VOLUNTARY COUNSELLING AND TESTING SITUATION ASSESSMENT FOR KAYUNGA DISTRICT

RERPORT

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LIST OF ABBREVIATIONS

AIC	AIDS Information Centre (AIC)
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARVs	Antiretroviral drugs
CBO	Community Based Organisation
CDD	Community Drug Distributors
CHAI	Community HIV/AIDS Initiative
COVCT	Community Owned Voluntary Counselling and Testing
CSOs	Civil Society Organisations
DHAC	District HIV/AIDS Committee
DDHS	District Director of Health services
LC	Local Council
HIV	Human Immuno Deficiency Virus
IGAs	Income Generating Activities
FGDs	Focus Group Discussions
MOH	Ministry of Health
MUK	Makerere University
NGO	Non Governmental Organisation
PRA/LA	Participatory Rural /Learning Approaches
PLWAS	Persons Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
STDs/STIs	Sexually Transmitted Diseases/Infections
TBA	Traditional Birth Attendant
UPHOLD	Uganda Program for Human and Holistic Development
VCT	Voluntary Counselling and Testing
VS&LA	Village Savings and Loans Associations

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EXECUTIVE SUMMARY

This report presents findings of participatory needs assessment research conducted in Kayunga District from July to August 2005 as a preparation for the implementation of Community Owned Voluntary Counselling and Testing Pilot Project (COVCT). The project is to be implemented by AIC in partnership with Kayunga District and communities. The project is part of AIC efforts to initiate a community based VCT approach where communities are more involved in mobilising and managing aspects of VCT delivery to meet the ever increasing demand. The purpose of the assessment was to generate baseline information on the general conditions of the communities that would inform the design of this COVCT pilot project.

Specific objectives:

1. To examine the socio-economic characteristics of the communities.
2. To identify existing institutions including HIV/AIDS providers and assess their roles, capacities and potential for supporting the COVCT project.
3. Establish the existing knowledge and utilisation of VCT services.
4. Facilitate the communities to identify priority problems and develop action plans to address the problems.
5. Examine factors necessary for the implementation of the COVCT project.
6. Generate recommendations to AIC on the design and implementation of the COVCT pilot project.

The assessment was carried out in Nyondo village, Kayonza Sub-County and Kakola village, Wabwooko Sub-County. The target population were men, women and youth (male and female) at community level and key informants at district, sub-county and health units. These included district HIV/AIDS focal point person, DDHS, Secretary for Health, LC II & III leadership and CSOs involved in HIV-related activities.

Participatory Rural Appraisal (PRA) methods were used to collect the data. The main tools used included mapping (resource, social, institutional, mobility), gender and livelihood analysis, ranking (wealth ranking, direct and pair wise), community visioning and key informant interviews.

The major findings were as follows:

Socio-economic characteristics: The majority of households in both villages according to wealth rankings were categorised as very poor and struggled to meet their basic needs.. The major source of livelihood is subsistence agriculture, a very unstable and unreliable source of livelihood due to price fluctuations and weather changes. The findings also revealed that people spend more than they earn and these vary according to seasons. Income is high during harvesting periods but nothing much is saved since much of it is spent on school fees, health care and feasts such as Christmas holidays. The high expenditures that exceeds income is met through sale of personal and household assets. Land is a major resource in both communities but over the last ten years, had become scarce and fragmented due to sub-dividing of land among grown-up sons, marrying more women, and selling to migrants to meet health costs and other household needs. Access to other basic amenities like safe water is very limited in both communities, with one borehole serving over 1000 people on average. This has resulted into overcrowding at

water points, conflicts, wastage of time, bad peer influence and exposure to risks of rape and HIV infection especially among the young girls.

Both villages are characterised by high population mobility in search for social and economic services and opportunities, mainly health, education, leisure, traditional ceremonies, markets and employment. Men and male youth dominated this mobility pattern. Women mainly move out to access health services and markets. The impact of this mobility is largely negative in that it increases the rate of unwanted pregnancies among young girls, risk of HIV infection and domestic violence.

Institutions/individuals: Key institutions/individuals that provide health services include Traditional Birth Attendants (TBAs), Community Drug Distributors (CDDs), Traditional Healers, drug shops and itinerant drug sellers. Social services are inadequate and as a result, communities seek services from distant facilities such as Lugasa, Busana, Wabwoko health units and Kayunga Hospital. There are other informal community initiatives that included *Nigiina (gift circles), Muno mukabi* (*a friend in need*) and *Akuwa gwowa (rotational savings and credit initiative),* which provide social and economic support to members. For example, *Niginas* help members to acquire household items through ratational gifts exchange and promote improved household hygiene while *Muno mukabis* are support groups that provide moral and economic support to their bereaved members. *Akuwa gwowa* is a rotational saving and credit initiatives that avails financial services to the members. There were no community HIV/AIDS care and support groups at community level.

Knowledge and utilisation of VCT services: There is very high awareness of VCT services but characterised with limited understanding of VCT benefits. VCT utilisation is also very low, for example, less than 1% of the total population in the district had tested for HIV in the period 2001-2003(Kayunga District Local Government, 2004). Low utilisation of VCT was attributed to low coverage of services, facility-based constraints (irregular supply of testing kits, lack of electricity, storage equipment), long distance (20 kms to Kayunga Hospital), negative attitude and perceptions towards VCT, and lack of care and support services. The majority of users of VCT services are women, followed by youth and lastly men ((Kayunga District Local Government, 2004). The main reasons were that women are the ones who access health services mostly because of the child care roles, the unique health problems, attending ANC services, mistrust of their husbands and ease to mobilise when it comes to participation in VCT related activities.

Opportunities/Threats in the promotion of VCT services: The following were the key factors:

- Provision of VCT services within the community.
- Massive sensitisation about the benefits of VCT and importance of positive living.
- Provision and linkages to post test care and support services.
- Logistical facilitation of service providers and community mobilizers (allowances and transport).
- High demand for VCT services compared to the testing places.
- Ensuring confidentiality/user friendly environment for those who need to use the services.
- Involvement of politicians purposely to solicit their support in mobilisation activities.

- Active community participation for ownership and sustainability of the project interventions.
- Appropriate timing of interventions following seasonal variations. The dry season would be appropriate to introduce the project since there are less activities taking place. The rainy season is unsuitable because it is characterised by high morbidity and intense agricultural activities.
- Mainstreaming gender issues into the project activities to empower women to take the lead in accessing services.

Community priority problems: The three crosscutting priority problems for both villages are:

1. Lack of health services (infrastructure and supplies).
2. Water shortage.
3. Bad roads.

Conclusions

The needs assessment findings revealed that the need for VCT services is very high in both communities in Kayunga as there were no such services in the nearby health units. Both communities had the potential to contribute to and manage the COVCT services as evidenced by existence of collective social initiatives such as support groups and savings associations where community members' participation, contribution and sustainability were high.

However, this potential is affected by low household incomes and savings, limited access and availability of productive resources, gender constraints, and inadequate management and entrepreneur skills. This raises the need for the project design to incorporate other innovative ways of generating the income to strengthen the communities' ability to take lead in 'marketing' the service, contribute to, utilise, manage and enjoy the benefits from the COVCT.

Key Recommendations

In light of the above, we propose the following recommendations that should be incorporated in the design and implementation of the COVCT project in order to ensure community ownership and active participation.

1. A comprehensive Information, Education and Communication Strategy (IEC)

The IEC strategy should emphasise the benefits of VCT services for the individual, household and community. The strategy activities should focus on prevention, stigma reduction, care and support, Political commitment and support to the project as these are crucial for the project activities to take off.

2. Strengthen communities' ability to contribute and utilise the COVCT services

The recommended intervention that will strengthen communities' ability to contribute and utilise the COVCT services is the promotion of Village Savings and Loans Associations (VS&LA) approach (for details of the methodology, see appendix II). This approach will help members of the community to strengthen their saving capacity, which is currently very low. The VS&LA approach uses the group solidarity model, which mobilises community members into self-selected groups, trains them on how to manage their groups

savings and credit operations. The group members are then facilitated to pool their money into a fund from which group members can borrow and pay back with interest, thus allowing the fund to grow. VS&LAs have almost no operating costs, and unlike banks and most micro finance institutions (MFIs) they have no drainage of funds from the group, all the savings and interest paid by the members remain within the group. This model has been tested and found to improve the living conditions of the poor in different parts of Uganda and elsewhere in Africa (see web www.vsla.net). These VS&LAs will be used as platform for dissemination of knowledge and information about VCT services as well as offering psychosocial support since the groups meet regularly.

This model should be supplemented by training of the community to improve their entrepreneur skills. The training should address some of the underlying causes that contribute to increased vulnerability to HIV/AIDS.

3. Apply a combination of approaches in the delivery of the COVCT services

AIC should focus on building the capacities of the following community structures to enable them deliver some of the COVCT services.

- Facilitate and build capacity of local councils, religious leaders, TBAs and Traditional healers to become mobilisers, counsellors, and educators as well as monitors of project activities.
- Build the capacity of the existing community support structure such as *Muno mukabi*, *Nigina* and others (*for details, see table 4 in section 2.2.1 of the report)* to provide the neccessary care and support.
- Build the capacity of the existing health structures in terms of skills, equipment and space to enable them provide comprehensive prevention, care and support services. More emphasis should also be put on establishing post test clubs at community levels.
- Establish a strong referral system that links the community with other health services
- Establish strong partnerships with some local CBOs/NGOs that are found in the sub-counties. The partnership approach will increase outreach in terms of scale (numbers) and provide quality services. However, AIC should carry out detailed assessment of potential partners (CBOs and Local government structures) to establish their capacity and partnership needs. This partnership should be clearly defined through a memorandum of understanding (MOU) that details the partnership objectives, obligations, accountability and reporting mechanisms, expected outputs and contribution of each stakeholder in terms of resources.

4. Mainstream gender issues into project activities

The project should involve both men and women as key stakeholders in deciding how the services are organised (timing, frequency, and siting) at the community level and specifically target men through sensitisation in order to increase their appreciation of the importance of VCT including couple dialogue on issues concerning VCT. In addition, the project should establish links and identify mechanisms for collaboration with other HIV/AIDS service providers to share information on effective responses to gender related HIV/AIDS issues as well as creating a referral and networking system to allows monitoring of the coverage and quality of COVCT delivery process.

5. Implement the project in two phases

It was initially envisaged that implementation of the COVCT project would start soon after the needs assessment exercise. However, given the findings and recommendations above, we strongly propose that AIC should revisit the project implementation plan and implementation be done in two phases as explained below:

Inception phase: approximately 6 months

- In consultation with stakeholders, AIC should develop a project framework that details the project goal, objectives, expected results, interventions and specific activities, implementation strategy including monitoring and evaluation plan, staffing and project budget). This should be done in consultation with all the stakeholders.
- AIC should also establish a project implementation and management structure. The structure should include among others, a full time staff that will coordinate and manage the project. This particular staff should have expertise in community development work as well as VCT.
- AIC should invest time and resources in promoting dialogue with the district and the community on the project framework and definition of roles and responsibilities of the different stakeholders. This is will create a shared understanding, appreciation and commitment to the implementation of the project. This will also help to solicit for community support and ownership.
- AIC should identify potential partners (CBOs, informal groups and resource persons) that will implement the project together with the community.

The second phase (around 18 months) should be a period when main activities as detailed in the project document will be carried out including monitoring and documentation of the lessons learnt.

CHAPTER ONE INTRODUCTON

1.1 Background

This report presents findings of the Participatory Needs Assessment research conducted in Kayunga District from July to August 2005. The research was part of the pre-implementation process of the Community Owned Voluntary Counselling and Testing Pilot Project (COVCT) in Kayunga district. The project is to be implemented by AIC in partnership with Kayunga District and communities. The project is part of AIC efforts to initiate a community based VCT delivery to lower levels to meet the ever-increasing demand for VCT. The Uganda Program for Human and Holistic Development (UPHOLD), a 5-year (2003 – 2007) USAID-funded bilateral program will provide the funding for the pilot project.

The purpose of the pilot project is to facilitate and build capacity of the community to provide information and mobilize themselves towards accessing VCT services as well as providing psychosocial and economic support through self-help initiatives. The expected outcome will be increased access to VCT services to more rural communities, disadvantaged women, the aged and people with disabilities who would otherwise find it difficult to access these services and improved livelihood status.

1.2 Purpose and objectives of the needs assessment

The purpose of the needs assessment was to generate baseline information on the general status of the communities that would inform the design of the COVCT pilot project in Kayunga District.

Specific objectives

1. To examine the socio-economic characteristics of the communities.
2. To identify existing institutions including HIV/AIDS providers and assess their roles, capacities and potential for supporting the COVCT project.
3. Establish the existing knowledge and utilisation of VCT services.
4. Facilitate the communities to identify priority problems and develop action plans to address the problems.

5. Examine factors necessary for the implementation of the COVCT project.
6. Generate recommendations to AIC on the design and implementation of the COVCT pilot project.

1.3 Methodology

1.3.1 Area of study

The assessment was conducted in Kayunga District in the two sub counties of Kayonza and Wabwooko. The district is located in the Central region of Uganda, 80kms East of Kampala City, bordering Mukono in the South, Jinja in the East, Kamuli in the Northeast, Apac in the North, Luwero in the West and Nakasongola in the Northwest. It comprises two counties (Ntenjeru and Bbaale), 8 sub-counties, one town council, 61 parishes and 348 villages.

The total population of the district according to the 2002 Population and Housing Census is 294,613 (143,099 males and 151,514 females) with an annual growth rate of 1.49% (MoEFP, 2002). The main ethnic groups are Baganda, Basoga, Bagisu, Banyala, Banyarwanda and some West Nile tribes.

The district has one referral hospital (Kayunga), 3 Health Sub-District hospitals, namely Ntenjeru County North, Ntenjeru County South and Bbaale, 16 health units, 78-registered drug shops and 21 private clinics. It has four resident doctors, 140 staff in both curative and preventive services. The doctor/patient ratio is 1:46,173, nurse/patient ratio is 1:8,505 and midwife/expectant mother ratio is 1:480[1]. The health units visited in Kayonza Sub-County were Busana and Lugasa and Wabwooko in Wabwooko Sub-County.

The lowest sampling units where PRA exercises were conducted were the villages of Nyondo and Kakola. The two communities were identified and selected by AIC and Kayunga District officials. Nyondo village is located in Kafumba parish, Kayonza Sub-County and bordered by Bisaka, Bukomba and Nawankonge villages. The village has two major roads, namely Busana as the main local government access road that links the community with the outside and Busoga line as a major community road. Nyondo is divided into two administrative units (A and B). According to the list of the household

[1] District Development Plan 2004-2007.

kept and updated by the Village LC1 authority, the village has 352 households[2]. The main ethnic groups are Basoga, Itesot, Baganda, Banyarwanda and Sudanese.

On the other hand, Kakola village is located in Kyelima parish, Wabwooko Sub-County and bordered by Nakaseta, Namabuga, Wabutiti villages, Lukonda and Nsanvu swamps. As in the records of the LC1 authority, the village has 155 households. This was established during the wealth ranking exercise. The main ethnic groups are Baganda, Basoga, and Banyarwanda.

In both villages, the main settlement pattern is linear, concentrating along the main access roads and paths in the community.

1.3.2 Methods

Qualitative methods were used to collect the data and comprised mainly of PRA tools as detailed in table 1 below. During the application of the tools, community members were put in groups using the gender and age criteria.

Table 1: Tools used in the Needs Assessment

Tools	Application in the field
Social and resource maps	This was used to obtain information such as number and distribution of households within a village, important community resources, existing infrastructures and their relationship with the village, and factors promoting or hindering utilisation of VCT services. Community members in their groups were facilitated to draw maps of their villages either by plotting the necessary features on the map, which was drawn on the ground or through discussions.
Mobility map	This was used to compare and analyse the movements of different groups in both villages and the impact of such mobility on the communities and how they would affect the implementation of the COVCT project. Community members in their groups were facilitated to draw to draw a map showing movements in and out of the village, reasons for the movements and their impact on the people's lives. Analysis was done together with the community members of how such movements are likely to affect the implementation of the proposed project. Other information on aspects of movement, like the frequency of visits, distance, and the importance of such places visited were also discussed.
Venn Diagram	This was done to show key institutions and individuals in both communities and their relationships and importance for delivery of services. Communities were facilitated to draw institutions in form of circles, the size of the circle signifying their importance (the larger the circle, the more importance of the institution to the community).
Seasonal	This was used to show seasonal variations in climate, crop sequences, food

[2] Established during the wealth ranking exercise.

Calendar	security, income-generating activities, health and disease patterns, high and low income and expenditure periods throughout the year and monthly variations.
Gender Analysis	Activity profile, Access, Control and Ownership of resources as well as Gender Decision Matrix tools were applied in order to define gendered roles of women, men, girls and boys, establish the power relationships between men and women and their differential authority to decide on their access to and control over resources as well as male and female negotiation and decision making powers over utilisation of VCT services. Community members in their groups were taken through a scoring exercise whereby each activity/resource/decision making was assigned ten stones, which were distributed among the men, women, girls and boys. During the analysis stage, a summary of all the activities was made to get the final total.
Income and Expenditure patterns analysis	This was done to assess different activities individuals are engaged in as sources of income, expenditure patterns, constraints and coping strategies of individuals and how the patterns are likely to affect the implementation of the COVCT project..
Direct Matrix Ranking	This was used generate a list of community problems and rank them according to magnitude.
Wealth Ranking	Was used to help the communities classify themselves into various categories of well being and define socio-economic characteristics of individual households. Cards equivalent to the number of households (per LC1 list of households) were used, each card representing a household. They were then sorted according to wealth categories defined by a mixed representative group of community members including the village local council chairperson. After sorting all the households, the cards were counted to establish number of households under each wealth category and percentages were calculated.
Pair wise ranking	To determine the most pressing problems according to their ranking criteria and the reasons for the ranking.
Key Informant Interviews	To obtain information about HIV/AIDS services in the district, VCT services access and utilisation patterns by gender and constraints therein, capacity issues in terms of staffing, equipment, space, funding etc.
Secondary data review	To obtain background information about the district and sub-counties.

1.3.3 Target group

The target group at village level included women, men, male and female youth. These were put into separate FGDs in order to promote active participation of all individuals. Key informant interviews were conducted with Sub-county and District officials. These included HIV/AIDS focal person, District Director of Health Services (DDHS), District Planner, and District Community Development Officer. Interviews were held with health unit staff of Wabwooko, Lugasa and Busana Health Units, Child Advocacy International (NGO) and Makerere University Walter Reed (Research). An FGD was held with sub-county officials in Kayonza involving LC, CBOs and representatives of informal groups such as *Nigina* representatives.

1.3.4 Needs assessment implementation process

The implementation process involved two key steps, namely training the assessment team in PRA methods, data collection and analysis. The team comprised AIC and District staff.

Training the assessment team in PRA methods: This involved a training workshop for AIC and Kayunga district staff that were involved in the exercise. The training was for five days and additional two days for practical application of the tools before the actual data collection. The training was aimed at equipping the team with basic knowledge and skills in PRA and developing a common approach in the application of PRA tools in the data collection. A list of the team members is in Appendix II

Data collection: A review of existing relevant documents was carried out to collect secondary data, which was used to supplement data collected through the primary sources. Primary data was collected using qualitative methods, which included Focus Group Discussions (FGDs) where different PRA tools were applied and Key-Informant Interviews. In FGDs, community members were separated into different social groups according to age and gender (men, women, male and female youth).

Key Informant Interviews were conducted at the district, the sub-county and health units' levels. At the district level, key informant interviews were held with HIV/AIDS focal point persons, DDHS, Secretaries for Health and leaders of CSOs involved in HIV-related activities. Key informants at the district level provided an overview of the VCT services in the district. At the lower local government level, key informant interviews were held with the sub-county AIDS Committee (SAC), Secretaries for Health, CSO/CBOs personnel, and members of the parish development or AIDS committees. Health personnel at health units were also interviewed.

Data Analysis: Analysis of the findings started in the field together with the participants. Content analysis was used on the basis of emerging themes and sub-themes in line with the assessment objectives. Descriptive summaries were made. Analysis of the data from Focus Group Discussions for each topic was carried out. This analysis facilitated comparisons and contrasts of participants' views within and among different social groupings.

1.3.5 Limitations

Late turn-up for meetings: In both communities, meetings used to start late. This meant that the team had to wait for some time before the FGDs would start and this meant the meetings would go on up to very late in the evening.

Gender differences: These were mainly encountered during the community visioning exercise where men and women were mixed as general community members. The women and female youth were not fully participating and the explanation was that some of them had in-laws and thus could not talk in front of them, according to the cultural practices. Therefore we recommend that during the community consultation process prior to implementation of the project the groups be separated to overcome this problem.

Team dynamics: Prior to the assessment, the majority of the participants (AIC and Kayunga district staff) had no prior exposure to PRA tools. This meant that a lot of time was spent clarifying the different tools. In addition, the team members had limited experience in probing, recording and analysis of data. These problems were overcome by supervising the team in application of the tools during the assessments, tape-recording all the discussions, and a review of each days' work prior to each field day. The review helped clarify problematic areas, and provide guidance to the team to improve their probing and recoding skills.

Suspicion about the intentions of the research: Much as there was detailed explanation about the purpose of the assessment, some groups, mainly the male youth in Kakoola, seemed not to have grasped the idea well. This was overcome by repeated explanations of the purpose of the exercise by the PRA team.

High expectations: Community members participating in the FGDs in Nyondo kept on demanding for soap and salt, while in Kakoola they asked for lunch. This indicated that the two communities expected much more from the exercise. Apart from their expectation of tangible benefits, they also expected their problems to be solved immediately after the exercise.

CHAPTER TWO FINDINGS

2.1 Socio-Economic Characteristics

The key socio-economic characteristics of the two communities analyzed were the wealth categories, resource base, income and expenditure patterns, mobility patterns and gender analysis.

2.1.1 Wealth categories

The majority of the households in both communities were categorised as very poor (80% in Nyondo and 57% in Kakoola)[3] and struggle to pay for health services and other basic necessities. This implies that their capacity to contribute and utilise some of the COVT project services is limited. The tables 2 and 3 describe respondents' perception of wealth and number of households per wealth category (for details of how the percentages were arrived at, see section 1.3.2 of the methodology, table 1 under wealth ranking tool).

Table 2 Wealth categories in Nyondo village

Category	Characteristic	Number of households
Rich	Consistent income from selling milk, pineapples, matooke. Own cows, motorcycle, shops, maize mill, blockhouses, *Amaka age simisa*- meaning that these are homes which one can admire, they can also afford to pay for health services.	11 (3%)
Relatively rich	Teachers who are paid monthly salary. Own at least 3 cows, 2 small pieces of land-*ebibanja,* iron roofed and house built with blocks but no longer have income due to coffee and banana wilt, one person has a motorcycle but sold cows to buy it, own latrines but are not in good condition.	60 (17%)
Poor	Live in grass-thatched houses; own at least 2 goats, and one *kibanja.* Have many children (sons) using that same piece of land, only depend on sale of crops and do not want to change their practices of cultivation.	90 (25%)
Very poor	Many of these are the youth, who have just married and depend on their fathers land, and the elderly. Some are widows.	143 (41%)
Very-very poor- *Lunkumpe*	Have no land, some had coffee and sold it off and remained with small pieces, no clothes, no help when they fall sick and they cannot afford treatment.	48 (14%)
Total		**352**

[3] These percentages were generated through listing all the households in each village and sorting them according to wealth by selected community members.

Table 3 Wealth categories in Kakoola village

Category	Characteristic	Number of households
Rich	Own cows, farms, land which is not less than six acres, motorcycle, permanent block houses and plastered, a big latrine like that of a school and equivalent to the house of a poor person, wholesale business, can afford to buy what they want and pay for health services even if it meant an operation and able to educate children to any level.	18 (12%)
Relatively rich	Sells Swissgarde supplements, make blocks, sell jackfruits, own *kibanja (customary owned land),* are able to buy plots and build a houses, can earn Ug. shs1, 000/= daily from own IGAs, burn charcoal, keep pigs, cows, small business like selling tomatoes and water melon, can afford to pay for health services and buy meat. They also own bicycles and can afford to educate their children to secondary level	49 (31%)
Very poor	Some are elderly, blind; some have no land, have not married, and cannot earn Ug. shs 1,000/= daily, have no adequate food, some have land (like the youth) but cannot utilise it, can not afford to buy seeds, cannot afford to pay health services and provide casual labour. Others stay with relatives.	88 (57%)
Total		**155**

2.1.2 Resource base

Important resources for both communities included land, water, roads, swamps and shops. The details are described below.

Land: There is over reliance on land in the two communities for their livelihood. Its uses included:

- Cultivation of crops for home consumption and selling.
- Rearing animals.
- Settlement.
- Supports trees, which are used as medicinal herbs, firewood, charcoal burning and construction of houses.
- Men especially in Nyondo emphasised use of land near the swamps and anthills for making bricks for house construction and at times sale.

However, in the last ten years, land in both villages has increasingly become scarce and fragmented due to subdividing among grown up sons, marrying more wives and selling to migrants to meet health costs mainly in Kakola village and other household needs. A male

participant in Kakoola had this to say, "*We have to sell land to get money for treatment for our children suffering from HIV/AIDs. A five-litre jerrycan of local herbs to treat HIV/AIDS costs Ug. Shs 30, 000/= and a bottle of Swissgarde health product is shs 50,000/=.*" The above practices have resulted into landlessness for some people and overcrowding in trading centres.

Water points: Both villages are underserved in terms of water supply with an average of 1000 people accessing one source. This is three times higher than the recommended figure of one borehole to 300 people by Directorate of Water Development Planning Guidelines. In Kakoola, three villages share one borehole, while in Nyondo one-borehole serves over 352 households and other neighbouring villages. Water shortage lead to the following problems:

- Overcrowding at water points
- Long waiting time (2-3 hours to collect water)
- Conflicts and bad peer influence, especially among young girls as well as exposure to risks like rape, which perpetuate the spread of HIV/AIDS.
- Negative effect on participation in community development activities due to the long hours spent looking for water.
- Persons Living with HIV/AIDS (PLWAS) would also be affected by shortage of water since positive living emphasizes good nutrition and safe water practices. Besides, those who are very sick may not have sufficient energy to look for safe water, which may worsen their health situation.

The water shortage situation is worse during the dry season. People, especially women and girls, walk long distances to fetch water. Those who cannot afford to fetch water, especially the elderly and those without bicycles suffer more because sometimes they miss their meals as a result of lack of water to use and find it difficult to bathe. In addition, scarcity of water in the dry season also often leads to deaths of livestock.

Swamps: In both villages, swamps are important boundary resources and are used as domestic water sources in the dry season. They are also used for growing crops (especially rice), grazing animals, thatching grass, obtaining weaving materials, fishing (*mamba)* in the rainy season and hunting.

Roads: In both villages, roads were important access points and for networking. In Kakoola, roads are used to access health services, education and markets outside the village. In Nyondo village, roads were emphasised for transportation of agricultural produce and linking the residents to other social services. Women emphasised that bad roads reduce accessibility to markets, leading to a reduction of incomes as traders offer them low prices. The bad roads especially in Kakoola would affect project mobilisation activities and accessing services including health outside the village.

Shops: These are used for sale of produce, obtaining essential commodities, bicycle spare parts (men), condoms especially for the male youth and men and painkillers. Men in Kakoola use shops as contact places for business, for example, people from Masaka have established stores in the trading centres where produce is sold. In addition, they are used for leisure (discos) locally termed as "*ebinyumu.*"

Other resources included institutions such as schools, churches and mosques. Community resource persons included traditional healers, traditional birth attendants (TBAs) and community drug distributors (CDDs). The details about their importance are described in the institutional analysis section.

2.1.3 Income and Expenditure Patterns

The main source of income in both villages is sale of agricultural produce, which is very unstable and unreliable due to price fluctuations and weather changes. The crops sold include maize, beans, groundnuts, watermelon, pineapple, sugarcane, sweet potatoes, and cassava. There are also cash crops like cotton, rice, and *ndizi/kayinja* (type of banana) predominantly in Nyondo, while Irish potatoes, vanilla, and coffee are predominant in Kakoola. Other sources of income in both villages are wages, remittances from children (for few households), casual labour, fishing, brick making, retail trading (shops) and sale of animals like goats, pigs, chicken, pigs and animal products - mainly milk. In Nyondo, land and grass for thatching houses are income sources as is brewing local beer and *Nigina (rotational gift circles)* in Kakoola.

The main expenditures in the two communities were on social services mainly health and education (school fees for secondary-going children and scholastic materials for primary)

and household basic needs. In addition, men were spending on leisure activities (alcohol consumption, girlfriends, gambling and entertainment of visitors) while women spend more on themselves and the children. Other expenditures of men included buying seeds for planting, farming tools, paying casual labourer, treatment of domestic animals, building houses and paying government taxes.

Analysis of income and expenditure revealed the following:

- Households spend beyond their income levels resulting into low levels of savings and increased vulnerability. However they adopt different coping mechanisms as listed below:
    - Liquidating the little savings and sell off assets. The most damaging is when the household sell off a productive asset on which future income is dependent such as land.
    - Taking children out of school.
    - Cutting down on household consumption (food, health, clothing) to save money.
    - Household members (especially men) engaging in piecework; men migrating to find work thus increasing their chances of engaging in risky sexual behaviours.
    - Some families call in favours and/or ask for help from family, friends and neighbours.
    - Those who belong to burial societies or traditional rotating savings and lending associations (ROSCAs and *Nigina*) seek assistance from the other members in their groups.

- Income and expenditure patterns vary according to seasons. People get income during harvesting periods, mainly in June- August and November – January each year. However, little of this income is saved because of high household expenditures and poor saving practices. The peak period for expenditure for both communities is December - February of each year because of Christmas season and paying school fees. Other periods of high expenditures were May-June, attributed to high occurrence of diseases and food shortage.

The above findings indicate that the potential for these communities to contribute either in cash or in kind is very low. This also means that utilisation of the project services may be affected negatively. Those who will be found HIV positive, may not have the capacity to meet health costs**.**

2.1.4 Gender Analysis

Gender division of labour/tasks: Findings revealed that women had the heaviest workload, followed by men, boys and girls. Women engage most in reproductive activities[4] compared to men and children, whereas men dominate productive[5] and community activities.[6] In Kakoola, the level of women's involvement in productive activities was almost similar to that of men and boy children compared to Nyondo where it was very low. This could be attributed to high redundancy among the male youth in Kakoola who marry at a very young age and leave the responsibilities of caring for the family to the wives.

There is minimal involvement of women and girls in community activities especially maintenance of roads and water points. The community activities that women get involved in reflect culturally ascribed tasks like cooking food and fetching water during community functions like burial, funeral and marriage ceremonies. The table below gives a summary of the scores[7] given to a list of activities performed by the different groups.

Table 4 Summary of gender activity profile by the different socio-groups

Activity	**Women**		**Men**		**Boys**		**Girls**	
	Kakoola	Nyondo	Kakoola	Nyondo	Kakoola	Nyondo	Kakoola	Nyondo
Productive	76	38	80	106	56	67	15	17
Reproductive	186	88	33	20	14	33	13	47
Community	31	21	55	41	55	21	15	6
Total	**293**	**134**	**168**	**150**	**125**	**113**	**43**	**63**
Grand Total	**427**		**318**		**258**		**106**	

The heavy workload for women would imply that they have limited time for leisure and participation in community development activities. However, this is not the case because all groups mentioned that women are heavily involved in community development activities such as attending trainings and sensitisation meeting. Reasons given for this trend were that women are regarded as custodians of their homes, therefore they have to look for knowledge and skills that would improve the welfare of their families and are highly committed compared to men. In addition, increased women's participation in

[4] Cooking, fetching water, cleaning compound and sweeping the house, washing (utensils, clothes), grazing and caring for animals, collecting firewood, caring for the sick and child care (guidance and immunisation) and building houses.
[5] Agricultural tasks (land clearing, ploughing, planting, weeding, harvesting), cutting trees, charcoal burning, brick making, trading/business and fishing. In Kakoola other activities included handicraft making, carpentry and brewing.
[6] Cooking food in funeral rites and burial functions, digging graves, collecting condolence contributions, road maintenance, and church construction.
[7] The above scores were generated by assigning each particular activity ten stones and then distributed among the men, women, girls and boys. A summary of all the activities was made to get the final total.

productive and development activities would imply that they are empowered socially and economically, but this was not the case in both communities. This is because of lack of decision-making powers in the household, which makes them more dependent on men.

Resource access: In both communities, all family members (female, male, girls and boys) had access to resources that they need to carry out day-to-day activities. These resources include land, bicycle, domestic animals (cattle, goats, pigs, chickens and their products), farm tools, and household assets such as radio, utensils, and beddings among others. However, this access is limited depending on the type of resource. For example, women and children have limited access to land, bicycles and cattle which are productive resources.

Resource control and ownership: There is gender imbalance in resource control and ownership. Men own and control most of the productive resources while women owned and controlled the less valued assets (household items). This was attributed to the fact that it is the men who buy the assets, and that culturally they have powers to control and own resources as heads of households. Women have therefore devised some ways of coping with the situation such as engaging in income-generating activities and joining informal rotational savings and credit schemes like *Nigina* and other self help groups.

The above situation show that women's capacity to effectively utilise the services is likely to be affected by the gender roles which limits their time to access services and power to make decisions on whether to access the service and action to take thereafter. The project will therefore need to involve women as key stakeholders in deciding how the services are organised (timing, frequency, and sites) at the community level and have a communication strategy targeting men to appreciate the importance of VCT and also to support and discuss with their spouses about accessing VCT services.

2.1.5 Mobility patterns

Both villages are characterised by high mobility (moving in and out) in search of social and economic services and opportunities mainly:

- Health for antenatal care, delivery, blood transfusion, rehydration, malaria and cough treatment and blood check-up as well as those coming in to provide outreach health services (immunisation), sell medicines (herbal and modern).
- Education (going out for secondary education and primary leaving examination centres as well as those coming in for primary education
- Social functions such as burials, funeral rites, marriage, *Nigina*, and visiting of friends and relatives
- Markets and employment

Impacts of mobility

The impacts of this mobility in both communities were generally negative and mostly affected the young girls as described below:

- **Unwanted pregnancies:** The traders who come to Nyondo and casual labourers in Kakoola were reported to impregnate young girls but abandon them afterwards. This has resulted to a big number of them becoming child mothers and increased girl child school drop out.
- Long distances to secondary education and water points also increase the risks of exposure to casual sexual encounters that could lead to pregnancy and risk of acquiring HIV.

Other negative impact includes:

- **Increased risk of HIV/AIDS infection:** Examples of these include those who move in and out for funeral rites where they engage in sex. Marrying outside the village was considered negative as it exposes young boys to HIV infection. Some cases were mentioned in Kakola where after a short time of marriage, the women died. Also women who come in to do business especially operating restaurants and food kiosks were reported to be already infected by the time they settle in the village.
- **Domestic violence:** This was reported to be on the increase especially by youth groups. The increase was attributed to women going out to markets where it is claimed that they engage in sex, alcohol consumption and stealing of goods. It was reported that this has caused breakdown of marriages and loss of money.

- **Low prices for agricultural produce:** It was reported that traders exploit the community members by offering lower prices for agricultural products. They were also accused of adjusting the weighing scales to record less than the actual weight

A few positive aspects of this mobility included:

- Obtaining income from sale of local produce,
- Improved health status of the community due to extension of health services by health personnel,
- New skills (tailoring and teaching reported in Nyondo).

For effective implementation of VCT services, the COVCT project design will have to take into consideration the impact of this high mobility especially the negative aspects especially in its education, information and communication strategy. In addition, the project delivery strategy should target place like schools, markets and trading centres.

2.2 EXISTING INSTITUTIONS/INDIVIDUALS AND RELEVANCY TO COVCT PROJECT

2.2.1 Village-level institutions

Both communities had institutions (mainly informal) and structures that were providing health and other social support services. However, none of them were primarily focusing on HIV/AIDS. Key among these institutions were the following:

- **Local Structures** especially the Local Council I **(LC1)** had a very strong relationship with other community structures and is crucial in mobilization for development and other community activities as well as information dissemination. Therefore, this structure may be an entry point for COVCT project. For instance, the LCI leadership in Nyondo village seemed to be stronger and influential showing a potential to provide leadership whereas in Kokoola, the LC leadership was weak but with strong influential elders.
- **Community Resource Persons** like CDDs and TBAs that were involved in providing health related services. This is another opportunity for mobilisation and delivery of VCT services.
- **Informal groups:** These included *Muno Mukabi, Nigina* among others whose activities mainly bring together community members. These would be instrumental in implementing care and support activities.

Table 5 below details activities, opportunities for COVCT and limitations of the various institutions.

Table 5 Important institutions and people in Nyondo and Kakoola villages

Institutions/Individuals	Activities	Opportunities for COVCT project	Limitation
TBAs – 2 in Nyondo but 1 is trained Kakoola – 1	• Deliver mothers • Examine pregnant mothers • In Kakoola, the TBA acts as a CDD	• Implementation of PMTCT services • Information dissemination • Promotion of family planning • Can provide care and support services	• Inadequate facilitation • Lack of relevant training in counselling • Inadequate relevant information
Traditional healers- one in each village	• Treatment like syphilis, love portions, hernia, *entalo*, HIV, mental illness, STDs/STIs • Men consult them in search of wealth while women look for love portions for men.	• Information dissemination • Treatment opportunistic treatment • Care and support • HIV counselling	• Involve in practices that can bear an increased risk of HIV infections and thus facilitate the spread of HIV/AIDS.
CDD- 2 in Nyondo and one in Kakola	• Give malaria treatment for children of 5 years and below	• Can be used as educators and counsellors	• Workload may be much for them
Clinics/drug shops (inside) in both villages	• Sell drugs • Wound dressing	• Counselling • Condom distribution	• Lack of proper facilities
Schools – One primary school in each village	• Education • Community meeting • Disseminate HIV/AIDS information	• School-based HIV/AIDS program • Can offer counselling services to both children and their parents	• Lack of relevant information • Lack of counselling skills
Parents and Teachers Association (PTA)	• Deals with issues concerning education quality, school management and development	• Can be used as a tool for mobilisation and sensitisation of parents and teachers • Outreach to out-of-school youth	• Lack of relevant information
Religious institutions Nyondo- 1 protestant 1 Mosque, in Kakoola -1 Catholic church & 1 Pentecost church	• Spiritual guidance and counselling • Classroom for children in Kakoola	• Awareness creation • Behavioural change • Stigma reduction • Psychosocial support • Counselling services	• Lack of proper training in HIV/AID counselling and relevant information

Institutions/Individuals	Activities	Opportunities for COVCT project	Limitations
Informal groups *Nigiina, Muno Mukabi, Akuwa gwowa* Kakola -*Nigina, Muno Mukabi, Twekambe* Women Group	*Nigina* – these are rotational gifts exchange that helps • Members to acquire household items • Construction of latrines and drying racks	• Gives foundation for promotion of savings and credit activities • Dissemination of knowledge and information about VCT services	• Lack of the relevant skills
	Muno Mukabi is a burial group that supports bereaved group members by • Collecting condolence contributions • Digging graves • Mobilizing and cooking food during burial ceremonies	• Provision of care and support services	• Lack of the relevant skills
	• *Akuwa gwowa are* rotational savings and credit groups	• Gives foundation for promotion of savings and credit activities	Lack of relevant skills
	• *Twekambe* women group - music and drama as well as making handicrafts for sale	• Information dissemination	• Inadequate information
LC I in Kakola	• Mobilization and ensuring security for the community • Resolution of conflicts related to land and marriage ➢ Link between the community and outside • LC 1 women representative ***"Nabakyala"*** as important because she settles domestic conflicts and counsels girls	• Counselling services • Mobilisation, sensitisation and monitoring of project activities	• Lack of adequate information • Lack of proper incentives
Bataka (in Kakoola)	• Demarcation of village boundaries and individuals' land marks • Settle land conflicts and marriage disputes	• Community mobilisation and sensitisation • Project management and monitoring	• Lack of relevant information and skills

The two villages had key linkages with other outside institutions. These included health units (Lugasa and Busana serving Nyondo village and Wabwooko serving Kakoola village[8]) and Kayunga Hospital that provides referral services for complicated cases and HIV testing. Others were District Water Department and JICA that had constructed water points (a borehole and Shaduff) in Kakoola village, Lugazi Catholic Diocese constructed

[8] The services provided by these health units included antenatal care (ANC), deliveries, treatment of malaria and diarrhoea, training of TBAs, immunization of children and rehydration.

latrines for the primary school. Cash Farm was mentioned in Nyondo and is involved in conducting sensitisation activities on agriculture, information dissemination and credit.

2.2.2 Sub-county and district based institutions

Institutions at these levels focusing on HIV/AIDS were categorised as government, NGOs and CBOs. However, none of them were implementing activities in the two communities. Despite the limited scope and outreach, their existence presents opportunities for the COVT project in terms of forging partnerships and experience sharing. Details of their activities, opportunities and limitations are detailed in appendix II.

The health units visited in Kayonza Sub-County were Busana and Lugasa and Wabwooko in Wabwooko Sub-County. Below is a detailed assessment of their capacities.

Table 6 Government health services Kayonza and Wabwooko Sub-Counties

Health Unit	Staffing	Activities and opportunities for COVCT	Constraints
Busana	11 staff (2 clinical officers, 1 enrolled nurse, 1 enrolled midwife, 1 registered midwife, 4 nursing assistants, 1 lab technician and 1 health assistant)	• Counselling (staff trained by AIC) and referrals • Outreach centre for counselling. • Mobilisation for VCT is carried out through parish mobilisers initially trained for immunisation	• At the time of the study, outreach activities were taking place due to lack of facilitation • The health unit has no facilities for testing and counselling, storage equipment and power. • Lack of records to track the number of referrals
Lugasa	8 staff (1 clinical officer, 1 midwife, 4 nursing assistants, 1 lab assistant and 1 health assistant)	• Counselling and referral • Has a counselling room • 2 people were trained (midwife and health assistant) by AIC and Walter Reed project	• Lack of services for proper diagnosis e.g. testing equipment • Inadequate skills to handle VCT, management of patients, • Lack of records to track the number of referrals
Wabwooko	7 Staff (1 clinical officer, 1 midwife, 3 nursing assistants, 1enrolled nurse, 1 lab assistant)	• Counselling and referral • Sensitise people on HIV/AIDS and hygiene and sanitation • Availability of laboratory, counselling room 2 staff were trained in counselling by AIC	• Lack of transport to conduct outreach, lack of kits and reagents • Fuel available from the district is only for immunisation activities

2.3 Assessment of VCT Situation

2.3.1 Knowledge and Awareness of VCT services

All groups were knowledgeable about HIV/AIDS[9] and existence of VCT services at Kayunga Hospital. However, majority did not know the importance and benefits of VCT services. There was misinformation on the access and use of these services. Male youth groups complained of high costs associated with transport to the hospital and the fee for testing. Sources of information on VCT and HIV/AIDS included, schools, radios but very few owned radios. For example, in the women's FGD in Kakola, only five out of 15 owned radios.

2.3.2 Utilization of VCT services

Utilization of VCT services is very low in the district. The available district records reveal that less than 1 % of the total population tested for HIV between 2001 and 2003.[10] Among those who tested, the number of those who are HIV positive is 22%. While the total number of people tested is not disaggregated by gender (see Table 7), the District HIV/AIDS focal point person revealed that the majority of those who have tested for HIV are women (7.5%), followed by young people both in and out of school aged 15-25 (3.5%) and lastly men (2.5%).

Table 7 HIV/AIDS trends for Kayunga District since 2001

Year	Total No of People tested	People who tested Positive			% of the PLWAS
		Female	Male	Total No	
2001	698	96	24	120	17.19%
2002	763	165	37	202	26.47%
2003	1,170	190 (16%)	61	251	21.47%
Total	**2631**	**451**	**122**	**573**	**21.78%**

Source: Kayunga District Three-Year Development Plan 2004-2007

The reasons given for the above trend were that:

- Women access health services more than men and youth, because of their unique health problems, childcare roles, and attending ANC services
- Women are easy to mobilise when it comes to participation in activities that influence their lives and general community development activities.

[9] They could mention some of the symptoms as well as the different modes of transmission.
[10] Data obtained from the Kayunga Three Year District Development Plan 2004-2007,

- Health in the household is largely a responsibility of a woman. *"They are the ones who take children for treatment and can easily get information about HIV testing once they are at the health unit" one respondent commented*
- Men fear the results because they engage in extra-marital relationships
- Fear of marriage breakdown in case they are found positive

Low utilisation of VCT services was attributed to the following factors:

Low coverage: As mentioned earlier, there are no VCT services in the two communities. In addition, VCT coverage in the district is low and ranges from 7% - 10% for the sexually active group, according to the HIV/AIDS focal point person. Currently, VCT is only provided in 3 Government Health Units out of 19 in the district. These include Kayunga Hospital, Kangulumira and Bbaale H/C IV units. This problem is compounded by limited outreach services, which are only provided at Busaana and Nazigo health units. This has led to overcrowding in these testing centres because of high demand and few staff to handle the clients. A youth who had tested from Kayunga Hospital mentioned that the testing centre is usually congested leading to long waiting hours. More so, these services are not provided on a daily basis, they have specific days thus leading to overcrowding in these testing centres because of high demand and few staff to handle the clients.

Facility-based constraints: These included irregular supply of testing kits, lack of electricity, storage equipment like fridges, limited ARVs, manpower constraints and limited funding.

- **Irregular supplies**: From December 2003 HIV testing had not been carried in the district due lack of reagents (Information from the district officials and the District Development Plan ((2004/05 – 2006/07). Testing kits were also out of stock in the district for a period of six months due to procurement problems at MoH. These problems discourage clients, most especially those who are mobilised in large numbers by some NGOs/CBOs to access VCT services.

- **Limited ARVs**: ARVs supplies in the district are inadequate compared to demand. The available ARVs are only meant to serve 100 people in the whole district.

- **Limited staff/personnel**: The district has only 15 trained counsellors but their effectiveness to perform is reduced by the heavy workload since they have to reconcile counselling with their normal duties. For example, Kayunga Hospital only provides a nurse and a nursing assistant to attend to VCT clinic. Because of understaffing, the clinic only runs up to 1.00 p.m.

- **Inadequate physical infrastructure**: According to a district official and health unit in-charge, the existing health facilities are not friendly to counselling and testing because of lack of counselling rooms. This compromises confidentiality and thus discourages some people to seek for this service.

Long distance: In both communities, access to health services is a big problem. On average, people walk 10 kms to reach a nearest government health unit. This distance is comparably longer than the recommended distance of 5 kms by Ministry of Health. In Nyondo, the nearest government health unit is 13 kms, which is Busana, and the distance from the village to Kayunga - a referral hospital is 26 kms. In Kakola, the nearest government health facility is Wabwoko HC III, which is 5 kms. In addition, both communities access health services at Lugasa Health Unit, which is 22 kms from Kayunga Hospital. Due to the long distance, people complained of transport costs, which were generally high and yet many indicated that they could not afford it.

Limited funding: Outreach is limited due to lack of funds to provide fuel and allowances to staff. This leads to irregular visits to communities, which negatively affect provider-client relationship in terms of continuity once the services resume. The sub-county officials also emphasised that their sub-counties are large, and this makes it difficult to cover large areas.

People's negative attitudes and perceptions: At community level, people's attitudes and perceptions toward HIV testing was generally negative. Their views were consistent with the officials from the sub-county and district. Most community members indicated that they feared to get results after testing, because if they are found positive would lead to breakdown in marriages.

Influence of gender: Women decision-making powers are limited since major health decisions like HIV testing, condom use, ANC and family planning are made by men. Women mainly make decisions regarding PMTCT.

Lack of care and support services: While discussing the issue of VCT, the main concern of the community was, *"After testing and I am found positive what happens next?"* Another sub-county official said, *"Many sensitisation activities have been conducted, people have been tested but there are no drugs."* This pointed to the lack of care and support services within communities. This contributes to the high levels of stigma at community level. Some participants indicated that if they were tested and found positive, they would eat all what they have while others said that they would prepare for death.

Uncoordinated and poor mobilisation approaches: This was pointed out in relation to the current research projects (MUK-Walter Reed), which are giving financial support and food to the participants. This may affect community participation if one comes without a monetary incentive.

2.3.5 Opportunities/Threats in the Promotion of VCT services

Findings from the FGDs and key informants revealed the following factors that would promote utilization of VCT services.

- Provision of VCT services within the community. This would address the issue of long distance and low coverage.
- Massive sensitisation about the benefits of VCT and importance of positive living
- Provision of care and support services e.g. treatment of opportunistic infections like tuberculosis, formation of post-test clubs and linking them to Kayunga Hospital for ARVs. This would address the concern of *"what happens after testing"*
- Logistic facilitation of service providers and community mobilisers (transport and allowances) to enable them conduct outreach activities.
- High demand for VCT services compared to the testing places. Currently the available VCT centres are overwhelmed with the number of clients seeking VCT services as mentioned by the district, sub county officials and some CBOs representatives in Kayonza. This is an opportunity for promotion of VCT services.

- Improved good relationship between providers and clients.
- Ensure confidentiality - This was a major concern of men in Nyondo village and among Kayonza sub-county officials that people do not want their status revealed to others.
- Have specific clinic days for VCT in health units: This generated a lot of discussion among the participants in Kayonza sub-county FGD. While one section felt that this would hinder some people to go for testing, others felt that this was the best option. Some examples of clinic days for certain health services already exist in the district such as immunisation, VCT and access to ARVs, among others. However, the above argument indicates that stigma is still high among communities**.**
- Package information in a way that would reduce false expectations.
- Application of an integrated approach to VCT: This was a main concern of sub-county and Nyondo community members especially care and support services.
- Work with already existing structures like health units, community resource persons, CDDs, chairpersons of *Niginas groups*, CBOs among others in mobilisation and sensitisation of communities. The reasons put forward were that these structures already have established relationships with community members and some have registered success. In addition, this would reduce the cost involved in the implementation of the project.
- Strategic involvement of politicians to solicit their support.
- **Ensure effective community participation:** Community participation is a crucial element in the implementation of any project including the COVCT pilot project. This is because it enhances ownership and has positive implications for sustainability through creating opportunities to clarify the myths surrounding HIV/AIDS, reducing stigma, empowering those infected and affected to be self-reliant and influencing people's willingness to know their HIV status or change risky behaviours.

  All the key informants expressed the need for community involvement because of the foreseen advantages of ownership and sustainability. They also regarded it to be a cheap way of project implementation since the communities would themselves be engaged in implementing certain aspects of the project such as mobilisation, reporting and monitoring among others. One informant had this to say, *"If a community owns a programme, you expect success. What they need is to be given the relevant skills and*

facilitated with materials in order to do the job. They may be motivated using cheap transport like a bicycle, badges, T-shirts and making them recognised such as introducing them whenever there is an activity." Complaints about the use of labour from outside instead of the village reflect the need for utilising skills available in the community as well as clarifying why they may not be used.

- **Consideration of seasonal variations:** The rainy season (April, May, October, September, October, and November) is characterised by high morbidity levels, extremely busy schedules for the community members due to engagement in agricultural tasks (like planting and weeding) that take much of their time, especially women. Daily survival is at the heart of communities' interests due to food shortage and scarcity of money due to lack of what to sell. Community involvement in the project during this time may be limited.

  The dry season (January, February, July, November and December) is characterised by high rate of redundancy that leads to increased engagement in leisure activities. This season can be partly substituted by involvement in other development activities. The community noted that this would be the appropriate time for participating in development activities.
- **Gender Mainstreaming:** As already explained in section 2.1.4,women, men, girls and boys are likely to utilise the COVCT services differently because they experience different vulnerabilities and have different capacities as prescribed by their gendered roles which are different, rigid and overlapping. In addition, the current power relationships between women and men and their differential authority to decide on access to and control over the use of resources shows inequalities. Similarly women decision-making power over utilization of services (VCT inclusive) is also limited. Therefore gender mainstreaming will ensure that gender inequalities are addressed in the design, planning, implementation, monitoring and evaluation of COVCT project, and that all (women, men, boys and girls) share the beneficial outcomes equitably. In addition, the project should promote joint planning and decision making at household level to mitigate incidents of domestic violence and marriage breakdowns in the event of spouses testing positive.

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CHAPTER THREE: COMMUNITY PRIORITY PROBLEMS AND ACTION PLANS

The two communities were taken through a process of identifying problems affecting their communities and prioritising them using the direct matrix and pair wise ranking. The list of problems per group and per village is detailed in appendix 3. Basing on the key identified problems an action plan was made.

3.1 Priority Problems

The four crosscutting priority problems for both villages were:

1. Lack of a health unit.
2. Water shortage.
3. Lack of training/sensitisation on development issues.
4. Bad roads.

The reasons pointed out for the above ranking included the following:

Lack of a Health Unit: For Nyondo, the nearest health unit is 13 km and it is very costly to travel either to Lugasa Health Unit or Kayunga Hospital. The categories who are most affected by lack of health services were the pregnant mothers and children. This is because women need ANC services and they are responsible for taking children to health centres and thus need transport. In Kakoola, the community needed a health unit which is well equipped and with qualified staff.

Water shortage: In both communities, the available water points are inadequate compared to the population served. One borehole serves more than 1,000 people resulting into overcrowding, conflicts at water points and inadequate water for consumption.

Bad roads: In both communities roads are bad and they become almost impassable during rainy seasons. This has hindered transportation of produce, thus forcing farmers to sell their produce at lower prices and transport in and out of the village very costly.

Lack of sensitisation and education on development issues: Communities complained of lack of access to information and opportunities for education on modern ways of farming and HIV/AIDS.

In Kakoola, male youth group emphasised unemployment, lack of markets and diseases than any other group. This could be attributed to the fact that male youth are more in need of employment or markets where they can trade and earn income since most of them were married with families to look after. In addition, many of the youth spend much of their time in gambling activities like playing cards and *Omweso* as earlier on mentioned.

On the other hand, only female youth mentioned lack of HIV/AIDS drugs and a vocational school. This is because most of them were child mothers who had dropped out of school at a very young age. They are faced with the responsibility of looking after their children and would thus require additional skills that would enable them earn some income.

Lack of VCT services was not mentioned among the community priority problems in Kakoola and was not among the top five in Nyondo. However, it was mentioned as one of the services that would be provided by the proposed health units. Therefore, the project design may use either existing or mobile health units as entry point for VCT services.

3.2 Community Action Plan

Community members were led through an exercise of action planning after identification and prioritisation of problems. Basing on the most pressing problem across all the groups, each community developed an action plan. The details are presented in the tables 8 and 9 below.

Table 8 Action Plan for construction of a health unit in Kakoola village

Activity	Responsibility	When	Where	Why	Resources	Risks	Opportunities
Form a committee	Community members	2 wks	Kakola P.S	To mobilise and sell the idea to other community members	Someone in charge of electing a committee	None	Need for a health facility
Mobilisation & sensitisation	Committee	1 wk	Kakola P.S	To bring on board every community member To understand the purpose	Transport-bicycles Meeting place Support from the committee	Community members not buying the idea Community conflicts Politics	Greatest need Community interest Willingness of the committee
Selecting a site/land	Community members		Kakola village	*Land offered by Mzee Nsaga	Land offered by Mzee Nsaga but needed to be debated further	Members may not contribute money	People with land can donate it
Construction	Community members	6 months	Kakola village	Land offered by Mzee Nsaga	Money, blocks-labour-own Sand, timber, stones by women Cement Iron sheets Agreement for land Food-women Fetching water-women	Lack of money, Lack of commitment community conflicts	Land is available Government may support us, friends and NGOs Sand, stones, blocks are available Women will feed the builders

Table 9 Action Plan for construction of a health unit in Nyondo village

Activity	Responsibility	When	Where	Why	Resources	Risks	Opportunities
Sensitising the community	LC & Community members	Once requested	Nyondo P.S	To share findings & update them on what they agreed during the exercise	Stationary -books, pens will be provided by the community	If the community members do not turn up for the meeting	The community is need of a health unit
Mobilising people who will be trained	LC & Community members	Once requested	Nyondo P.S	So that they can serve others	Bicycles, stationary	If AIC does not fulfil its promise	Availability of trainable people
Mobilising people for family planning	LC & Community members	All the time	Nyondo village	Prevent diseases	Bicycles		
Mobilising people for family planning	Community members	All the time	Nyondo village	There is a need for family planning	Bicycles		
Construction	Community members	Once requested	Nyondo village	We are in need of a health unit	Land, sand, stones, bricks Cement Food	If land is not available Politics, failure to bring sand & stones Community not being committed If AIC does not fulfil its promise	Availability of land (1/2 acre) and local materials

Some of the services that the proposed health unit would offer include treatment (malaria, T.B, hernia, epilepsy), ANC, HIV testing, care and support services, management of STI (syphilis, candida), free/subsidised condoms, family planning, immunisation, blood transfusion, eye and dental clinic and rehydration. Some of the above services are good entry points to the COVCT project since they indicate a need for provision of HIV/AIDS related services. However, provision of such services has to be linked to the existing government policy framework.

Community members indicated that if the health unit was constructed, they would benefit through reduced child mortality, increased savings due to reduced distance and thus improved nutritional status, increased productivity, planning for their families resulting

from knowing about their HIV status and accessing family planning services. In addition, some community members would gain skills since some would be trained as counsellors.

CHAPTER FOUR: CONCLUSIONS AND RECOMMENDATIONS

The needs assessment results show that the feasibility of establishing the COVCT project is high. This is because there were no VCT services in the nearby health units thus the project will contribute in filling this gap. Available district statistics show that from 2000-2003 less than 1% of the total population had tested for HIV, indicating low utilisation of HIV testing services in the district. This is attributed to low coverage, facility based constraints, long distance, lack of understanding the importance and benefits of VCT service, and lack of care and support services.

The available VCT services are largely provided in static units with limited outreach activities. Even where the services are provided, they are faced with several problems, namely shortage of skilled counsellors, lack of counselling rooms, which do not ensure confidentiality and inadequate supply of HIV testing kits. In addition, outreach services are severely constrained by lack of facilitation in terms of fuel and allowances.

Despite the above constraints, the willingness to participate in the project was high in both communities and they both had the potential to contribute to and manage the COVCT services. This is based on the assessment of existing collective social initiatives such as support groups and savings associations where community members' participation, contribution and sustainability were very high. However, this potential is affected by low household incomes and savings, limited access and availability of productive resources, gender constraints, and inadequate management and entrepreneur skills. This raises the need for the project design to incorporate innovative ways of strengthening the communities' ability to take lead in 'marketing' the service, contribute to, utilise, manage and enjoy the benefits from the COVCT.

Key Recommendations

In light of the above, we propose the following recommendations that should be incorporated in the design and implementation of the COVCT project in order to ensure community ownership and active participation.

1. **A comprehensive Information, Education and Communication Strategy (IEC)**

The IEC strategy should emphasise the benefits of VCT services for the individual, household and community. The strategy activities should focus on prevention, stigma reduction, care and support, Political commitment and support to the project as these are crucial for the project activities to take off.

2. **Strengthen communities' ability to contribute and utilise the COVCT services**

The recommended intervention that will strengthen communities' ability to contribute and utilise the COVCT services is the promotion of Village Savings and Loans Associations (VS&LA) approach (for details of the methodology, see appendix II). This approach will help members of the community to strengthen their saving capacity, which is currently very low. The VS&LA approach uses the group solidarity model, which mobilises community members into self-selected groups, trains them on how to manage their groups savings and credit operations. The group members are then facilitated to pool their money into a fund from which group members can borrow and pay back with interest, thus allowing the fund to grow. VS&LAs have almost no operating costs, and unlike banks and most micro finance institutions (MFIs) they have no drainage of funds from the group, all the savings and interest paid by the members remain within the group. This model has been tested and found to improve the living conditions of the poor in different parts of Uganda and elsewhere in Africa (see web www.vsla.net). These VS&LAs will be used as platform for dissemination of knowledge and information about VCT services as well as offering psychosocial support since the groups meet regularly.

This model should be supplemented by training of the community to improve their entrepreneur skills. The training should address some of the underlying causes that contribute to increased vulnerability to HIV/AIDS.

3. **Apply a combination of approaches in the delivery of the COVCT services**

AIC should focus on building the capacities of the following community structures to enable them deliver some of the COVCT services.

- Facilitate and build capacity of local councils, religious leaders, TBAs and Traditional healers to become mobilisers, counsellors, and educators as well as monitors of project activities.

- Build the capacity of the existing community support structure such as *Muno mukabi*, *Nigina* and others (*for details, see table 4 in section 2.2.1 of the report)* to provide the neccessary care and support.
- Build the capacity of the existing health structures in terms of skills, equipment and space to enable them provide comprehensive prevention, care and support services. More emphasis should also be put on establishing post test clubs at community levels.
- Establish a strong referral system that links the community with other health services
- Establish strong partnerships with some local CBOs/NGOs that are found in the sub-counties. The partnership approach will increase outreach in terms of scale (numbers) and provide quality services. However, AIC should carry out detailed assessment of potential partners (CBOs and Local government structures) to establish their capacity and partnership needs. This partnership should be clearly defined through a memorandum of understanding (MOU) that details the partnership objectives, obligations, accountability and reporting mechanisms, expected outputs and contribution of each stakeholder in terms of resources.

4. Mainstream gender issues into project activities

The project should involve both men and women as key stakeholders in deciding how the services are organised (timing, frequency, and siting) at the community level and specifically target men through sensitisation in order to increase their appreciation of the importance of VCT including couple dialogue on issues concerning VCT. In addition, the project should establish links and identify mechanisms for collaboration with other HIV/AIDS service providers to share information on effective responses to gender related HIV/AIDS issues as well as creating a referral and networking system to allows monitoring of the coverage and quality of COVCT delivery process.

5. Implement the project in two phases

It was initially envisaged that implementation of the COVCT project would start soon after the needs assessment exercise. However, given the findings and recommendations above, we strongly propose that AIC should revisit the project implementation plan and implementation be done in two phases as explained below.

6. Inception phase: approximately 6 months

In consultation with relevant stakeholders, AIC should:

- Develop a project framework that details the project goal, objectives, expected results, interventions and specific activities, implementation strategy including monitoring and evaluation plan, staffing and project budgets.
- Establish a project implementation and management structure. The structure should include among others, a full time staff that will coordinate and manage the project. This particular staff should have expertise in community development work as well as VCT.
- Invest time and resources in promoting dialogue with the district and the community on the project framework and definition of roles and responsibilities of the different stakeholders. This is will create a shared understanding, appreciation and commitment to the implementation of the project.
- Identify potential partners (CBOs, informal groups and resource persons) that will implement the project together with the community.

The second phase (around 18 months) should be a period when main activities as detailed in the project document will be carried out including monitoring and documentation of the lessons learnt.

REFERENCES

Kayunga District Local Government (2004) District Three-Year Development Plan 2004/2007.

Concept Paper on AIC's Pilot Project on Community Owned VCT.

Family Health International (2002) A Guide to Establishing Voluntary Counselling and Testing Services for HIV.

APPENDICES

Appendix I: Team Composition

The needs assessment was lead by two core consultants, namely Grace Majara Kibombo and Juliet Kanyesigye. They were supported by the following AIC and Kayunga District staff as team members:

1. Florence Mahoro
2. Rebecca Mukasa
3. Beatrice Bhanji
4. Crescent Tirinawe
5. John Tsekoko
6. Ruth Tinka
7. Yusuf Salim Giduno
8. James Rwebikire
9. Benedict Lubega
10. Mubanda Senoga

Appendix II: Key District and Sub county HIV/AIDS institutions

Institutions	Activities	Opportunities for the COVCT project	Limitations
Kayunga Hospital – District based	• VCT services • ARTs • Treatment of opportunistic infections • Houses projects like MUK Walter Reed, and Child Advocacy International that focus on HIV/AIDS.	• Referral for ARTs • Support outreach activities • Technical support such as training using the existing resource persons	• Transport costs • The available ARVs can only serve 100 and yet the demand is high • Unreliability of condoms and other supplies such as testing kits • Understaffing
DHAC (District HIV/AIDS Committee	• Coordinates HIV/AIDS activities in the district, • Appraises, monitors and supervises the CHAI groups	• Supervision and coordination • Technical advice • Monitoring	• Lack of funds • High demand for financial support but district has limited capacity
CHAI	• Provides care and support services through sub projects at community level • Targets orphans, widows and PLWAS. • Use drama and testimonies	CHAI groups can be used to integrate in VCT services	Do not operate in the two sub counties
Walter Reed Project	• VCT services (HIV testing, provide kits) • Provide counselors and train staff in counseling • Vaccine trial and laboratory support • Provide ARVs • Prevention, control and support to PLWAS within their cohort	Technical assistance using the existing staff	• It is a research based project raising concerns of sustainability • Mobilization strategy attaches monetary incentives for clients
Child Advocacy International	Targets HIV/AIDS positive children through • Nutritional, medical (including ARVs to 75 children) and psychosocial support • Educational support • VCT services to the children	• ARVs for children • Care and support service for children	• Target only children • Outreach is limited
AIC-Jinja branch	• Set up static units (Kangulumira health unit) • Supplies testing kits, • Provides outreach • Training of counselors	• Outreach services • Technical support i.e. training • Supply of kits	Support static units which are distant

Institutions	Activities	Opportunities for the COVCT project	Limitations
Protecting Families against HIV/AIDS (PREFA)	Operates at Kangulumira health unit focusing on • PMTCT, HIV/AIDS sensitization • Training counselors (5 staff) and counseling aides • Referrals for ARVs for pregnant mothers.	PMTCT services therefore good opportunity for linkages	It is relatively new and outreach is limited
Programme For Enhancing Adolescent Reproductive Life	Programme under Ministry of Gender, Labour and Social Development. • Promotes safe living for young people in Kayonza, Galilaya, Kayunga and Kangulumira, • Mobilization and sensitization through games and drama • Distribution of condoms • Counseling • Train peer mobilisers and parent educators • Refer youth for VCT and treatment of STIs, .	• Youth groups are channels for dissemination of information • Promotion of condoms	Target specific i.e. youth
FARE ministries	Operates in Nakyesa, Kavule, Namatagona and Kika • Focus on sensitization and training on care and support • Help to build shelter for the sick • Nutritional support • Gives credit facilities	Linkage to care and support	Do not operate in the proposed project area
Rubaga Youth Development Association (RUDAR)	• Mobilizing people for VCT services by providing transport from Kayinza, Kayunga TC, Busana to Kayunga hospital • Works with Kyamugogo AIDS patients and Kitwe CBOs to distribute condoms	• Mobilization and sensitization • Condom distribution	• Limited coverage
Kayunga Networking for PLWAS	• Facilitates joint planning • Information Sharing	• Care and support • Stigma reduction • Psychosocial support	Lack of relevant skills
National Forum for PLWAS	• Training on will making and positive living	• Stigma reduction • Mobilization and sensitization	
Nakabango AIDS Patients Support-CBO	Operates in Kayonza sub-county • Mobilization of people for HIV testing • Home visits • Provision of food and drugs (herbal medicine) to needy orphans,	• Home based care	Inadequate skills and resources

Institutions	Activities	Opportunities for the COVCT project	Limitations
Kitwe Charity Initiative Orphanage and Orphans	Operates in Kayonza sub-county • Education support to orphans, currently supports 130 orphans (70 boys and 60 girls), • Engage in IGAs to raise income to support the orphanage • Lead agency for Global Fund in five parishes • Mobilizes clients for VCT.	• Implementation of economic activities • Care and support services	Limited resources
Kangulumira Integrated- and SPENCON	• Mobilizes people for VCT services	• Mobilization	
Community level (Nyondo and Kakoola	No services		

Appendix III: List of Community Problems

Priority Problems for Kakola Village

Priority problem	Women	Men	Female youth	Male youth	Total Score	Rank
Lack of health unit	3	3	6	5	17	1
Unemployment	-	-	-	2	2	8
Lack of training and sensitisation	2	5	-	5	12	2
Poverty	2	2	-	3	7	5
Bad roads	3	2	3	2	10	3
Lack of markets	-	-	-	1	1	9
Diseases	-	-	-	3	3	7
Water shortage	6	6	5	-	17	1
Lack of secondary school	4	3	1	-	8	4
HIV/AIDS treatment	-	-	5	-	5	6
Vocational school	-	-	2	-	2	8
Transport	1	-	-	-	1	9

Priority Problems for Nyondo Village

Priority problem	Women	Men	Female youth	Male youth	Total Score	Rank
Lack of health unit	4	6	7	5	22	1
Lack of VCT services	-	4	-	-	4	7
Poverty/low income	2	1	-	-	3	8
Bad roads	2	5	7	-	14	3
Lack of safe water	2	3	7	4	16	2
Lack of secondary school	2	-	-	3	5	6
Lack of transport	-	2	7	1	10	4
Modern farming	-	-		2	2	9
Lack of sensitisation	-	2	6	-	8	5