Contextual barriers, motivations, and coping strategies in the uptake of HCT and condoms among fisherfolk in a fish landing site in Busia District

Findings of a Rapid Qualitative Assessment

December 2014

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Communication for Healthy Communities (CHC) is a USAID-funded project implemented by FHI360 and its partner, Uganda Health Marketing Group (UHMG).

Communication for Healthy Communities

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CONTENTS

ACRONYMS

ARV	Anti-retroviral
CHC:	Communication for Healthy Communities
FGD	Focus Group Discussion
FSW	Female Sex Worker
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
IP	Implementing Partner
LQAS	Lot Quality Assurance Sampling
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
USG	United States Government

SUMMARY

Background: High risk taking behaviors including multiple concurrent partnerships and low uptake of condom and HCT (HIV counseling and testing) have been widely documented in fishing communities. However, certain fisherfolk in the same circumstances somewhat manage to maintain positively deviant behaviors. This report highlights the findings of a rapid qualitative assessment to understand characteristics and coping strategies in the uptake of HIV preventive measures including HCT services and condom use among fisherfolk in Majanji, Busia District.

Methods: Focus group discussions (FGD) were used to explore normative perceptions about HCT and condom use among male and female fisherfolk aged 18-49 years, regardless of their personal HCT or condom uptake status. In-depth interviews (IDI) were used to explore characteristics and motivations for fisherfolk reporting HCT uptake and condom use at last sex. Analytical review of the data was iterative, involving a search for themes and patterns in factors reinforcing behaviors, particularly among positive deviants.

Results: Eighteen participants overall participated. There appeared general awareness of HCT services and condom use. However, participants highlighted limited access to up-to-date HIV information. Provider communication of HCT test results reportedly poor, and there was mistrust of HCT results from outreach services. The subsequent misconceptions and ambivalence about HCT and condom uptake were exacerbated by generalized assumed HIV-positive status and reduced fear of HIV attributed to availability of anti-retrovirals (ARV).

The assessment highlighted gaps in women's perception of risk: 1) inclination towards non-condom use in 'quickie' sex, 2) periodic abstinence following suspected partner infidelity, and 3) imbalanced fear of pregnancy versus HIV. Women also appeared to assume responsibility for protection lay mainly with a man—after all, the main protective measure is a male condom which a man could either refuse or agree to wear.

Fisherfolk who had taken up HCT and/or condom use did not necessarily rule out multiple concurrent partnerships or alcohol consumption. The resonating theme among them was responsible enjoyment and taking charge of one's personal protection, which included 1) keeping one's life goals in focus such as staying in good health for the benefit of spousal and/or parental obligations, 2) avoiding compromised judgment by limiting alcohol intake, and 3) anticipating and preparing for sex by always having condoms at hand [both at home and when going out]. They were open to dialogue about HIV prevention and underscored the role of skills for disclosure as a critical step to encourage HCT uptake.

Conclusions: The findings concur with literature on HIV risk behaviors in fishing communities. Additional insight on the coping strategies of fisherfolk who have taken up preventive services highlights opportunities for SBCC. Consistent supply of up-to-date information is needed,

especially targeted on addressing misconceptions about 1) available HCT services and 2) the extent of exposure that puts one to risk.

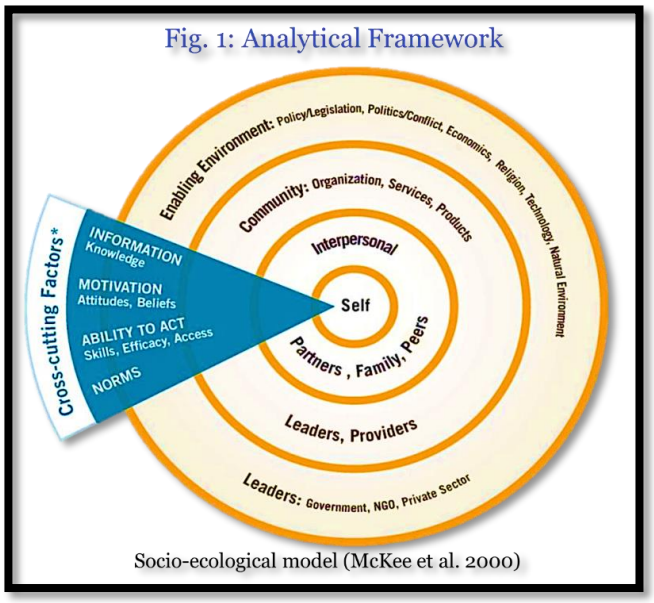
SBCC interventions should also facilitate identification of personal goals and support matching these with practical do-able actions to support uptake of prevention. Gender and social norms interventions should especially target women and young persons. For women, interventions should aid recognition and reflection on shared responsibilities for protected sex, plus negotiation skills. Interventions targeting young people should aim especially to break the vicious cycle of perceptions that fisherfolk lifestyle is synonymous with uncontrollable libido, alcohol, and generalized sexual liberalism.

1. INTRODUCTION

An assessment by the Food and Agriculture Organization of the United Nations (FAO) in 1991 (http://www.fao.org/docrep/006/AD150E/AD150E01.htm) estimated Uganda's fishing community population at 130,000. Fisherfolk are highly mobile – a key coping strategy to overcome the unpredictable, cash based nature of the fishing industry. This mobility has major implications for public health attempts to stem the spread of HIV, including limited access to comprehensive HIV/AIDS information and/or services. Although HIV/AIDS knowledge appears high across population groups in Uganda, comprehensive HIV knowledge among fisherfolk is estimated at 45.8 percent and 48.8 percent among women and men respectively. Early sexual debut and multiple concurrent partnerships are common. The mean age at first sexual intercourse among women on fishing landing beaches is estimated at 15.4 years, while for men is about 16.2 years. Keeping a regular [often marital] partner while at the same time engaging in sex [mostly transactional] with non-marital or non-cohabiting partners is common among fisherfolk. However, condom use at last sexual intercourse is low, estimated at 26 percent. Barriers to condom use include dislike for condoms, high alcohol consumption, and difficulty negotiating condom use [in transactional sex and among regular partners with known MCP] (Allison & Seeley, 2004, Asiki et al., 2011; Opio et al., 2013; Tumwesigye et al., 2012).

2. PROBLEM STATEMENT AND CONCEPTUAL FRAMEWORK

Barriers to the uptake of HIV prevention measures among key populations including fisherfolk have been widely documented. Evidence highlights the role of misinformation, stigma, and discrimination, and a vicious cycle of high HIV risk-taking behaviors (MacLachlan et al., 2002; Kher, 2008; Ugarte et al., 2013).



To add to the evidence base of fishing communities in Uganda (Karukuza & Bob, 2005; Opio et al., 2013; Asiki et al., 2011; Tumwesigye et al., 2012), this paper describes an exploratory rapid qualitative assessment focused on coping strategies among positive deviants,[¥] i.e., persons reporting condom use at last sex and knowledge of their HIV status. This information is critical to identifying potential tipping points for tailoring social and behavior change communication (SBCC). The

[*] The premise of the assessment was that certain fisherfolk in the same circumstances somewhat manage to maintain positively deviant behaviors, hence the need to understand their peculiar characteristics and potential lessons for SBCC.

assessment and data interpretation were guided by the Socio-Ecological Model (Fig. 1) and CHC's theory of change (Appendix 1).

3. OBJECTIVES

The general objective was to document specific barriers for fisherfolk and more closely examine the role that these barriers play in the process of health and care-seeking decisions and behaviors specific to HIV prevention, i.e., HCT and condom use.

The specific objectives were:

1. To document barriers (technical, social, gender-related, fears, misconceptions and/or misinformation) and perceived benefits of HCT and condom use among fisherfolk in general i.e. non-adopters and adopters of HCT and condom use, and

2. To explore characteristics, decision-making factors, coping strategies and processes among current fisherfolk who are adopters of HCT services and condom use.

4. DESIGN AND METHODS

4.1. Study population

We purposively selected an ethnically mixed fishing community in Busia district,♦ with priority on catchment areas of public health services supported by USG implementing partners.♣ Maduwa landing site was selected in consultation with USG IPs in Busia district. The study population comprised of adult male and female individuals, aged 18-35 years and residing in Maduwa landing site—henceforth called male or female fisherfolk.♠

4.2. Methods

This exploratory study deployed FGDs and IDIs. Participants for specific objective 1 were comprised of male and female fisherfolk, regardless of whether they were current non-adopters or adopters of HCT and/or condom use. An FGD guide was used to explore their normative

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♦ Busia District was selected based on insight from LQAS 2013 draft report that indicated low uptake of HCT and condom use, particularly among key populations in hotspots around night entertainment joints and fish landing sites.

♣ To minimize discussions centering on non-availability of services (fixed or mobile) and instead focus the study to the research questions (i.e., non-access related barriers), we prioritized areas supported by USG IPs and assumed to have readily accessible services and complementary SBCC programs.

♠ Reference to male fisherfolk in this report includes: 1) a fisherman, or 2) an adult or young adult male working/residing on the landing site although not necessarily a fisherman. Female fisherfolk refers to: 1) a wife of a fisherman, 2) an adult or young adult woman working/residing on the landing site though not necessarily married to a fisherman, or 3) female sex workers residing and selling sex on the landing site.

perceptions about factors affecting uptake of HCT and condom use among fellow fisherfolk on Maduwa landing site and its environs. Sex homogeneity was observed in the deployment of FGDs.

Interviews commenced with FGDs to provide a starting point for sampling participants for IDIs. Specifically, during FGD sessions, we collected participant demographic profiles including age, duration in fishing community as a (spouse, sex worker, fisherman, fish trader, or other occupation), condom use at last sex, knowledge of own HIV status, and pregnancy prevention practices. Potential participants for IDI were identified from these FGD demographic profiling sheets and asked whether they would be interested in participating in the IDIs.

IDIs were deployed specifically for objective 2, prioritizing male and female fisherfolk identified through FGDs as potentially in the adopter category for HCT (ever taken an HIV test AND collected/knows test results) and/or used condom at last sex. Snowballing technique was used to identify additional participants, i.e., we asked these initial respondents to direct the study team to other 'adopters' that were known to them.

4.3. Data collection

Data was collected by three trained and experienced interviewers—two female and one male. CHC staff provided support supervision at the beginning and midway into data collection. An FGD guide was used to document socio-demographics and explore sexual relationships, condom use barriers and motivations, sources of HIV/AIDS information, HIV/AIDS risk perception, HCT barriers and motivations, pregnancy prevention, access to information and services and barriers. An IDI guide covering the same discussion topics was used to explore characteristics of 'adopters' of condom use and HCT among fisherfolk including their motivations and coping strategies for avoiding HIV risk behaviors. As highlighted in participant recruitment above, data collection began with FGDs after which FGDs and IDIs ran concurrently.

4.4. Data analysis

Analytical review of the data was done using a flexible, interactive process involving a search for patterns and concepts emerging from the data. A code book was developed from key cross-cutting themes in the Socio-Ecological Model (see Fig. 1) and patterns that emerged from the dataset. Data was coded using qualitative software that enabled the cross-classification and retrieval of transcripts and segments of text by theme. The themes and interpretations were reviewed, discrepancies and contradictions were discussed with the data transcription and coding team, and relevant supporting verbatim quotes were systematically abstracted from the transcripts.

4.5. Ethical Considerations

This assessment included slightly greater than minimal risk to participants. All study staff completed training in human subjects' protection. Also, as condom use and sexual behavior are very personal and some people may not want to talk openly about them, strategies for obtaining information without causing offense were emphasized. During field work, all interviewers followed standard international research ethics requirements for protection of human subjects. All study participants were informed at the recruitment point about project

goals and their rights: to refuse being interviewed, to interrupt the conversation at any time, and to withdraw any information they provided during or after the interview. Oral informed consent was obtained from each participant. In accordance with the July 2014 Uganda National Council for Science and Technology (UNCST) guidelines (UNCST, 2014: 21-22), participants were given a flat rate cash token in appreciation of their participation in the interviews.

4.6. Limitations of the study

This qualitative assessment was conducted in one location only. The findings may be context specific and their interpretation and use must take cognizance of this factor. However, this study generated insight on peculiar coping strategies of male and female fisherfolk who are effectively able to take up HCT and/or use condoms in an environment characterized by widespread deviant health behaviors.

5. RESULTS

5.1. Socio-demographic characteristics of participants

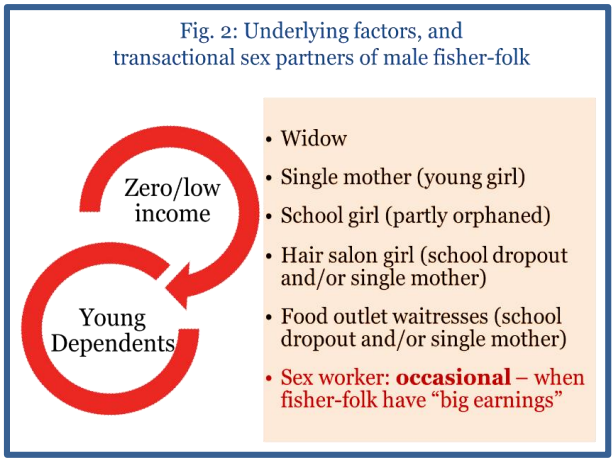
Table 1 summarizes demographic characteristics of 18 female and male participants who took part in FGDs and IDIs. More female participants took part in the assessment, attributed to male fisherfolk being at rest during the day time. Participants were aged 20-39 years, and the majority had attained up to senior four level of education. Most participants were married. Most had resided on the landing site for between 5 - 10 years, and only four had lived there consecutively for 16 years or more.

Table 1: Participants' characteristics	N=18
Sex	
Female	12
Male	6
Age	
18-19	1
20-29	8
30-39	9
Education level	
P1-P7	6
S1-S4	11
Marital status	
Single	2
Married	15
Widowed	1
Duration of residence in the landing site	
5-10 years	8
11-15 years	1
16+ years	4

5.2. Transactional sex partners of male fisherfolk, and underlying factors

Figure 2 highlights the common transactional sex partners of male fisherfolk, and key underlying mutually intervening factors including zero or low income, and having immediate dependents. Male fisherfolk mainly engaged in transactional sex with women ranging from young school age girls to adult women (widows or wives of fellow fishermen) who are apparently struggling to make ends meet.

Fig. 2: Underlying factors, and transactional sex partners of male fisher-folk



"…as for the school girls…mostly those that live here, but the majority are widows. Many others have not studied at all…some came to work in hotels…and then we get them from there…"-Male fisherfolk in FGD

"…yes…you find they have problems…and has not even earned 50 shillings…then why wouldn't she end up with you and at least you give her 10,000?...why wouldn't she accept?…we find them in such circumstances…amidst their problems." -Male fisherfolk in FGD

Often, women (mostly widowed) who commonly purchased fish on credit from fishermen ended up in debt. The woman then became easier to lure into sex. Depending on the interest of the fisherman, the arrangement may gradually develop into a common 'friendship' activity, or an option for settlement of debts.

> *"We fishermen have many ways of trapping women just as my brothers have said…there is a woman who can just come as a new person in the area…I can even deceive her like this; I will be giving you fish [on credit] as we record the amount of money you owe me...this is a loan. However, after that…when time comes for you to pick your money…the woman may realize that the money she owes you is too much [she cannot afford to pay back]. If for instance the money was UGX 50,000…I will tell her [pretending to be nice]; Why don't you deduct that UGX 20,000 and I take UGX 30,000…now as a woman…she will end up softening at heart and she will feel this man is so good and was the first to help me…indeed once you try luring her…she can't say no…"* Male fisherfolk in FGD

Fishermen also enticed school age girls from struggling homes (where the girl was an orphan) by giving them gifts in the form of cash or fish. Widows may also indirectly push their daughters to transactional sex to help support the family.

> *"…these girl children* [school age]*…you know we…here in Uganda, especially in Majanji…many children have lost their fathers and remain with their mothers…now that child…the mother does not have adequate means of taking care of the children…so the mother can send the child; go to Luwengo and take what...take food...go to the lake and fetch what...water, go to the landing site and bring what...fish. She sends her with an intention because she has no resources…and yet she sees her daughter is grown up…in case she*

gets someone [a sex partner/ provider] *she can be supported a little…and at least the younger children will remain being helped with something little for food…*" -Male fisherfolk in FGD

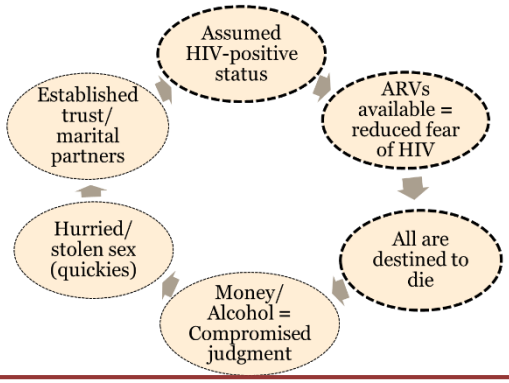
Transactional sex was seasonal, depending on cash flow. Similarly, female sex workers were at a higher level, and only occasionally accessible when fisherfolk had made big earnings.

"*…as we said already…we fisherfolk…we have seasons…we carry out even that activity* [transactional sex] *in seasons. During the catch season we have money…when you have money you have to spend it…even on that…female sex workers…So when season get off…and also your money becomes little…you can't proceed as how you were earning…*" -Male fisherfolk in FGD

5.3. Barriers to condom use

Figure 3 highlights a range of underlying factors for unprotected sex. Perceptions of pre-assumed HIV-positive status among the majority of fisherfolk and reduced fear of HIV attributed to the availability of ARVs were particularly prominent. These heightened a fatalistic attitude that all humans are destined to die, anyway. Condom use was also affected by compromised judgment linked to 1) ready access to money resulting in, 2) a carefree lifestyle of alcohol consumption and women, and 3) hurried/stolen sex, i.e., quickies. These are discussed in detail below.

Fig. 3: Factors driving un-protected sex



5.3.1. Reduced fear of HIV linked to availability of ARVs

Noting that the decline in preventive sexual behaviors, including condom use, was common among both men and women, participants attributed these behaviors to widespread perceptions that AIDS was less threatening because ARVs are available.

"*…as he has said…the condoms are available…but we fishermen believe that AIDS does not kill nowadays…and they have brought us medicine* [ARVs] *and we take…therefore we just have sex without thinking of protection*." Male fisherfolk in FGD

"…they don't care about using condoms...they are now saying that there is medicine for AIDS, and that HIV is now nothing [to worry about]…they say; *I will be taking tablets* [ARVs] *and I will survive."* Female fisherfolk in FGD

When responding to questions about their risk perception, participants cited students, especially young adolescent males aged 13-18 years, among the population groups most at risk of getting HIV. In this case, a reverse circumstance was noted—a young male is the client of an older female. However, the practice was blamed on high libido apparently caused by fish consumption. There was no suggestion of an economic link. It is possible as well that young

adult males cannot attract girls in their age group because they [boys] may not have the resources to entertain and/or maintain them.

> "*People who are at high risk are children* [adolescent boys] *between the ages of 13 to 18 years; they love women so much...most of them are students because like I told you that fish causes us problems* [high libido]*, so those young boys love women so much…they go to women whose ages are more than theirs."* -Male fisherfolk in FGD

5.3.2. Negative effect of knowledge of one's HIV status

Knowing one's HIV status had pros and cons around efforts to manage the spread of HIV. HIV-negative test results often encouraged condom use. However, it is not uncommon to find people in multiple and concurrent sexual partnerships who assume that their partner is 'safe to go with unprotected' simply because of their HIV-negative status.

> "*Many* [of my friends] *are using condoms. Now the person who doesn't use condoms is one who got tested and knows that they are HIV positive*." -Male fisherfolk in IDI

> *"…however there is another one who has not taken any alcohol and is still cautious* [early in a relationship] *and he calculates that at least I should do what…I should use a condom…until am sure of this woman's health status before I do what…"* -Male fisherfolk in IDI

HIV-positive results may increase high risk sex.

> *"You see fishermen can have three women at a go or have one apart from his wife. Others are infected with HIV so they want to kill others…so we have people like that."* -Male fisherfolk in FGD

These findings point to a need to revisit the value of knowing one's HIV status, especially during outreach sensitization campaigns and pre/post-test counseling.

5.3.3. Complex mix of trust, presumed HIV-negative/positive status, and fatalistic attitudes.

Condom use reportedly diminished as transactional sex partners became more acquainted with one another. The ensuing trust relationship resulted in an assumption that they were safe with each other, not taking into cognizance that 1) there may be other partners, and 2) the HIV status is mostly assumed rather than confirmed through HCT.

> "*It is very risky with these women…it is not easy to maintain condom use; she will have sex* [using a condom] *on the first and second encounters. At the third encounter they say to each other; you know I love you so much...I am not sick and I have proved* [assumption based on good physical status] *that you are also not sick. This is what I know...someone can't lie that they can use a condom with their partners from the start till the end. Yet they have even as many as five different partners."* Male fisherfolk in FGD

Yet again some fisherfolk reportedly assumed they were already HIV-positive, based on the widespread practice of unprotected sex with multiple and concurrent partners. This thinking exacerbated risk behaviors and fatalistic attitudes linked to arguments that every human being is destined to die.

"…In addition to that they often say that HIV came to kill people, it never came to kill dogs or what; it [death] *is ours* [every man's destiny] *when time comes, we will go*." -Male fisherfolk in FGD

"I fell ill at one time and I told my husband; please go for an HIV test. He asked me to go alone and test if I want. He said; do you think that if you don't have HIV you will not die?" -Married female fisherfolk in FGD

This 'destined to die' argument was also used by deviant peers who tried to discourage people in their circles who appeared to adopt condom use (albeit for other motives such as pregnancy prevention, with obvious unintended benefits for HIV prevention).

"*Now like me, I have a friend who asked me that how is it that you have never become pregnant? I said that I use a condom and she told me that the condoms will bring infections to you because it is lubricated…that I will get infections as a result of the lubricant from the condom…then she added that: you are still fearing that virus...everyone is dead already, you remain there alone*" -Female fisherfolk in IDI

5.3.4. Gaps in women's perception of risk and control

Three themes emerged that highlighted a critical need for SBCC programs to inform women's perceptions of HIV risk: 1) non-condom use in 'quickie sex', 2) periodic abstinence when a spouse was suspected of having been unfaithful, and 3) imbalance between fear of pregnancy and fear of HIV.

Male fisherfolk may have intentions for condom use, but the female partner declines, citing need to hurry up lest they be caught. In this instance, the suggestion is that it takes time to wear a condom. Although our interviewers did not probe, the verbatim remark below suggests a likelihood for the woman to demand protected sex when in a relaxed and 'more private' space.

"*…you get a woman and then you move somewhere just here* [in the neighborhood] *and she says…aahhh...we are pressed for time and they might catch us...just do like this* [without condom]*... so that we finish very fast. Other times you have gone to someone's wife* [for pre-arranged sex]*…and she says; there is no time* [to wear a condom]*...do it fast. The thing is that if you have got a lady…it is only if you have gone to Busia or you have taken her to a private room that you can comfortably wear a condom and have protected sex. She will say; please put on [a condom] and you will also say ok*." -Male fisherfolk in FGD

On the other hand, some married women with spouses known to be unfaithful appeared to practice abstinence for a given period after which they may resume normal conjugal responsibilities [unprotected sex] with their husband.

"When I look at what my husband does…things that I think may cause me risk [drinking, women]*; I sometimes take a month or two without having sex with him*" -Married female fisherfolk in IDI

Fear of pregnancy appeared to outweigh fear of HIV as reported by women who operated as sex workers on the fish landing site. When asked whose responsibility it was to ensure condom use, these women appeared to assume that their responsibility lay with avoiding a pregnancy, while HIV prevention, including condom use decisions, was the preserve of men.

> *"Others fear getting pregnant not HIV, when they suspect that they will get pregnant they use a condom"* -Female fisherfolk in FGD

> *"It is the man to use the condom because you may be in the house or when you are on family planning, he is the one to use the condom or when you are aware that you have HIV…still he is the one to use a condom whenever you have sexual intercourse."* -Female fisherfolk in FGD

These three scenarios point to a critical need for SBCC programs to understand and address women's perceptions of risk and shared spousal/partner responsibilities for HIV prevention.

Occasional unprotected sex could result from several situations. The sex partners may already be in a room and aroused for sex, yet neither of them carried condoms. Additionally, alcohol consumption sometimes compromised judgment.

> *…ok…you realize there is need of using a condom…but they are not available* [both of you did not carry any] *and yet you have wanted her…and where you have gone they are far to buy a condom or you forgot to purchase a condom…You will just have sex…then when you finish you come to your senses [you have had unprotected sex]…so you first wait for one month…and then you go to the health centre for HIV testing…* -Male fisherfolk in FGD

> *…you may be saying; aahh...no matter what may happen, I will use a condom till the end…now in case he has taken some alcohol…you know when you consume alcohol you reach there…you can even reach at…at…in the bed and you start your romance …and then you may feel; aahhh...I just want to have sex right away...no time to bother with condoms…* -Male fisherfolk in FGD

In other instances, unintended unprotected sex resulted from technical issues with condom use, particularly where a male partner is rough. This limits women's self-protection options that a female condom may offer.

> "*…we are saying that because that female condom if you get a rough person it enters inside or it goes on one side and when it goes on one side, there is no prevention; you will have had unprotected sex. That is why we have spoken about that* [female] *condom. It is not that easy to use."* -Female fisherfolk in FGD

5.3.5. Condom negotiation dilemma for married female fisherfolk

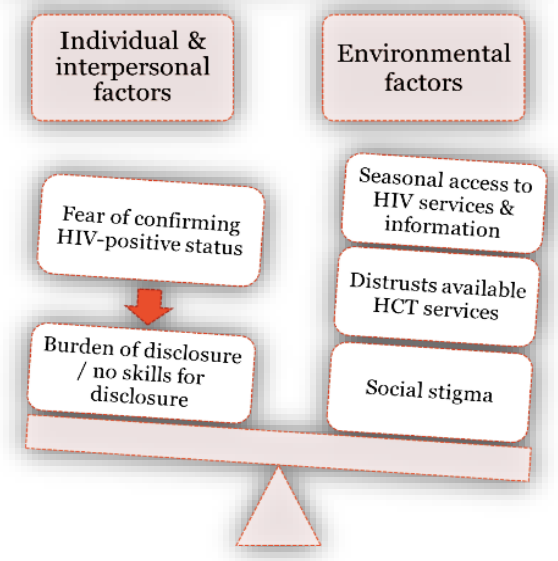
The perception that condoms are only reserved for use in extra-marital relationships left the majority of married female fisherfolk with limited options to negotiate safe sex with their husbands who may openly have other sex partners.

"I think about using a condom but my partner does not like it…he says; a housewife doesn't use a condom. Only outside women [casual sex partners] *use a condom."* -Female fisherfolk in IDI

5.4. Barriers to HIV Counseling and Testing

Participants cited perceived barriers to testing for HIV and knowing one's HIV status [by collecting test results] to several factors, mainly linked to: 1) limited access to HIV information and services, 2) perceived efficiency of available HCT services, and 3) the burden of disclosure of HIV status, exacerbated by lack of skills for disclosure. These are summarized in Fig. 4.

Fig. 4: Reluctance to test for HIV



5.4.1. Limitations linked to health services

- *Limited access to sexual and reproductive health information*

Participants observed that HIV prevention information services are mainly posted and/or available at health centers, with the suggestion that the nearest is located as far as 22 km away. The implication is that fisherfolk may have limited access to consistent and up-to-date sexuality and/or HIV information.

"There are no posters and I have not heard of any issues that there are programs that sensitize people…we don't have. Another challenge is that the health center is very far from here and there are no nurses…so if you want information about sexual issues you have to go to Lumino which is 22kms from here." -Male fisherfolk in IDI.

- *Structural and technical gaps in HCT services*

Participants noted that HCT services are available, but the extent they may be used depends on their perceived efficiency. Long queues and/or waiting time, especially at health centers, were

particularly prohibitive to these presumably busy fisherfolk. To be effective, outreach services should also not be hurried.

> "*To improve our services we need to put aside one to two weeks for you to come* [bring outreach services] *here at the fishing landing site so that you test people. If you go to Majanji at times there are so many people and other people say (clicking his tongue)... aaah...let me just go and do my work...I will be in the queue till what time!"* -Male fisherfolk in IDI

Suggestions of technical gaps in outreach HCT services emerged, including failure of service providers to actually communicate test results to clients. Instead, they reportedly simply delivered the test result slip to their client without discussing its meaning.

> *"They* [HCT services] *are near because at times they come* [outreach services] *and others go to Masafu. But others who come here for testing* [mobile clinics]*, they may give you results and not tell you* [no discussion of the results]. *Somebody remains there thinking that they are negative and when you go to the health worker to ask…they ask you; were you not told [the test result]? You say; no…and you also fear to tell her because the other health workers did not tell her. And she tells you to come back and test on another day…now that person because they fear so much they will not go back to test."* -Male fisherfolk in FGD

There was also the suggestion that people may sometimes be given incorrect test results, especially during outreach HCT services. This caused distrust in HCT kits commonly brought for use during testing on fish landing sites, with many participants suggesting that HCT was a waste of time unless someone travelled to accurate facilities in Entebbe.

> *Those testing kits of theirs* [outreach clinics] *are usually few, they test few people. Also somebody may go knowing very well that they are infected. She is tested and told that she is HIV-negative* [yet she is on ARVs at the time] *so she goes away and other men get irritated and they beat her up one day saying; I am infected and they deceive* [gave false results]." -Female fisherfolk in IDI

> *"When they came here to test us, everybody would be found to be negative but these testing kit that they use for testing blood; are they genuine because they say that the actual testing kits are in Entebbe...the ones that give results whether you have HIV or not."*
> -Female fisherfolk in FGD

5.4.2. Fear of knowing personal HIV status

Reluctance to take HCT was attributed to four interlinked factors;

1. Widespread risk sex behaviors
2. Widespread perceptions that nearly everyone was already HIV positive
3. Apparent fear of confirming an HIV-positive status, and
4. The subsequent concern about worrying oneself into premature death.

> *"Another says that I can't go there. I know that am already dead and everybody is going to die...and another is like this/ like that* [has not yet made a decision regarding HCT]*, so mobilizing them is difficult."* -Female fisherfolk in IDI

The distress that potentially comes with the need for disclosure following a confirmed HIV-positive status caused particular concern, especially because both disclosure and failure to disclose could result in other undesirable social consequences; for example, loss of sex clients as highlighted in the verbatim quote below.

> *"Most of them don't go...they fear. They* [outreach/ mobile HCT] *used to come here… but you hear somebody saying; I don't want to get pressure* [distress from confirmed HIV-positive status]. *Going there and they get me infected that will inconvenience me with my business."* -Female fisherfolk in IDI

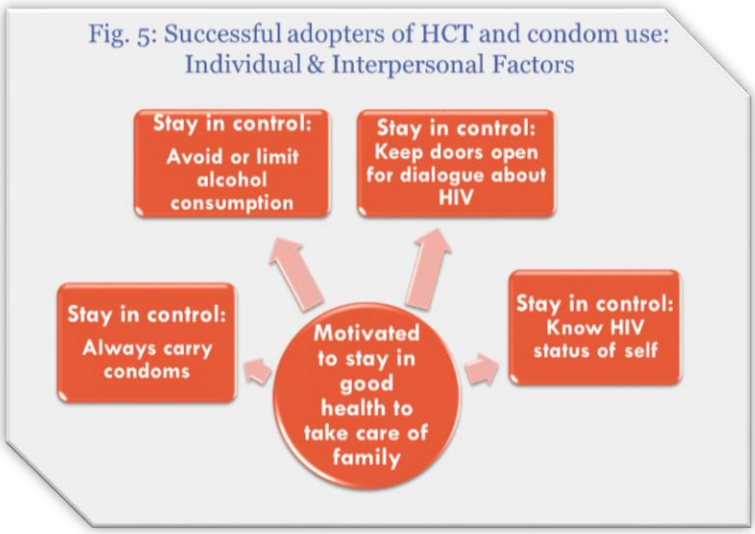
5.4.3. Distress linked to HIV-positive results and disclosure

Reluctance to test was also attributed to limited or no support for disclosure of HIV status, with the suggestion that if people could get such support they may not fear HCT.

> *Just like the way we have talked. Testing can be improved if people are free* [willing and know how to disclose] *about their HIV status…that is, if somebody is HIV-positive…people can say; Oh! Even HIV-positive persons can survive the way so and so is surviving* [successfully living with HIV]! *That can encourage people that they can survive and educate their children. It will help when this project* [CHC] *comes and helps us with such issues.* -Male fisherfolk in FGD

5.5. Coping strategies among adopters of HCT and condom use

The theme that resonated among fisherfolk who had successfully taken up HCT and/or condom use was that responsibility to family outweighed any enjoyment, whether alcohol or sex. While male fisherfolk did not necessarily rule out multiple and concurrent partnerships, they reported that one must act responsibly by remaining in control of every situation, summarized in figure 5, and discussed in detail below.



5.5.1. Responsibility to family

The majority of men and women who had taken up HCT and condom use were married and cited responsibility to family as driving their motivation to stay in good health. The term 'family' was used to refer to one's own spouse and children, with a particular emphasis on being able to parent one's children. There was no direct reference to

other social responsibilities, such as taking care of immediate extended family, e.g., widowed mother or siblings. Desire to protect their family was also conceptualized from the perspective of maintaining a manageable family size, hence openness to condom use with a spouse for birth control, although this was not very common.

> "*If you see a man or woman who accepts to use a condom you will know that he is safeguarding his life…also because he doesn't want to take the virus to his home, to his wife…*" -Male fisherfolk in IDI

> *"You know the thing that makes me to use condoms with my wife...you know I have children and now am a grown up and want my children to go to school. So now I am conscious not to leave my children early* [avoid premature death]*…or to have many children."* -Male fisherfolk in IDI

Participants recognized that HCT is critical to protecting oneself, regardless of whether the test results show HIV-positive or HIV-negative status.

> "…*what makes a person go for testing is that they want to know their HIV status. When you don't know your status you will not know how you are progressing. If you know your health status; if you don't have* [are HIV-negative] *you will know how to protect self, and if you have* [are HIV-positive] *you will know how to continuously care for yourself to manage the virus for you to go on living*." -Male fisherfolk in IDI

5.5.2. Taking charge of one's own protection

Responsibility also came with taking charge of one's own protection, especially by anticipating situations that may compromise one's judgment and taking advance action over them, i.e., always having condoms within reach and avoiding or limiting alcohol intake.

It was important, when going out with a 'friend' of the opposite sex, to anticipate situations and have condoms ready at hand, and not to always rely on the expectation that a potential sex partner will have them. It was suggested that this practice was not a preserve of women. Men also kept condom reserves.

> *"…if I know I am going out I have to keep mine* [condom reserve] *in the bag because you might reach there and the man says that you know I have forgotten. Now the person who is supposed to carry these condoms is both of them, but especially the lady; you know we might reach there and he will say oh, I have forgotten...now what can we do? That is the time I pull out mine* [condoms from my bag] *and give him…" -Female fisherfolk in IDI*

> *"…because that* [using condoms always] *is the thing that they have trained me…many times. Even when we* [because everyone gets the information] *hear that they are distributing condoms; it is a must I will be on the frontline to go and pick…because I know that is the thing that is going to help me…" -Male fisherfolk in IDI*

Our interviews also highlighted that women married to fishermen could effectively negotiate condom use, especially if either one or both spouses were HIV-positive, and had disclosed their HIV status.

> "*The first time I talked to my husband about condoms was a problem. He said he didn't want to use condoms. Are you my friend* [casual sex partner] *so that I use a condom with you? I told him to prevent exchanging the virus. I refused* [sex] *for something like two weeks and he came around on his own and he said; OK, please give me the condom. I picked it and passed it over to him. A condom is a must*." -Female fisherfolk in IDI

While they did not necessarily rule out alcohol consumption, participants in the adopter category noted that one must not get carried away to the extent that they may lose focus on their priorities and commitment to stay in good health for their family.

> "*Those other ones who are at reduced risk are people who think twice…a person who thinks of his home even when he has gone to drink…he tells himself; I have left a family at home and even I have children and those children am their provider…and he is alert…now before he does anything weird…it is a must he will think about his people…he can't mess up* [getting drunk]." -Male fisherfolk in IDI

5.5.3. Open to dialogue on HIV

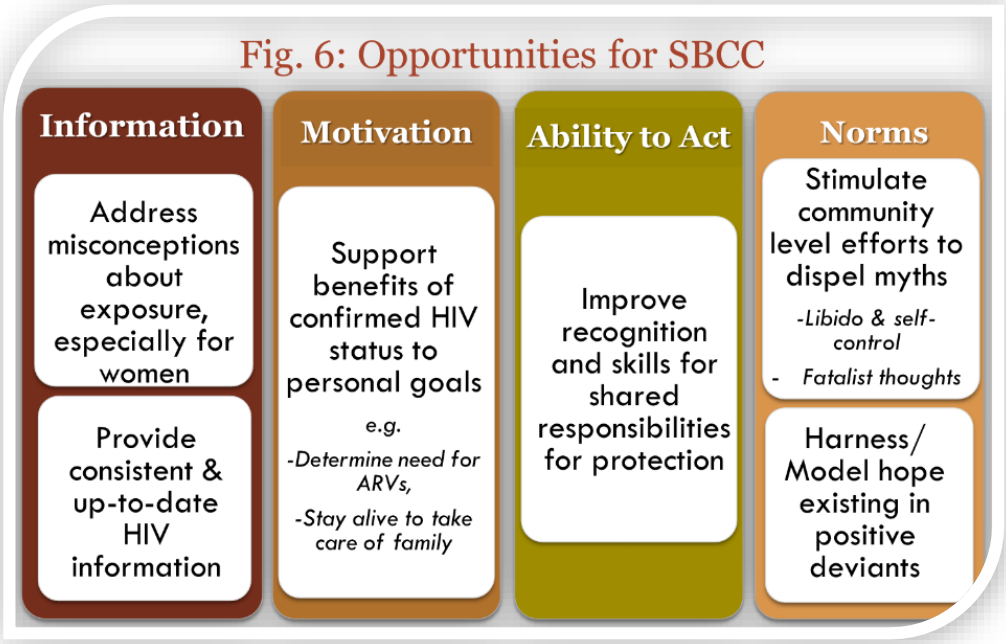
Adopters readily discussed sexual and reproductive health issues with their partners, friends, peers and health workers. They were also inspired to use condoms following testimonies from their peers who are living with HIV.

> *"We always have time when I meet my friends and we can discuss HIV issues, ways we can protect ourselves, things like that…"* -Male fisherfolk in IDI.

> *"I speak without fear; I talk to them, the community members or my friends who I hang with about HIV and condom use."* -Female fisherfolk in IDI

6. OPPORTUNITIES FOR SOCIAL BEHAVIOUR CHANGE AND COMMUNICATION

The opportunities for SBCC are summarized in Fig. 6 from the perspective of four cross-cutting levels of the socio-ecological model including information, motivation, ability to act, and perceived social norms.



Information

Consistent supply of up-to-date information is critical to encourage uptake of HCT and condom use. Information is also needed to address misconceptions about extent of exposure that puts one at risk of HIV; suggested in 1) the likelihood to forego condom use in 'quickie' sex, and 2) tendency to drop condom use with selected partners.

Information is especially needed to address women's understanding of the power of control that often lies with them, but is rarely exercised because of their subjective perceptions of gender and social norms regarding negotiating safe sex. Information is also needed to address misconceptions about the validity of HCT obtained at outreach clinics, although this should be supported by parallel efforts to improve health workers handling and/or counseling skills with patients.

6.1. Motivation

Participants who reported correct and consistent condom use and HCT uptake were mainly motivated by personal responsibility to family. They made calculated decisions including advance anticipation of risk and execution of practical steps (do-able actions), including knowing their HIV status as a first step to protection, maintaining a condom reserve within reach, and limiting alcohol intake. SBCC programs should explore life goals and support matching these with practicable do-able actions to support uptake in the deviant group.

6.2. Ability to act

Open dialogue between peers and partners about HIV is at the center of successful condom use and uptake of HCT. This is particularly important for balancing the fear of dealing with disclosure of a positive HIV test result. Participants cited need for disclosure skills.

Failure to act among women, especially with regard to condom use, was linked to subjective perceptions about whose responsibility it was to initiate condom use. The interviews suggested that many women apparently had power of control, but they rarely recognized this power and left condom use decisions to a male partner's preference. Besides condom negotiation skills, SBCC should engender an understanding among women about the shared responsibilities for protection (of self and partner), plus recognition of the opportunities when they have power of control.

6.3. Norms

A common myth that consumption of fish causing high uncontrollable libido reinforced risk behaviors including multiple and concurrent partnerships and unprotected sex. Fatalistic attitudes also led to high alcohol consumption that exacerbated sexual permissiveness. SBCC interventions targeting these myths and norms should be linked with interventions to explore motivations and identification of practicable action steps towards personal and partner protection.

Gender and social norms interventions targeting young people in fishing communities should especially aim to break the cycle and perception that fisherfolk lifestyle is synonymous with dependence on transactional sex, reckless alcohol intake, and generalized sexual permissiveness.

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APPENDIX 1: CHC CONCEPTUAL FRAMEWORK/THEORY OF CHANGE