization regarding sexuality and relationships
Service provision factors influencing knowledge levels on identifying ways of preventing HIV transmission, rejecting major misconceptions and the correct steps on how to use a condom	<ul style="list-style-type: none"> • Availability of HIV prevention information and services • Content of HIV prevention IEC messages • Modes of delivery used in IEC/BCC campaigns

No.	Questions	Coding Categories	Go To
101	(RECORD THE SEX OF RESPONDENT)	Male -----1 Female-----2	
102	How old are you?	AGE IN COMPLETED YEARS <input type="text"/> <input type="text"/>	
103	When were you born? (RECORD DATE OF BIRTH) If don't know insert 88	Day..... <input type="text"/> <input type="text"/> Month..... <input type="text"/> <input type="text"/> Year..... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
104	What ethnicity do you belong to? (WRITE IN THE SPACE. IF FROM OUTSIDE UGANDA, RECORD COUNTRY OF ORIGIN)	_____	
105	What is your highest level of Education? (PROBE FOR THE HIGHEST LEVEL OF EDUCATION ATTAINED)	No Education1 Functional Adult Literacy.....2 Primary incomplete3 Completed Primary.....4 Seconday (O level).....5 Secondary (A Level)6 Tertiary/University7 Other Specify_____	
106	What is your religion?	Catholic1 Protestant2 Muslim3 Seventh Day4 Orthodox5 Born Again/Pentecostal.....6 Traditional7 Bahai8 Other (specify)_____	
107	What is your current marital status? (PROBE FOR SPECIFIC STATUS)	Single, No partner1 Single Non regular partner2 Single with Regular Partner3 Married4 Living together as if married.....5 Widowed6 Divorced/Separated7 Other (specify)_____	
108	How long have you been living continuously in (name of Current place of residence)? IF LESS THAN ONE YEAR, RECORD '00' YEARS.	YEARS <input type="text"/> <input type="text"/> Born here.....1 Always, most times.2 Visitor3	If Visitor Skip To 110
109	Just before you settled here, were you living in a city, town, trading centre, country side or village?	City/Town/Trading centre1 Country side/village.....2	
110	What is your relationship to the household head?	Head.....1 Spouse.....2 Children3 Father.....4 Mother.....5 Grandparent6 Paternal Auntie.....7 Maternal Auntie.....8 Paternal Uncle.....9 Maternal Uncle.....10 Sister.....11	

No.	Questions	Coding Categories	Go To
		Brother12 Cousin.....13 Niece.....14 Nephew.....15 Not related16 Others (Specify)_____ 17	
111	a) In this household, who is the most influential person to you in your social life? INDICATE THE AGE IN YEARS OF THE MOST INFLUENTIAL PERSON IN THE BOX <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto; display: flex; justify-content: space-around;"> <div style="width: 15px; height: 15px;"></div> <div style="width: 15px; height: 15px;"></div> </div> b) Is this person older, younger or of the same age?(CIRCLE ONE OPTION ONLY) 1. Older 2. Younger 3. Same age	Head.....1 Spouse.....2 Children3 Father.....4 Mother.....5 Grandparent6 Paternal Auntie.....7 Maternal Auntie8 Paternal Uncle.....9 Maternal Uncle.....10 Sister.....11 Brother12 Cousin.....13 Niece.....14 Nephew.....15 Others (Specify)_____ 16	
112	Have you delivered/fathered a child in the last 5 years?	Yes1 No.....2	If No skip to 114
113	When did you last deliver/father a child? (WRITE YEAR THE CHILD WAS BORN)	_____	

114	What is your occupation or job where you spend most of your working time? (CIRCLE THE OPTION AND WRITE THE ACTUAL JOB MENTIONED IN THE SPACE BELOW) 	Nothing.....1 Informal employment.....2 Formal employment.....3 House wife.....4 Others (Specify)_____ 5																									
115	What is your Main Source of income? (CIRCLE THE OPTION AND WRITE ACTUAL SOURCE OF INCOME MENTIONED) 	Trading/ Services1 Commissions.....2 Remittances from relatives3 Farming4 Working with Govt5 Working with NGO/Private Sector .6 Others (Specify) _____																									
116	Does any member of this household own? (READ OUT AND CIRCLE ALL RESPONSES MENTIONED)	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr> <td>Radio</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Television</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Mobile Telephone</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Fixed phone</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Computer</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Internet</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td> </td> <td></td> <td></td> </tr> </tbody> </table>		Y	N	Radio	1	2	Television	1	2	Mobile Telephone	1	2	Fixed phone	1	2	Computer	1	2	Internet	1	2				
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Internet	1	2																									
117	What information sources are available in this household? (CIRCLE ONLY RESPONSES MENTIONED)	Radio.....1 TV.....2 Friends/Relatives.....3 Community/Health workers.....4 Posters/brochures.....5 Billboards.....6 Newspaper/magazine7																									

		Members of household.....8 Other (Specify).....9																																																							
118	Does your household or any member of the household own any of the following property? (READ OUT AND CIRCLE ALL RESPONSES MENTIONED)	<table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>Refrigerator</td><td>1</td><td>2</td></tr> <tr><td>Bicycle</td><td>1</td><td>2</td></tr> <tr><td>Motor cycle</td><td>1</td><td>2</td></tr> <tr><td>Car</td><td>1</td><td>2</td></tr> <tr><td>Truck/Van/Bus</td><td>1</td><td>2</td></tr> <tr><td>Boat with Engine</td><td>1</td><td>2</td></tr> <tr><td>Boat without Engine</td><td>1</td><td>2</td></tr> <tr><td>Tractor</td><td>1</td><td>2</td></tr> <tr><td>Local cattle</td><td>1</td><td>2</td></tr> <tr><td>Exotic cows/cross breed</td><td>1</td><td>2</td></tr> <tr><td>Horse/Mule</td><td>1</td><td>2</td></tr> <tr><td>Donkey/Mule</td><td>1</td><td>2</td></tr> <tr><td>Goats</td><td>1</td><td>2</td></tr> <tr><td>Sheep</td><td>1</td><td>2</td></tr> <tr><td>Pigs</td><td>1</td><td>2</td></tr> <tr><td>Chicken</td><td>1</td><td>2</td></tr> <tr><td>Land</td><td>1</td><td>2</td></tr> </tbody> </table>		Y	N	Refrigerator	1	2	Bicycle	1	2	Motor cycle	1	2	Car	1	2	Truck/Van/Bus	1	2	Boat with Engine	1	2	Boat without Engine	1	2	Tractor	1	2	Local cattle	1	2	Exotic cows/cross breed	1	2	Horse/Mule	1	2	Donkey/Mule	1	2	Goats	1	2	Sheep	1	2	Pigs	1	2	Chicken	1	2	Land	1	2	
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PART 2 SERVICE FACTORS

201	Is there a place in this parish/ward where you can access HIV/AIDS related services?	Yes.....1 No.....2	If No Skip to 204
202	If yes, what is the name of the place? (CIRCLE THE TYPE AND PLEASE WRITE THE NAME OF THE PLACE)	Hospital.....1 Health Centre.....2 Clinic.....3 Community outreach centre.....4 Others specify5	
203	What HIV services can you get from this place? (CIRCLE ALL MENTIONED, MORE THAN ONE OPTION ARE POSSIBLE)	Condom promotion/distributionA HIV counseling..... B HIV testingC Safe Medical Circumcision D Family Planning/ANC E PMTCT F OI care (Septrin, etc) G STI screening/treatmentH ART.....I Other (specify).....J	
204	In the last 3 months, have you sought any HIV/AIDS related services	Yes.....1 No.....2	If No Skip to 207
205	Did you get the kind of HIV/AIDS related services that you sought?	Yes.....1 No.....2	
206	What HIV/AIDS related services have you received in the last 3 months? (CIRCLE ALL MENTIONED, MORE THAN ONE OPTION ARE POSSIBLE)	Condoms.....A HIV counseling..... B HIV testingC Safe Medical Circumcision D Family Planning/ANC E PMTCT F OI care (Septrin, etc) G STI screening/treatmentH ART.....I Other (specify).....J	

207	(IF INFORMATION, OR EDUCATION ABOUT HIV IS NOT MENTIONED IN RESPONSES ABOVE, ASK) Have you got any information or sensitization about HIV/AIDS related issues in the last 3 months?	Yes..... 1 No2	If No Skip to 210
208	What source have you learned Most from about HIV/AIDS related issues in the last 3 months? (RECORD ONE OPTION)	Radio.....1 Health Workers.....2 Posters/Leaflet.....3 Peer/non-formal discussions.....4 Community awareness campaigns.....5 Workshops/seminars.....6 Others (specify)7	
209	In your view, do the messages about HIV/AIDS you get sufficient to enable you obtain the answers to all your questions or concerns about HIV/AIDS?	Yes.....1 No2	
210	Is there a place within two kilometers /LC1/Ward where one can get a free condom? (REFERS TO ANY PERSON, NOT NECESSARILY RESPONDENT)	Yes..... 1 No2	
211	Is there a place within two kilometers/LC1/Ward where one can buy a condom?	Yes..... 1 No2	
212	Do the providers/givers/sellers of the condom explain how it is used? Write source that explains_____	Yes..... 1 No2 Some do, Others don't.....3 I don't Know.....4.	
213	Do you have problems in getting condoms?	Yes..... 1 No2	If No Skip to 215
214	What problems do you face in obtaining condoms?	They are costly1 Fear to buy them2 Others specify3	
215	Can you tell me how to use a male condom? (Probe for steps or processes one needs to follow in order to correctly use and dispose off a male condom) (CIRCLE ALL MENTIONED)	Check expiry dateA Check presence of air before opening ...B Check presence of lubricant.....C Tear packet openD Hold tip while unrolling E Put on erect penis F Inside out and touches penis, use new condom in case of tear or slip off..... G Be careful not to tear the tip of the condom when removingH Remove before penis is flabbyI Dispose off in a safe place J Other J Do not knowY	
216	What would be your preferred source for condoms? (ONLY ONE SOURCE)	Shop 1 Hospital 2 Health Centre 3 Clinic/Drug shop 4 Pharmacy 5 Community distributors 6 Friend 7 Spouse 8 Others Specify..... 9	
217	Do you know your HIV status?	Yes..... 1 No2	If No Skip to 220

218	How did you get to know your HIV status? (MAY PROBE USING CODES, CIRCLE ONLY ONE)	Got HIV test.....1 Partner died of AIDS..... 2 Partner tested & was +ve/-ve3 Our baby is okay 4 Intermittent illnesses 5 Others specify_____6	
219	What process did you go through to get an HIV test? (CIRCLE ALL MENTIONED)	Pre- test counseling.....A Information on HCT.....B Consenting to testing.....C Testing.....D Posttest counselingE Consent for getting results.....F Receiving test results.....G ReferralsH Posttest continuous counseling, follow up and support.....I	
220	Which year did you last test for HIV?	Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Never Tested.....1	

PART 3 KNOWLEDGE ON HIV TRANSMISSION

No.	Questions	Coding categories	
301	In what ways can HIV be spread? (CIRCLE ALL MENTIONED)	Unprotected sex with an HIV infected partnerA HIV Infected mother to child during pregnancyB By HIV infected Mother to Child during delivery.....C By HIV infected Mother to Child during BreastfeedingD Sharing non-sterile sharps.....E HIV Infected blood transfusion /contact.....F Deep kissingG Sneezing.....H Multiple partnershipI Excess use of alcohol.....J Other specify, _____ K	
302	In what ways can one avoid getting infected with HIV? (CIRCLE ALL RESPONSES MENTIONED)	Abstinence/not having sex.....A Correct & consistent condom use....B Limiting sexual intercourse to one uninfected partnerC Seeking PMTCT servicesD Wearing protective gloves.....E Safe blood transfusionF Infected persons taking ARVsG Not sharing sharp objectsH Regular check upI Sex after marriage J Avoid blood contact K Avoid alcohol..... L Other specify, _____ M Dont Know..... Y	
303	Can HIV be transmitted through the following ways? (READ OPTION RESPONSES BELOW TO THE RESPONDENT) 1. Mosquito bites ----- 2. Touching an infected person -----3.	YES NO DK 1 2 8 1 2 8	

	Sharing food with infected person -----4. Sharing utensils with infected person -----5. Sharing toilets with infected person -----6. Witchcraft (magic/casting evil spell) -----	1 2 8 1 2 8 1 2 8 1 2 8	
304	When can HIV be transmitted from an infected mother to her baby? (CIRCLE AS MANY RESPONSES AS MENTIONED)	During pregnancy A During delivery..... B Breastfeeding..... C Other..... D Don't know..... Y	
305	Can the risk of transmitting the HIV from an infected mother to her child be reduced?	Yes..... 1 No 2	If No Skip to 307
306	What are the ways of reducing HIV transmission from an infected mother to child? (CIRCLE ALL RESPONSES MENTIONED)	MOTHER Delivery in the hands of trained health workerA Using ARVs.....B Testing and receiving results for HIV..... C Prevention of malaria during pregnancy..... D By operating the mother (caesarean section.....E STI screening, prevention and treatment..... F Attending ANC..... F Other.....G BABY Using ARV syrup..... H Supplementation of vitamin a & Deworming tablets.....I Replacement feeding.....J Exclusive breast feeding for first six monthsK Others Specify..... L	
307	(CHECK IF RESPONDENT IS NEVER MARRIED Q107AND RECORD)	Single, No partner1 Other Specify..... 2	If 2Skip 309
308	Have you ever had sexual intercourse in your life?	Yes1 No 2	If 2 Skip to 401
309	(Check If Respondent currently MARRIED or living as if married) Do you usually use a condom every time you have sex with a person who is not your wife/husband?	Yes1 No 2 I do not engage in extra marital sex.....3	
310	(Check if respondent is single with regular or non regular partner, or living as if married) Do you usually use a condom every time you have sex with your sexual partner/s?	Yes1 No 2	

PART 4: SEXUALLY TRANSMITTED INFECTIONS

401	Have you ever heard about sexually transmitted infection other than HIV?	Yes1 No.....2	If no, skip to 404
-----	--	------------------------	-----------------------------------

402	What sexually transmitted infections, other than HIV, do you know? (CIRCLE ALL RESPONSES MENTIONED)	SyphilisA GonorrhoeaB Genital wartsC Herpes simplexD ChancroidE CandiasisF Other specify _____G Dont KnowY	
403	What are the sources of information on Sexually Transmitted Infections? (CIRCLE ALL RESPONSES MENTIONED)	Parents/guardians/relativesA Peers.....B Support/counselling clubs/ organizationsC Community or social workersD Written books/ materials/flyersE Radio/TV/films /videosF Hospital/health clinic/post workerG School clubs/teachersH InternetI ChurchJ Other (Specify)_____ K	

PART 5: SAFE MALE CIRCUMCISION

404	What is safe male circumcision? (PROMPT USING CODES)	Cutting the fore skin of penis in health facility setting1 Cutting the fore skin of penis by trained health worker2 Others specify, _____3 Don't Know88	If don't know, skip to 501
405	Where can one get Safe Male Circumcision? (CIRCLE AND WRITE NAME OF PLACE)	Hospital1 Government Health Centre2 Private clinic3 Others specify.....4	
406	What was your source of information about SMC mention above?	Radio.....1 Health Workers.....2 Posters/Leaflet.....3 Peer/non-formal discussions.....4 Community awareness campaigns.....5 Workshops/seminars.....6 Others (specify)7	
407	What are the advantages of Safe Male Circumcision? (MORE THAN ONE OPTION POSSIBLE, CIRCLE ALL MENTIONED)	Reduces the risk of infection in men ...A Personal hygieneB Increase enjoyment of sex.....C Reduces promiscuityD Reduce risk of infection in women ...E Makes a man a strongerF Others Specify.....G	

408	What are the disadvantages of Safe Male Circumcision? (MORE THAN ONE OPTION POSSIBLE, CIRCLE ALL MENTIONED)	Increases the risk of HIV infectionA Encourages un protected sex.....B Increases unprotected sexC Reduces the enjoyment of sex.....D Increases promiscuityE Excess bleedingF Other Specify _____G None Don't Know	
-----	---	---	--

PART 6: OTHER COMMUNITY INFLUENCES ON HIV KNOWLEDGE

In this community people may believe many things about HIV/AIDS and condoms. I am going to read some of the things they say, and feel free to say whether you “agree” or “disagree”. If you “do not know” feel free to say so.

Qn	Statement	Response		
		Agree	Disagree	DNK
501.	This community is interested in any new information and education about HIV/AIDS	1	2	3
502.	There are local initiatives within this community for giving information and education about HIV/AIDS to our members	1	2	3
503.	Most community members show up at sessions for learning about HIV/AIDS whenever such activities are arranged	1	2	3
504.	Talking about HIV/AIDS especially in relation to sex is considered taboo in this community	1	2	3
505.	Most people consider HIV talk offensive to their cultural values	1	2	3
506.	In this community, there are deliberate activities to promote condom use	1	2	3
507.	Within this community there is enough and suitable information on condoms	1	2	3
508.	People in this community do not like using condoms even with non-regular partners	1	2	3
509.	STIs apart from HIV can be treated and individuals get healed	1	2	3
510.	HIV can be treated and individuals get healed	1	2	3
511.	In this community there are people that can bewitch others to acquire HIV	1	2	3
512.	People doing HIV/AIDS sensitization programs/ activities simply have their own personal benefits	1	2	3

Please let me know if you have any question. Thank you so much for your time.

A2 Focus Group Discussion Guide

FGD Guide for Populations (Youths 15-24, Women 15-49, Men 25-54 years and mothers of children 0-24 months)

General Discussion on HIV/AIDS

1. In your view how big is the problem of HIV/AIDS in this community? Why do you think so?
Probe for:
 - Prevalence of the HIV/AIDS
 - Category of people most affected

Misconceptions about HIV/AIDS

2. What are the beliefs in this community regarding HIV sexual transmission? Probes for:
 - *Mosquito bites*
 - *Touching an infected person*
 - *Sharing food with infected person*
 - *Sharing utensils with infected person*
 - *Sharing toilets with infected person*
 - *Witchcraft (magic/casting evil spell)*
3. Why these beliefs? What leads/sustains these beliefs? Please explain to us?
4. Among which age categories are these beliefs more pronounced and why?
5. What are the beliefs in this community regarding HIV prevention?
6. What is the basis for each of the beliefs mentioned? (Why these beliefs?)
7. Among which age categories are these beliefs more pronounced and why?

Now lets talk about Condom Access and Use

8. What condom access opportunities exist in your community? (Probe for where one can get condoms
9. What age categories have access to condoms more than others and why?
10. For what reasons would you go for condoms?
11. In your view, what factors affect the correct use of condoms (ie factors that affect condom effectiveness) among people of your age category? (Probe for: Limited information, Illiteracy, culturally- rooted misconceptions etc)

Community Perspectives on HIV/AIDS Service Provision

12. What are your various sources of information about HIV/AIDS transmission and prevention in your community?
13. What is your commonest source and why?
14. What do you think about the quality of HIV/AIDS related services (Includes info. Given from the source mentioned in **Qn12 (Probe for: service hours, convenience, confidentiality, follow ups, Health worker attitudes, access factors etc)**)
15. How can we improve on people's knowledge regarding:
 - Preventing sexual transmission
 - Rejecting misconceptions (or filling knowledge gaps) about HIV/AIDS spread and prevention
 - Correct use of condoms

Closing Question

16. Is there anything else that we have not talked about that you would like us to discuss?

A3 Interview Guide (Key Informant Interviews)

A.3.1 Key Informants: *District Health Officials, Community Development, Health Facility, Religious Leaders*

HIV/AIDS Prevalence and Incidence

1. How big is the problem of HIV? (Probe for facts and opinions on infection rates, sexual behaviours etc)

Delivery of HIV/AIDS Services by Non-Government Organisation

2. What HIV transmission and prevention services/activities are available in the district? Probe for:
 - Name of the agency and project area sub-county/Health facility/school (note the uneven distribution of services)
 - Agency and target groups
 - Agency and type of HIV/AIDS education and behavioural change activities and services being provided
 - Agency and project implementation strategies used to prevent and control the spread of (including HIV education and BCC)
3. What are the strengths associated with the existing HIV/AIDS interventions in this district?
Probe for:
 - Geographical coverage (small, wide, inconsistent)
 - Population targeted (Youth, women, men)
 - Duration of intervention
 - Strategies used: HIV education and BCC methods/strategies
 - Capacity (finance, human resource, relationship)
 - Partnership arrangement and forum
4. The LOAS Survey conducted in this district by the CSF revealed that the proportion of the population that had comprehensive knowledge of HIV/AIDS prevention was ----% (refer to the table below). In your view, what factors are responsible for the low level of knowledge on all key ways of preventing HIV transmission in the district?

Adjumani	43.9%
Mukono	32.5%
Masindi	32.2%
Mubende	23.5%
Kaberemaido	

5. What are the weaknesses associated with the HIV/AIDS intervention in the district?
 - Characteristics of the target population
 - Community factors – socio-cultural, economic, politics
 - Psychological - attitude
 - Provider factors – coverage, capacity, strategies,
 - Physical/geographical factors – accessibility (islands, roads)

6. What can be done to improve the delivery of HIV/AIDS prevention by CSO/Agencies in the district?

Delivery of HIV/AIDS Services by the Local Government

7. In this district do you have a mechanisms for:
 - Equitable distribution of HIV/AIDS services (accessing hard-to-reach areas)
 - Ensuring quality of HIV education service given provision to various populations
 - Monitoring and evaluating the work of the HIV/AIDS agencies
 - Forum for networking
8. What are the district priorities in the control and prevention of HIV/AIDS?
9. What was the impact of such HIV/AIDS programme
10. What gaps and challenges are experienced by the DDHS in the control and prevention of HIV/AIDS?
11. How can such challenges be effectively addressed?

A.3.2 Key Informants: District Health Officials CSO Programme Managers, HIV Service Providers in Health Facility/School/Community settings

HIV/AIDS Prevalence and Incidence

1. How big is the problem of HIV? (Probe for facts and opinions on infection rates, sexual behaviours etc)

Nature of Services Provided

Ask/pick any available project document having performance indicators

2. What HIV/AIDS programmes are currently being implemented?
3. What HIV transmission and prevention components are being implemented? Probe for:
 - Geographical coverage (districts/sub-county/Health facility/school (note the rationale, bias in geographical spread)
 - Target groups (youth, women, men, most-at-risk) and rationale
 - What HIV/AIDS education and behavioural change activities and services being provided
4. What impact have you registered in the implementation period? Get all the necessary indicators?
5. The LOAS Survey conducted in this district by the CSF revealed that the proportion of the population that had comprehensive knowledge of HIV/AIDS prevention was ----% (refer to the table below). In your view, what factors are responsible for the low level of knowledge on all key ways of preventing HIV transmission in the district?

Adjumani	43.9%
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Kaberemaido	

- **Socio-demographic** (target groups) – age, gender, marital status, education, religion, ethnicity, occupation, residence, relation to the household, knowledge
 - **Community factors** (structural condition) – social & cultural beliefs, politics, perceptions which deter or facilitate access to HIV/AIDS information
 - **Service Factors** (provider factors) capacity (human, financial), targeting strategies
 - **Bio-psychological factors** (target) Health (HIV), physical conditions, mental stability, Substance abuse, attitude
 - **Physical/geographical factors** (Physical accessibility)
6. Assess the nature of information given and the communication methods used:
 - Topics and content prevention and condom use –see whether it addresses misconceptions
 - Adequacy of information
 - simplicity/illustrations
 - Communication methods used
 - Consistency in supply of information materials and messages
 - Integration of information on the above with reproductive health and other services

- Attitudes of service providers towards providing information on the different modes of preventing HIV transmission, correct steps of condom use, etc
 - Follow-up made
7. Assess the capacity of the service providers in providing HIV information and education on prevention methods
 - Level of staffing and load allocation
 - Incentive structure (salary, social incentives)
 - Qualification and training programmes
 - Funding levels
 - ICT infrastructure
 - Office space
 - Logistics (vehicles, motor cycles, bicycles)
 7. How do you organise the delivery of services? - Assess
 - Facility-based
 - Community outreach
 - Networking and partnership
 8. What is the level of Strategic Planning and management practices?
 - Existence of a strategic plan
 - Monitoring and evaluation capacity
 - Timeframe and Work-plans
 - Duty allocation and responsibility
 - Institutional development (governance and management)
 - Value for money mechanism
 9. In your view, what should be done to ensure complete knowledge on the correct ways of preventing HIV transmission among different population groups in this community?

Thank you very much for taking time to contribute your views and experiences