# EAC/AMREF LAKE VICTORIA PARTNERSHIP (EALP) PROGRAMME

***"ADDRESSING MOBILITY, VULNERABILITY AND GAPS IN INTEGRATED RESPONSE TO HIV&AIDS IN THE LAKE VICTORIA BASIN"***

# HIV SERO-BEHAVIOURAL STUDY IN AGRICULTURAL PLANTATIONS IN LAKE VICTORIA BASIN, UGANDA

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**Participating study sites**
Kaweri coffee plantation
Kakira Sugar Works
Oil Palm Uganda Ltd.- Kalangala
Tilda Rice Plantation

**EALP Programme Partners**
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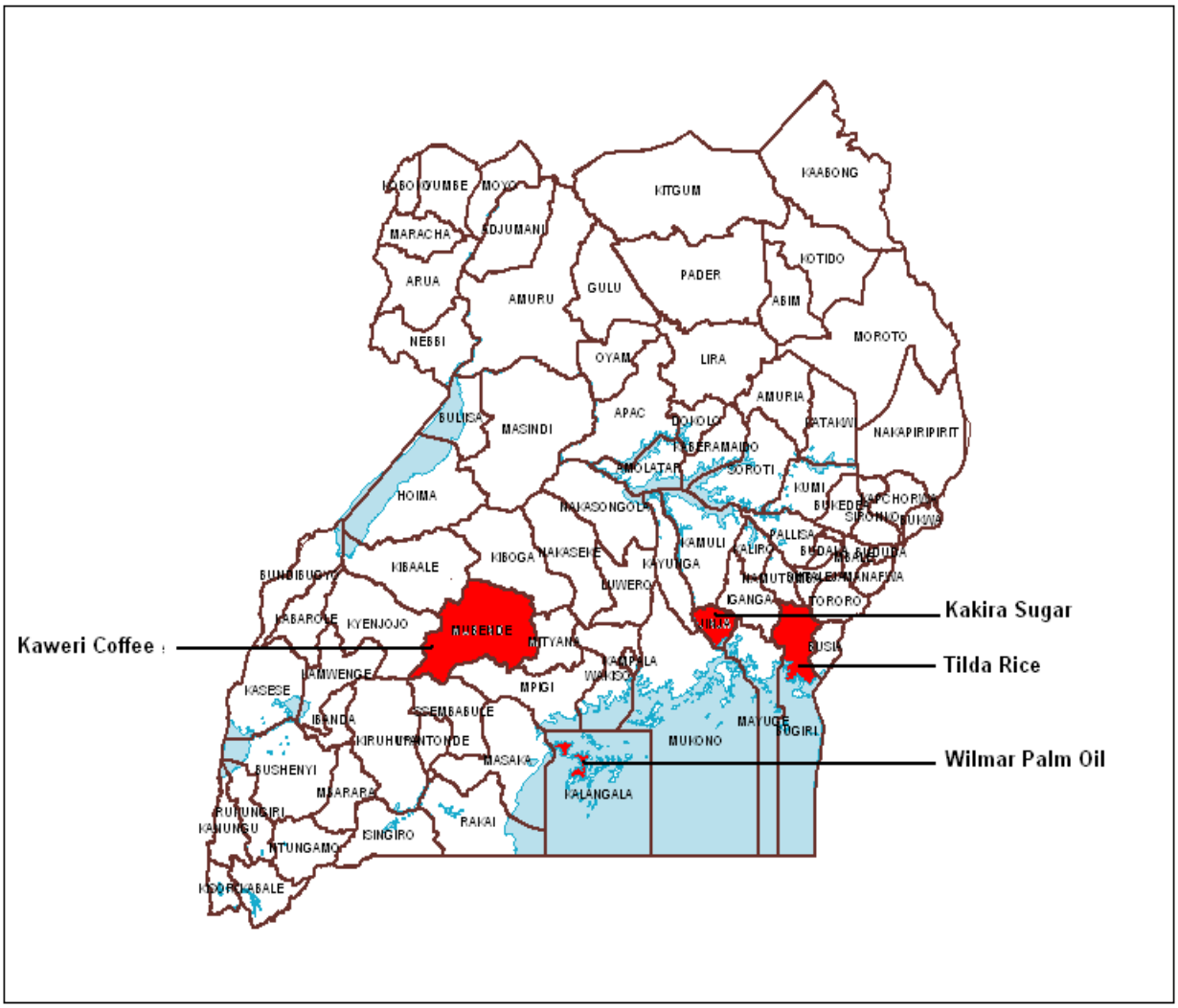



LABEL ON DISTRICT (80)

DISTRICT

LAKES: PERENNIAL

COUNTRY

**DISTRICTS/PLANTATIONS**

| | |
|---|---|
| Bugiri | Tilda Rice |
| Jinja | Kakira Sugar |
| Mubende | Kawere Coffee |
| Kalangala | Wilmar Palm Oil |

One Centimeter = 46 Km

Km 50 100 150 200

# ABBREVIATIONS

| | | |
|---|---|---|
| AMREF | - | African Medical Research Foundation |
| ANC | - | Antenatal clinic |
| ARVs | - | Antiretroviral drugs |
| CBOs | - | Community based organizations |
| CSOs | - | Civil society organizations |
| BMU | - | Beach Management Unit |
| DBS | - | Dry blood spots |
| EAC | - | East Africa Community |
| EALP | - | East Africa Lake Victoria Project |
| EIA | - | Enzyme immunoassay |
| FGDs | - | Focus group discussions |
| HB HCT | - | Home based HIV counseling and testing |
| HCT | - | HIV counseling and testing |
| ID NOs | - | Identification numbers |
| KI | - | Key Informants |
| LC1 | - | Local council 1 |
| LVB | - | Lake Victoria Basin |
| LVBC | - | Lake Victoria Basin Commission |
| LVFO | - | Lake Victoria Fisheries Organization |
| MAAIF | - | Ministry of Agriculture, Animal Industry and Fisheries |
| MOH | - | Ministry of Health |
| MoJCA | - | Ministry of Justice and Constitutional Affaires |
| MoLG | - | Ministry of Local Government |
| MoPS | - | Ministry of Public Service |
| NTT | - | National Technical Team |
| NGOs | - | Non-governmental organizations |
| OIs | - | Opportunistic infections |
| PPS | - | Probability Proportional to Size |
| STI | - | Sexually transmitted infections |
| HIV | - | Human immunodeficiency virus |
| ART | - | Antiretroviral treatment |
| PMTCT | - | Prevention of mother to child transmission |
| STD | - | Sexually transmitted diseases |
| UBOS | - | Uganda Bureau of Statistics |
| UHSBS | - | Uganda HIV Sero-Behavioral Survey |

# EXECUTIVE SUMMARY

## Background, aim and survey methods

The survey was conducted in four agricultural plantations of the Lake Victoria Basin of Uganda between April and May 2010. The main aim was to establish HIV prevalence among plantation workers, the associated drivers of risk and vulnerability; and the effectiveness of HIV and AIDS response.

The survey methods consisted of individual interviews, focus group discussions and key informants interviews. A desk-review was also conducted to document HIV service availability and utilization, as well as institutional policies and structures for the coordination and delivery of HIV services. Laboratory testing for HIV was also conducted both in the field and at central level.

A total 1432 women and men aged 15-59 years were interviewed by four fieldwork teams; of these, 1,072 (75%) are men. About two thirds of the respondents are aged 20-39 years.. Each team consisted of 4 interviewers, 1 counselor, 1 laboratory technician and 1 supervisor. Before the main survey, a pretest was carried out. All respondents provided written consent before the interviews. The survey protocol was approved by the Sicience and Ethics Committee of the Uganda Virus Research Institute; and cleared by the Uganda National Council for Science and Technology. Data was captured using EPIINFO following a double data entry strategy.

## Main findings

About seven percent of the plantation workers are infected with HIV; HIV prevalence among women is higher (13.4%) than among men (4.5%). Of the 4 plantations, Kaweri has the highest HIV prevalence (8.3%) while Tilda has the lowest (5.1%). Across all the 4 plantations, HIV prevalence is highest among widows/widowers (28.6 percent) followed by that among divorced people (14.2 percent). HIV prevalence is highest among respondents with higher number of living children.

Knowledge of single HIV prevention methods is widespread among plantation workers and is similar among women and men. Over three quarters of women (79.2 percent) and more than two thirds of men (68.4 percent) know that HIV can be transmitted from a mother to her child by breastfeeding. About two thirds of the respondents know that there are special drugs (antiretroviral drugs) that a doctor or nurse can give to a pregnant woman infected with the AIDS virus to reduce the risk of transmitting the virus to the baby. Knowledge of at least one source of a condom is widespread; ranging from 77 percent in Tilda to 91 percent in Kaweri.

Misconception about HIV/AIDS is low. About 90% of both women and men know that a healthy-looking person can have the virus that causes AIDS. Much fewer respondents understand that the AIDS virus cannot be transmitted by mosquito bites: 56 percent of women and 60 percent of men know that AIDS cannot be transmitted by mosquito bites. The proportions of women and men who know that people cannot get the AIDS virus by sharing food with a person who has AIDS are 68.6 and 65.2 percent, respectively. The vast majority of plantation workers say that witchcraft is not a means of transmission of HIV, with 81.1 percent of women and 84.4 percent of men saying so.

The majority of respondents have a caring attitude. Over ninety percent of women and men say they would be willing to care for a relative who is sick with AIDS in their own

household. About 77% of respondents agree that a female teacher who has the AIDS virus but is not sick should be allowed to continue teaching in the school. Equally, about 77% of women and men say they would buy sugar or fresh vegetables from a vendor if they knew that he/she is HIV positive. Furthermore, about 48% of women and 63% of men say that if a member of their family got infected with the AIDS virus, they would not necessarily want it to remain a secret. The proportion of women and men who express positive attitudes on all four indicators are 31.5 and 40.4 percent, respectively.

Over 96 percent of the respondents said that they have ever had sex. The median ages at first sex for women and men were 16 and 18 years, respectively. Overall, 37 percent of women and 24.5 percent of men initiated sex before the age of 15 years. Primary abstinence was more common among men (12.9%) than in women (3%). There is a widespread acceptance of the ability of women to negotiate safer sex with their husbands. About 96 percent of women and 92 percent of men agree that a wife is justified in refusing to have sex with her husband if she knows he has a sexually transmitted disease and/or believe that a wife is justified in asking that he uses a condom if she knows that her husband has a sexually transmitted infection. Additionally, some of the respondents who were sexually active in the 12 months preceding the survey engaged in multiple sexual relationships (27.1% of men and 9.1% of women). The mean number of lifetime sexual partners was 6.3 in men compared to 3.2 in women. Higher risk sex is more common in men than in women. Similarly, condom use during the last higher risk sexual encounter is higher in men than in women.

Women are more likely than men to undergo HIV counseling and testing; about 71 of women and 58 percent of men reported that they have ever had HIV tests. Fifty seven percent of pregnant women who gave birth in the last two years were counseled during antenatal care. Among those women who were offered and accepted HIV test during antenatal care, 27.2 percent received their results.

The key factors cited by the key informants to be influencing the spread of HIV infection included: poverty; low female-to-male ratio, inadequate information on HIV/AIDS among plantation workers, low risk perceptions, the practice of commercial sex work as a means of supplementing income, seeking for favours, widow inheritance, negative beliefs on condoms and negative cultures/values. On policy, only two plantations (Kakira and Kaweri) have written workplace policies; although the one for Kaweri is still in draft form. The other two have unwritten policies. Never-the-less, all the surveyed plantations are implementing workplace policies and programmes. Among others, emphasis is being put on ensuring non-discrimination of HIV infected workers, gender sensitivity, safer work environment and confidentiality in handling HIV information. HIV related services that are being offered include awareness creation, health education, HCT, general HIV care and ART services.

## Conclusion

Some action is required to address the key issues emerging from the survey. For instance, Tilda, Kaweri and Wilmar plantations should develop their HIV/AIDS work place policies; and the coordination structures for HIV prevention and control should be strengthened in the plantation sector. The range of HIV services in Tilda, Kaweri and Tilda should be expanded to make them comprehensive. To increase the levels of HIV-related knowledge, there is need to strengthen the programmes for information-education-communication (IEC) in the plantations and surrounding areas. Programmes for behavior change communication also need to be strengthened. HIV counseling and testing should be promoted among the general population. Pregnant women should be particularly targeted with HCT. Finally, strategies consider the key emerging issues should be designed to address the high level of HIV infection among the plantation workers.

# CHAPTER 1: INTRODUCTION

## 1.1. Background

Following the advent of the HIV/AIDS epidemic almost three decades ago, the epidemic has ravaged mankind both in Uganda and the world over. During this period, different population sectors have been disproportionately affected by the epidemic. Some population sectors such as commercial sex workers, STD clinic attendees, long distance truckers, fishing communities and plantation workers seem to be more vulnerable to the epidemic. Due to the long times fishers and fish traders spend away from home, their access to cash income, their demographic profiles, the ready availability of commercial sex in fishing sites and risk-taking behaviors among fishermen, fishing communities are among the highest risk groups for HIV infection in countries with high overall rates of HIV prevalence [2]. In the case of plantation workers, it has been demonstrated that these communities have a much higher rate of HIV infection than that estimated for the general population. Furthermore, HIV infection has been found to be independently associated with risk-taking behaviors such as having multiple concurrent sexual partners and non-use of condoms [3]. Moreover, both plantation workers and fishing communities are mobile populations who stay away from home. These factors are unique to these populations and put them at risk of and raise their vulnerability to HIV infection [4]. Therefore, to guide the planning of HIV/AIDS services targeting these groups, it is prudent to determine HIV prevalence and HIV-related behavioral risks among these populations sectors [5]. Similarly, there is need to establish the range, availability and utilization of HIV/AIDS services, as well as existence of HIV-related policies and coordination structures; because they have a bearing on both HIV prevalence and behaviors [6,7,8].

Although some studies have been conducted in agricultural plantations and fishing communities worldwide [2,4,8], only a few have been done in Uganda [9,10,11,12,13,14,15]. Moreover, these few studies have focused mainly on HIV knowledge, attitudes and behaviors; with little done to determine HIV prevalence and its determinants. Arising from this, there is information gap. This study was designed to address such information gap; and especially that on HIV prevalence among the populations of focus. Currently, there is some limited literature describing HIV/AIDS programmes targeting the two populations [16,17,18,19]. Additionally, although there are some programmes that have been designed to target these groups specifically [20,21], there are HIV/AIDS programmes for the general population which also benefit these groups. This study has shed light on these services.

In response to the HIV epidemic, prevention and control strategies have been put in place at national, regional and international levels. To date, most of the interventions target the general population as a whole leaving special population groups such as mobile populations inadequately targeted. It is in this context that the East Africa Lake Victoria

Project (EALP) made a move to establish a framework for improving the effectiveness of the HIV/AIDS responses targeting mobile populations; including migrant workers in fisheries and agricultural plantations.

In order to facilitate the formulation of an evidence-based framework, EALP commissioned baseline studies with four major dimensions; namely, a) HIV sero-prevalence, (b) behavioral risks among the populations of focus, (c) service availability and utilization, and (d) coordination, institutional policies and structures. The results of the studies will be used in the development of the framework and planning of HIV/AIDS services targeting mobile populations. The generated will also complement the national HIV/AIDS database.

### 1.2. Objectives of the survey

The purpose of the survey is to establish the HIV prevalence, the associated drivers of risk and vulnerability and the effectiveness of HIV and AIDS response for agricultural plantation workers in the Lake Victoria Basin. Specific objectives include:

1. To determine HIV sero-prevalence among populations in agricultural plantation systems in Lake Victoria Basin in Uganda.
2. To establish the demographic and behavioral risk factors, knowledge and attitudes regarding HIV and STI transmission among plantation workers and fishing communities.
3. To establish the range, breadth, availability and utilization of HIV and AIDS related services.
4. To determine the existence and effectiveness of policies, programs and coordination structures on HIV and AIDS in plantations.

### 1.3. Sample Size and Design

The study was sub-national and cross-sectional in design with a focus on four plantations located in the Lake Victoria Basin of Uganda. The plantations surveyed included Tilda Rice Plantation (Bugiri district), Kakira Sugar Works (Jinja district), Kaweri Coffee Plantation (Mubende district) and Wilmar Palm Oil Plantation (Kalangala district).

**Table 1.1; Study Areas**

| Plantation type | Name | District of location | Total population |
|---|---|---|---|
| **Sugar Cane** | Kakira Sugar Works | Jinja | 9,641 |
| | | | |
| **Rice** | Tilda Rice plantation | Bugiri | 1,405 |
| | | | |
| **Palm Oil** | Wilmar Palm Oil | Kalangala | 1,400 |
| | | | |
| **Coffee** | Kaweri Coffee plantation | Mubende | 1,200 |

The sample for the survey covered all women and men aged 15-59 years who were supplying labor to the plantations. A representative sample of size of 564 was estimated for Kakira, 420 for Tilda, 400 for Kaweri and 416 for Wilmar making a total of 1,800 for all the four plantations. The sampling strategy however could only allow reliable interpretation

of data at individual plantation level, but not at regional level (aggregated data for all four plantations)

The main variable used for sample size determination was HIV prevalence; and was obtained from the Uganda HIV Sero-Behavioral Survey 2004-05. In order to ensure that the different strata levels (proportions) are taken care of, probability proportional to size (PPS) technique was used to allocate the different cadres of plantation workers into the sample. The elements of employees included permanent, seasonal and casual workers (both contractual and non contractual). Before the commencement of the sampling procedure, the 4 sampling frames were updated to ensure that they were complete. This exercise was done in conjunction with the of plantation managers.

To allow generation of comprehensive data, a combination of survey methods were used. Since there is no single method which by itself is sufficient to achieve a good understanding of the HIV risks and vulnerabilities among the plantations, it was imperative to use a combination of survey methods. Structured questionnaire interviews were used to obtain quantitative information on demographic characteristics, HIV-related behaviors, knowledge and attitudes, and STI. Focus group discussions (FGDs) were used to obtain a deeper understanding of sensitive topics such as sexual behaviours. The key informant's interviews were used to engage policy makers, managers, programme people and funding agencies to provide information on HIV/AIDS policies, HIV/AIDS services, and coordination structures for the delivery of HIV services to the agricultural plantation workers and fishing communities. Each of the specific survey methods is further discussed below.

### 1.4. Desk review

Desk review of a number of relevant documents was conducted. The documents included those on HIV service availability and utilization, as well as coordination, institutional policies and structures for the delivery of HIV services to the agricultural plantation workers. Where available, and given their importance, institutional HIV-related policies and plans were also reviewed. Furthermore, coordination structures and service delivery outlets were examined to determine their relevance in the delivery of plantation-related HIV interventions. To achieve the above, the managers of the surveyed plantations were approached to avail any written policies and plans which describe HIV-related issues. In addition, regional and national level policies and plans were reviewed to determine whether there are any which articulate HIV services that target plantation workers. Policies and plans from the Ministry of Health, Uganda AIDS Commission, Ministry of Agriculture, Animal Industry and Fisheries (MAAIF) and EALP were also reviewed.

### 1.5. Key informant's interviews

Key informant's interviews were conducted using topic guides. During the interviews, discussions were held to determine the existing institutional HIV policies and services, as well as the coordination structures for the delivery of HIV services to the agricultural plantation workers. Additionally, a checklist was used to assess and determine the comprehensiveness of the available services.

In order to generate relevant and comprehensive information, participants of KI were purposively selected. The participants were drawn from the districts of Bugiri, Jinja, Mubende, Kalangala, Ministry of Health, Uganda AIDS Commission, Ministry of Agriculture, Animal Industry and Fisheries (MAAIF), World Health Organization, UNAIDS and some senior officials from each of the surveyed plantations (Table 1.2). The interviews were conducted by the survey coordination team.

### 1.6. Structured questionnaire interviews.

The individual survey respondents were interviewed using structured questionnaires. The questionnaires were adapted from that of the AIDS Indicator survey (AIS). The AIS has been done in all the countries of East Africa. This adaptation has enabled uniformity in questions asked such that the results of this survey can be compared with the results of AIS and other surveys that have been conducted in the general population. The questionnaire adaptation however took into consideration the uniqueness of plantations. The questionnaires were translated into Luganda and Kiswahili (the main local languages spoken around LVB) and back translated into English. To ensure that the meanings of the questions were not lost, back-translation into English was done by people other than the initial translators. The questionnaires were pretested before the actual survey was done. After the pretest, translation related issues which had been identified were addressed. In addition, all aspects of the survey data collection was pretested before the main survey commenced. All respondents provided written consent before the interviews.

From the structured questionnaires, the survey was able to generate quantitative information. Specifically, the individual interviews were used to collect information from all women and men aged 15-59 and it covered the following topics:

- Background characteristics (age, sex, ethnic background, educational attainment, marital status, for the married whether staying together with spouse, occupation, main source of income, length of stay in study area, etc)
- Reproduction
- Marriage and sexual activity
- HIV-related behaviors
- HIV-related knowledge
- HIV-related attitudes
- HIV/AIDS care services (range, breadth, availability, utilization) – HCT services, condom availability, PMTCT, ART, OI treatment.
- Health seeking behaviors for Sexually transmitted infections (STI)

For the survey, four teams were formed, each with 1 supervisor, 2 female interviewers, 2 male interviewers, 1 counselor and 1 laboratory technician. Team members were trained for ten days, both in theory and practical. Training ended with the pretest of the survey instruments and procedures. The pretest was done at Kajansi Rose Flower plantation. Thereafter, the team proceeded to the plantations to conduct the fieldwork.

### 1.7. Focus group discussions (FGDs)

To supplement information from the structured questionnaires, a number of FGDs were conducted using topic guides. In each of the plantations, one FGD was performed and each of them composed of ten to twenty members including both men and women. In total,

4 FGDs were conducted in the 4 plantations (Table 1.2). The FGD interview sessions were moderated by the behavioral scientist.

### 1.8. Laboratory tests.

All women and men aged 15-59 who were interviewed were asked to voluntarily provide a blood sample for subsequent testing for HIV. Blood draw was done using capillary tubes. The protocol for the blood specimen collection and analysis was developed by the study team in consultation with the National Technical Team and was approved by the Scientific and Ethics Committee of the Uganda Virus Research Institute (UVRI) and cleared by the National Council for Science and Technology (UNCST).

For the purpose of blood collection, one laboratory technician was included in each of the teams. As part of the informed consent, the laboratory technician explained the procedure to be used, the fact that the equipment to be used was sterile, confidentiality of data and the tests to be performed on the blood. After the consent, capillary blood samples were taken and some processed into dry blood spots for storage and onward transportation to the National STD Reference Laboratory based at Mulago where the central level HIV testing was performed. In the field, HIV counseling and testing was offered free of charge to all respondents to enable them know their sero-status. The national HIV rapid testing algorithm was used. The respondents who were found to be HIV positive were referred for further HCT at the nearest health facility.

For the purpose of reporting of the overall HIV prevalence for the survey, central level testing of HIV was conducted on eluted serum from the 6 mm discs punched from the dry blood spots. The central level HIV testing was based on the national HIV surveillance testing algorithm. Serum samples were tested by a two HIV EIA parallel testing algorithm (Vironostika HIV + Genetic Systems rLAV) following the manufacturer's recommendations and in accordance with national guidelines. Specimens with unambiguously positive or negative results on both assays were reported without further testing, while all others were tested by Western blot. For external quality control, the HIV Reference Laboratory (HRL) at UVRI Entebbe carried out retesting of all HIV positive samples and 5% of HIV negative samples.

### 1.9. Data processing, entry and management

Completed questionnaires were received at the central level, registered and checked against the shipping inventory to verify that what was sent from the field had been received. Two data entry clerks were recruited to enter data. Data entry was done using EPIINF0. As a quality assurance measure, double data entry strategy was employed. A statistician oversaw data entry and conducted data management and analysis. Data cleaning included the checking of ranges, structure and internal consistency.

To facilitate data analysis, a comprehensive data analysis plan was developed ahead of time. In the case of FGDs and key informants' interviews, the proceedings were transcribed and summarized into themes. The data which emerged from interviews were then analyzed using thematic analysis. The predetermined themes were the basis of the initial analysis and thereafter any emerging issues were addressed using the new sets of themes. The analysis started from the field at the level of reviewing the transcribed notes and observations.

**Table 1.2; List of the Key Informants and FGD Participants**

| Site | Category and Positions of persons interviewed | Number of Study Participants |
|---|---|---|
| **National level** | **Key Informants**<br>▪ Programme Manager-ACP<br>▪ DG- UAC<br>▪ HIV/AIDS Prevention Coordinator UAC<br>▪ HIV/AIDS Focal Person-Ministry of Agriculture, Animal Industry and Fisheries.<br>▪ WHO HIV NPO<br>▪ HIV Prevention Coordinator-UNAIDS | **05** |
| **Kakira** | **Key Informants**<br>▪ Production officer Jinja<br>▪ Senior Nursing Officer Jinja<br>▪ Senior Welfare Officer Kakira<br>▪ Human Resource Manager Kakira.<br>▪ HIV/AIDS Focal Person-Kakira Hospital | **05** |
| | **FGDS**<br>▪ Welfare Assistants Kakira<br>▪ Plantation Staff | **20** |
| **Kaweri** | **Key Informants**<br>▪ Human Resource Manager-Kaweri<br>▪ District Production Officer | **02** |
| | **FGDS**<br>▪ Plantation Staff-Kaweri | **10** |
| **Wilma** | **Key Informants**<br>▪ Human resource Manger<br>▪ Nursing Officer<br>▪ DHE | **03** |
| | **FGDs**<br>Plantation Staff | **10** |
| **Tilda** | **Key Informants**<br>▪ Human resource Manager-Tilda<br>▪ District Health Inspector-Bugiri<br>▪ Production Manager-Bugiri | **03** |
| | **FGDS**<br>▪ Plantation staff-Tilda | **08** |
| **Grand Total: KI = 18 and FGDs = 48** | | |

Finally, the analysis process ended with a selection of the key statements from the different informants in the respective themes. The process also utilized the principle of triangulation for enhancement of validation of the data where information from key informants was compared with that from FGDs.

### 1.10. Survey Mobilization

Advocacy and mobilization for the survey was done immediately before the commencement of the survey and throughout the survey period to ensure smooth and successful implementation. The mobilization took different forms and employed different themes and messages depending on the target audiences. During the mobilization, the purpose of the survey, its design, implementation, use of survey data and the need for

community participation were discussed. Issues of confidentiality during the survey and reasons for anonymity of HIV testing were also discussed.

Posters, pamphlets and manuals were developed and distributed to the survey sites to facilitate mobilization. In addition, local community mobilizers and leaders were trained to equip them with mobilization skills to enable them assist the survey team in the identification of the selected individuals in their respective selected places.

### 1.11. Response rate

Tables 1.3, 1.4 and 1.5 show that the sample distribution by survey site, the number of clients contacted, number interviewed, number tested for HIV and the reasons for non-response by each of the plantations. The overall sample estimate for the four plantations was 1800. Furthermore, in all the four plantations, a total of 1443 respondents were contacted for interviews whereas 1432 respondents were interviewed. Additionally, of the 1432 respondents interviewed, 1407 were tested for HIV.

The above data indicates that the overall plantation sample attainment rate was 80 percent; varying from 75 percent in Tilda, 78 percent in Kakira, 82 percent in Kaweri to 87 percent in Wilmar. The data further indicates that the response rates for both interviews and blood draw were very high (Tables). The interview response rates were over 99 percent in all the surveyed plantations. For HCT, the response rates varied from 95% in Kakira to 99% in all the other 3 plantations.

The shortfall between the estimated sample size and those workers who were contacted for interviews is largely due to the discrepancy between the numbers of those plantation workers who had been listed during the population updating compared to that of those people who were still working for the plantations at the time of interviews. There was a bit of time lag from the time the population updating was done and the survey implementation time. By the time of interviews, some workers who had been included in the sample had left plantation work and moved away; and yet no new update had been done. On the other hand, the actual causes for non-response consisted of refusal to be interviewed, absence from the plantations for extended period and incapacitation of the respondent. The real non-response rate calculation was however based on those persons who were approached and were not interviewed.

**Table 1.3; Sample estimates, response rates for interviews and number tested for HIV**

| Name of Plantation | Sample Estimates | Number Contacted | Sample Response Rate | Number Interviewed | Number Tested |
|---|---|---|---|---|---|
| 1. Kakira | 564 | 439 | 78% | 432 | 415 |
| 2. Tilda | 420 | 316 | 75% | 314 | 312 |
| 3. Kaweri | 400 | 328 | 82% | 328 | 324 |
| 4. Wilmar | 416 | 360 | 87% | 358 | 356 |
| Total | 1800 | 1443 | 80% | 1432 | 1407 |

**Table 1.4; Response rate for Blood Draw**

| Name of Plantation | Number Contacted | Number Tested | Response Rate for Blood Draw (%) |
|---|---|---|---|
| 1. Kakira | 439 | 415 | 95 |
| 2. Tilda | 316 | 312 | 99 |
| 3. Kaweri | 328 | 324 | 99 |
| 4. Wilmar | 360 | 356 | 99 |
| Total | 1443 | 1407 | 98 |

**Table 1.5; Number of interviews, reasons for non-response and response rates**

| Name of plantation | Item | Total |
|---|---|---|
| **Kakira** | Number of selected respondents (A) | 564 |
| | Number of selected respondents identified (B) | 439 |
| | Number interviewed (C) | 432 |
| | Number refusing (D) | 5 |
| | Number not interviewed and didn't refuse (E): | 129 |
| | Incapacitated (F): | 2 |
| | Moved Away/Absent for extended period (G): | 127 |
| | **Plantation coverage rate (P)** | **77.84%** |
| | **Plantation response rate (R )** | **99.54%** |
| **Tilda** | Number of selected respondents (A) | 420 |
| | Number of selected respondents identified (B) | 316 |
| | Number interviewed (C) | 314 |
| | Number refusing (D) | 1 |
| | Number not interviewed and didn't refuse (E): | 106 |
| | Incapacitated (F): | 1 |
| | Moved Away/Absent for extended period (G): | 105 |
| | **Plantation coverage rate (P)** | **75.24%** |
| | **Plantation response rate (R )** | **99.68%** |
| **Kaweri** | Number of selected respondents (A) | 400 |
| | Number of selected respondents identified (B) | 328 |
| | Number interviewed (C) | 328 |
| | Number refusing (D) | 0 |
| | Number not interviewed and didn't refuse (E): | 73 |
| | Incapacitated (F): | 0 |
| | Moved Away/Absent for extended period (G): | 73 |
| | **Plantation coverage rate (P)** | **82.00%** |
| | **Plantation response rate (R )** | **100.00%** |
| **Wilmar** | Number of selected respondents (A) | 416 |
| | Number of selected respondents identified (B) | 360 |
| | Number interviewed (C) | 358 |
| | Number refusing (D) | 0 |
| | Number not interviewed and didn't refuse (E): | 59 |
| | Incapacitated (F): | 2 |
| | Moved Away/Absent for extended period (G): | 57 |
| | **Plantation coverage rate (P)** | **86.54%** |
| | **Plantation response rate (R )** | **99.44%** |
| **All** | Number of selected respondents (A) | 1,800 |
| | Number of selected respondents found (B) | 1,443 |
| | Number interviewed (C) | 1,432 |
| | Number refusing (D) | 6 |
| | Number not interviewed and didn't refuse (E): | 362 |
| | Incapacitated (F): | 5 |
| | Moved Away/Absent for extended period (G): | 357 |
| | **Overall coverage rate (P)** | **80.17%** |
| | **Overall response rate (R )** | **99.65%** |
| **Explanation** | B = C + D + F<br>Plantation coverage rate; P = B/A; Plantation response rate (15-59 years); R = C/(B-D) | |

# CHAPTER 2: RESPONDENTS' CHARACTERISTICS AND THE RESPONSE RATE

## 2.1 Key Findings

- Of 1,432 respondents interviewed, 1,072(75 percent) were men. Thus, the majority of the respondents were men.
- Most of the respondents (65 percent) were in the age bracket 20-39 years.
- Most of the plantation workers were in the category of casual workers (50 percent) followed by contract workers (26 percent).
- Most of the respondents attained primary level education (54 percent) followed by those attained secondary level education (27 percent).
- Twenty three percent of the respondents have never married and 54 percent are currently married.
- The majority of respondents said they had one or more living children (72 percent), thus, only 28 percent of respondents has no living children.

## 2.2 Introduction

During the survey, information was collected on characteristics of the respondents. This chapter presents information on the background characteristics of the respondents, including; age, sex, ethnic background, educational attainment, marital status, for the married whether staying together with spouse and length of stay in study area. On the basis of the information, the relationship between demographic, socioeconomic and HIV-related indicators can be studied.

**Table 2.1. Summary Totals for Survey Participants**

| | Number Selected | | | | Number Identified | Number Interviewed | | | | Number Tested | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name of Plantation | P | Cas | Cont | Tot | | P | Cas | Cont | Tot | P | Cas | Cont | Tot |
| 1. Kakira | 228 | NA | 336 | 564 | 439 | 182 | NA | 250 | 432 | 175 | NA | 240 | 415 |
| 2. Tilda | 71 | 152 | 197 | 420 | 316 | 57 | 134 | 123 | 314 | 57 | 133 | 122 | 312 |
| 3. Kaweri | 87 | 313 | NA | 400 | 328 | 83 | 245 | NA | 328 | 81 | 243 | NA | 324 |
| 4. Wilmar | 22 | 394 | NA | 416 | 360 | 16 | 342 | NA | 358 | 16 | 340 | NA | 356 |
| Total | 408 | 859 | 533 | 1800 | 1443 | 338 | 710 | 384 | 1432 | 329 | 716 | 362 | 1407 |

**Note:** P: Permanent Workers; Cas: Casual Workers; Cont: Contract Workers; NA: Not Applicable

The distribution of the de facto population (those found at the time of interview) by demographic characteristics are shown in Table 2.1, Table 2.2 and Figures 2.1 and 2.2. A grand total of 1042 respondents were reached. Of these, 1072 (75 percent) were men. When work categories of the plantation workers were considered, the results show that in all the plantations apart from Kaweri and Wilmar, the workers fell into 3 categories; namely, permanent, casual and contract workers. Kaweri and Wilmar did not have contract

workers, while Kakira did not have casual workers. Overall, most of the plantation workers were in the category of casual labourers (50 percent), followed by contract workers (26 percent) and permanent workers (24 percent).

On age distribution, the results show that most of the respondents are of the age category 20-39 years. The peak number of respondents is in the age bracket 20-29 years; and only a small proportion of the respondents are in the age group 55-59 years. In regard to sex distribution, the results show that almost three quarters of the respondents are men.

**Table 2.2. Respondents by age**

**Percent distribution of women and men by age**

| Background characteristic | Women | | Men | | Total | |
|---|---|---|---|---|---|---|
| | Percent | Number | Percent | Number | Percent | Number |
| Age | | | | | | |
| 15-19 | 6.9 | 25 | 6.1 | 65 | 6.3 | 90 |
| 20-24 | 21.1 | 76 | 23.7 | 254 | 23.0 | 330 |
| 25-29 | 18.6 | 67 | 26.0 | 279 | 24.2 | 346 |
| 30-34 | 16.1 | 58 | 16.5 | 177 | 16.4 | 235 |
| 35-39 | 16.7 | 60 | 10.4 | 111 | 11.9 | 171 |
| 40-44 | 8.3 | 30 | 7.6 | 81 | 7.8 | 111 |
| 45-49 | 8.3 | 30 | 5.5 | 59 | 6.2 | 89 |
| 50-54 | 3.6 | 13 | 2.7 | 29 | 2.9 | 42 |
| 55-59 | 0.3 | 1 | 1.6 | 17 | 1.3 | 18 |
| **Total 15-49** | **96.0** | **346** | **95.8** | **1,026** | **95.8** | **1,372** |
| **Total 15-59** | **100.0** | **360** | **100.0** | **1,072** | **100.0** | **1,432** |

When the respondents were grouped by educational status, about half (54 percent) had stopped at primary level and less than 10 percent had reached college or university. There was no marked difference in educational attainment between women and men. On marital status, 65 percent of the respondents were either married or living together; and a very small proportion (2.4 percent) was widowed. Twenty three percent of the respondents had never married. Generally, the above trends were seen in all the 4 surveyed plantations and among both women and men. The results further show that although most respondents are married (Table 2.3).

Respondents were also asked whether they have ever had/fathered children. For those who said they have had children, they were requested to state the numbers of their living children. In response, the majority of men and women (72 percent) reported that they had living children, with 29 percent having 1-2 living children, 20 percent having 3-4 living children and 23 percent having 5 or more living children. Furthermore, disaggregation of data by religion revealed that most respondents are Roman Catholics (43.7 percent), 39.4 percent are Protestants, 96 percent Muslims and the remainder (7.3 percent) falls into the category of no religion/others.

**Figure 2.1; Percent distribution of the de facto survey population by five-year age groups, according to sex**

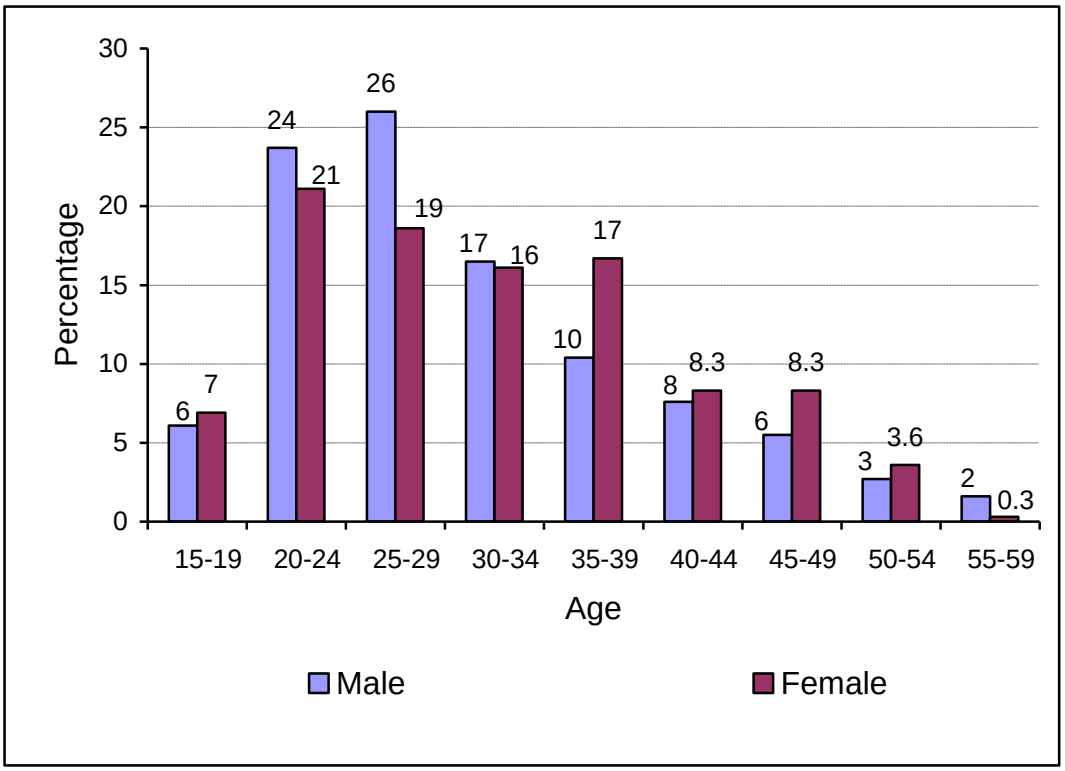
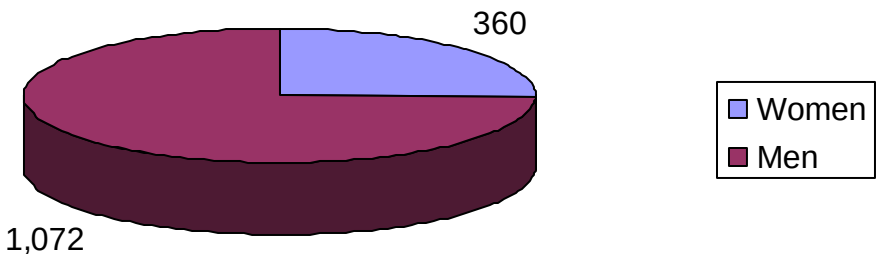



**Figure 2.2.** Sample distribution by sex (Age 15-59 years)



## Table 2.3. Percent distribution of women and men by selected background characteristics

| Background characteristic | Kakira | | | Tilda | | | Kaweri | | | Wilmar | | | ALL | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | F | M | T | F | M | T | F | M | T | F | M | T | F | M | T |
| Form of Employment | | | | | | | | | | | | | | | |
| Permanent | 38.2 | 43.0 | 42.1 | 6.5 | 24.3 | 18.2 | 20.0 | 27.5 | 25.3 | 1.2 | 5.4 | 4.5 | 15.6 | 26.3 | 23.6 |
| Contract | 61.8 | 57.0 | 57.9 | 42.6 | 37.4 | 39.2 | NA | NA | NA | NA | NA | NA | 25.8 | 26.1 | 26.0 |
| Casual | NA | NA | NA | 50.9 | 38.3 | 42.7 | 80.0 | 72.5 | 74.7 | 98.8 | 94.6 | 95.5 | 58.6 | 47.6 | 50.3 |
| Age | | | | | | | | | | | | | | | |
| 15-19 | 0.0 | 1.1 | 0.9 | 8.3 | 4.4 | 5.7 | 7.4 | 6.4 | 6.7 | 11.1 | 13.4 | 12.8 | 6.9 | 6.1 | 6.3 |
| 20-24 | 2.6 | 16.3 | 13.9 | 17.6 | 19.4 | 18.8 | 24.2 | 28.3 | 27.1 | 39.5 | 32.5 | 34.1 | 21.1 | 23.7 | 23.0 |
| 25-29 | 18.4 | 30.3 | 28.2 | 20.4 | 17.0 | 18.2 | 18.9 | 27.5 | 25.0 | 16.0 | 26.0 | 23.7 | 18.6 | 26.0 | 24.2 |
| 30-34 | 21.1 | 18.3 | 18.8 | 17.6 | 16.0 | 16.6 | 13.7 | 18.0 | 16.8 | 12.3 | 13.4 | 13.1 | 16.1 | 16.5 | 16.4 |
| 35-39 | 25.0 | 14.3 | 16.2 | 13.0 | 13.1 | 13.1 | 18.9 | 6.4 | 10.1 | 11.1 | 6.5 | 7.5 | 16.7 | 10.4 | 11.9 |
| 40-44 | 15.8 | 10.4 | 11.3 | 8.3 | 12.1 | 10.8 | 5.3 | 3.9 | 4.3 | 4.9 | 3.6 | 3.9 | 8.3 | 7.6 | 7.8 |
| 45-49 | 10.5 | 6.7 | 7.4 | 11.1 | 10.2 | 10.5 | 9.5 | 3.9 | 5.5 | 1.2 | 1.8 | 1.7 | 8.3 | 5.5 | 6.2 |
| 50-54 | 6.6 | 1.7 | 2.5 | 2.8 | 4.9 | 4.1 | 2.1 | 3.4 | 3.0 | 3.7 | 1.8 | 2.2 | 3.6 | 2.7 | 2.9 |
| 55-59 | 0.0 | 0.8 | 0.7 | 0.9 | 2.9 | 2.2 | 0.0 | 2.1 | 1.5 | 0.0 | 1.1 | 0.8 | 0.3 | 1.6 | 1.3 |
| Marital status | | | | | | | | | | | | | | | |
| Never married | 1.3 | 18.5 | 15.5 | 13.9 | 16.0 | 15.3 | 12.6 | 33.0 | 27.1 | 9.9 | 42.2 | 34.9 | 10.0 | 27.3 | 23.0 |
| Married | 53.9 | 62.9 | 61.3 | 55.6 | 72.3 | 66.6 | 28.4 | 45.1 | 40.2 | 48.1 | 38.3 | 40.5 | 46.4 | 54.5 | 52.4 |
| Living together | 17.1 | 11.8 | 12.7 | 5.6 | 9.2 | 8.0 | 15.8 | 12.9 | 13.7 | 24.7 | 13.7 | 16.2 | 15.0 | 12.0 | 12.8 |
| Divorced/Separated | 13.2 | 6.2 | 7.4 | 17.6 | 1.5 | 7.0 | 33.7 | 8.6 | 15.9 | 16.0 | 5.4 | 7.8 | 20.6 | 5.6 | 9.4 |
| Widowed | 14.5 | 0.6 | 3.0 | 7.4 | 1.0 | 3.2 | 9.5 | 0.4 | 3.0 | 1.2 | 0.4 | 0.6 | 8.1 | 0.6 | 2.4 |
| Education | | | | | | | | | | | | | | | |
| Nursery | 0.0 | 0.0 | 0.0 | 1.9 | 1.0 | 1.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.6 | 0.2 | 0.3 |
| Primary | 46.1 | 52.5 | 51.4 | 62.0 | 45.1 | 51.0 | 54.7 | 54.1 | 54.3 | 64.2 | 57.0 | 58.7 | 57.2 | 52.6 | 53.8 |
| Post Primary/Vocational | 5.3 | 5.3 | 5.3 | 2.8 | 2.9 | 2.9 | 3.2 | 3.9 | 3.7 | 4.9 | 2.5 | 3.1 | 3.9 | 3.8 | 3.8 |
| Secondary/'A' Level | 14.5 | 28.4 | 25.9 | 17.6 | 37.4 | 30.6 | 24.2 | 32.2 | 29.9 | 22.2 | 26.4 | 25.4 | 19.7 | 30.4 | 27.7 |
| College | 11.8 | 7.0 | 7.9 | 4.6 | 6.8 | 6.1 | 4.2 | 5.2 | 4.9 | 1.2 | 5.8 | 4.7 | 5.3 | 6.3 | 6.0 |
| University | 2.6 | 3.1 | 3.0 | 0.0 | 1.0 | 0.6 | 0.0 | 1.3 | 0.9 | 1.2 | 1.8 | 1.7 | 0.8 | 2.0 | 1.7 |
| Not Stated | 19.7 | 3.7 | 6.5 | 11.1 | 5.8 | 7.6 | 13.7 | 3.4 | 6.4 | 6.2 | 6.5 | 6.4 | 12.5 | 4.8 | 6.7 |
| Religion | | | | | | | | | | | | | | | |
| Roman Catholic | 40.8 | 51.7 | 49.8 | 28.7 | 35.9 | 33.4 | 56.8 | 39.9 | 44.8 | 40.7 | 45.5 | 44.4 | 41.4 | 44.5 | 43.7 |
| Protestant/Other Christian | 47.4 | 36.8 | 38.7 | 40.7 | 44.7 | 43.3 | 30.5 | 44.6 | 40.5 | 33.3 | 36.5 | 35.8 | 37.8 | 39.9 | 39.4 |
| Muslim | 7.9 | 8.4 | 8.3 | 12.0 | 10.2 | 10.8 | 1.1 | 6.4 | 4.9 | 21.0 | 12.6 | 14.5 | 10.3 | 9.4 | 9.6 |
| No Religion | 0.0 | 0.0 | 0.0 | 1.9 | 0.5 | 1.0 | 1.1 | 0.0 | 0.3 | 0.0 | 1.4 | 1.1 | 0.8 | 0.5 | 0.6 |
| Other | 3.9 | 3.1 | 3.2 | 16.7 | 8.7 | 11.5 | 10.5 | 9.0 | 9.5 | 4.9 | 4.0 | 4.2 | 9.7 | 5.7 | 6.7 |
| Number of living children | | | | | | | | | | | | | | | |
| 0 | 6.6 | 25.6 | 22.2 | 15.7 | 19.9 | 18.5 | 13.7 | 37.3 | 30.5 | 13.6 | 48.7 | 40.8 | 12.8 | 33.0 | 27.9 |
| 1-2 | 22.4 | 28.1 | 27.1 | 24.1 | 20.4 | 21.7 | 36.8 | 30.9 | 32.6 | 49.4 | 30.0 | 34.4 | 32.8 | 27.7 | 29.0 |
| 3-4 | 25.0 | 23.0 | 23.4 | 29.6 | 18.0 | 22.0 | 28.4 | 15.0 | 18.9 | 24.7 | 13.4 | 15.9 | 27.2 | 17.8 | 20.2 |
| 5+ | 46.1 | 23.3 | 27.3 | 30.6 | 41.7 | 37.9 | 21.1 | 16.7 | 18.0 | 12.3 | 7.9 | 8.9 | 27.2 | 21.5 | 22.9 |
| **Total** | **100** | **100** | **100** | **100** | **100** | **100** | **100** | **100** | **100** | **100** | **100** | **100** | **100** | **100** | **100** |
| **Number** | **76** | **356** | **432** | **108** | **206** | **314** | **95** | **233** | **328** | **81** | **277** | **358** | **360** | **1,072** | **1,432** |

F; Female, M; Male, T; Total and NA; Not Applicable

# CHAPTER 3: HIV RELATED KNOWELDGE

## 3.1. Key Findings

- Knowledge of single HIV prevention methods is widespread among plantation workers across all the plantations; and the knowledge is similar in both women and men.
- More than three quarters of women (79.2 percent) and more than two thirds of men (68.4 percent) know that HIV can be transmitted from a mother to her child by breastfeeding.
- About two thirds of the respondents know that there are special drugs (antiretroviral drugs) that a doctor or nurse can give to a pregnant woman infected with the AIDS virus to reduce the risk of transmitting the virus to the baby.
- Knowledge of at least one source of a condom was widespread; ranging from 77 percent in Tilda to 91 percent in Kaweri.

## 3.2. Introduction

HIV-related knowledge is important in HIV prevention and control. Knowledge of how HIV is transmitted is one of several factors that enable people to protect themselves from HIV. In addition, correct knowledge can reduce stigma and discrimination against people living with HIV/AIDS. Knowledge is also an important prerequisite for positive behaviour change or adoption of risk reduction behaviours such as abstinence, reduction in premarital sex, avoiding non-spousal sex, and condom use during non-spousal sex. In line with above, the national response to the HIV/AIDS epidemic includes promotion of HIV/AIDS prevention and control interventions, including promotion of their availability and access to them, as well as behavior change communication (BCC). In addition, the programme discourages misconception about the modes of HIV transmission. Behavior change communication facilitates the adoption of HIV prevention behaviours and uptake of HIV prevention, care and treatment services.

In this survey, knowledge information was through an assessment of the level of knowledge regarding transmission of the AIDS virus among plantation workers. Survey respondents were asked if they had ever heard of AIDS, about their main source of information, about specific means of transmission of the virus, and if they were aware of mother-to-child transmission. Respondents were also asked about antiretroviral therapy, and sources of mother-to-child HIV transmission. Specifically, the following variables were examined; proportion of respondents who knows that abstaining from sex reduces risk of HIV infection (prompted), proportion who knows that having only one sexual partner who is HIV un-infected reduces risk of HIV infection (prompted), proportion who knows that using condoms when having sex reduces risk of HIV infection (prompted), proportion with comprehensive knowledge of HIV/AIDS, proportion who knows that HIV can be transmitted from mother to child, proportion who knows that ARV drugs can reduce mother-to-child transmission and proportion who knows source of condoms.

## 3.3. Knowledge of Methods of avoiding HIV Infection

The results in Table 3.1 show that in response to prompted questions, knowledge of single HIV prevention methods is very high among both men and women aged 15-49 years across all the plantations; the knowledge is similar in both women and men. The

proportion of women who indicated that their chances of getting the AIDS virus can be reduced by limiting sex to one partner who is not infected and who has no other partners varied from 91.6 in Kaweri to 93.4 percent in Kakira. Among women, those who said that people could reduce their chances of getting the AIDS virus by using condoms every time they have sex varied from 77.8 percent in Tilda to 87.7 percent in Wilmar. Knowledge of both these means of avoiding HIV transmission is also high, varying from plantation to plantation; in women, from 75 percent in Tilda to 81.5 percent Wilmar where the respondents cited both as ways of reducing the risk of getting the AIDS virus. As expected, the proportion of both women and men who know that abstaining from sex reduces the chances of getting the AIDS virus is high. Equally, for each of the above indicators, the knowledge indicators are high among men. However, generally, there is no difference in the knowledge of these indicators between men and women. There is also no clear trend in knowledge across the four surveyed plantations.

### 3.4. Knowledge of a Source of a Condom

Condom use among sexually active people plays an important role in the prevention of transmission of HIV and other sexually transmitted infections. In youth, it is also useful in preventing unwanted pregnancies. Knowing a place to get condoms helps people to obtain and use condoms. During the survey, respondents were asked whether they knew a place from where they can get a condom. Table 3.3 shows that knowledge of at least one source of a condom was widespread; ranging from 77 percent in Tilda to 91 percent in Kaweri. Knowledge of a source of a condom was highest among the permanent workers compared to other work categories. In general, the indicator varies with the area surveyed, age of the respondent, educational attainment and marital status. Knowledge of a source of a condom was lowest among younger respondents, widows and respondents of less than primary educational attainment.

### 3.5. Knowledge of Methods of Prevention of Mother-to-child HIV Transmission

Table 3.2 shows that more than half of women (79.2 percent) and men (68.4 percent) know that HIV can be transmitted from a mother to her child by breastfeeding (Table 3.4). The results further show that knowledge about antiretroviral drugs (special drugs) that a doctor or nurse can give to a pregnant woman infected with the AIDS virus to reduce the risk of transmitting the virus to the baby is slightly less widespread, 67.2 percent of women and 63.8 percent of men know that there are. The combined indicator shows that 58.6 percent of women and 47.2 percent of men know that HIV can be transmitted through breastfeeding and that the risk can be reduced by special drugs.

### 3.6. Comprehensive Knowledge about HIV/AIDS

An indicator which combines several other indicators of knowledge about HIV/AIDS was constructed. This indicator referred to as comprehensive HIV/AIDS knowledge combines five individual indicators; namely: the percentage of respondents aged 15-49 who say that: 1) people can reduce the chances of getting the AIDS virus by using a condom every time they have sex, 2) people can reduce the chances of getting the AIDS virus by having sex with just one partner who is not infected and who has no other partners, 3) that people cannot get the AIDS virus from mosquito bites, 4) that people cannot get the AIDS virus from sharing food with a person who has AIDS, and 5) that a healthy-looking person can have the AIDS virus.

As shown on Table 3.4, the results show that comprehensive knowledge about HIV/AIDS is very low compared knowledge of individual prevention methods. Among women and men aged 15-49, comprehensive knowledge about HIV/AIDS is 38 and 34 percent, respectively. There is variation in the level of comprehensive knowledge by individual plantations, age grouping and marital status. Comprehensive knowledge is highest at Kakira (42 percent), followe by both Kaweri and Wilmar (33 percent) and lowest in tilda at 30 percent. Staff in the permanent category have the highest level of comprehensive knowledge (52 percent) compared with those in the casual category (30 paercent). Generally, the youger age groups had the lowest level of comprehensive knowledge. In regard to marital status, comprehensive knowledge was highest at 52 percent among those widowed compared to 29 percent among those who have never married.

## Table 3.1. Knowledge of HIV prevention methods

Percentage of women and men who, in response to a prompted question, say that people can reduce the risk of getting the AIDS virus by using condoms, by having sex with just one partner who is not infected and has no other partners, and by abstinence, by site

| | WOMEN | | | | | MEN | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Knowledge of HIV prevention by: | | | | | Knowledge of HIV prevention by: | | | | |
| Name of Plantation/ Form of Employment | Using condoms | Limiting sex to one uninfected partner | Using condoms, and limiting sex to one uninfected partner[1] | Abstaining from sexual intercourse | Number of women | Using condoms | Limiting sex to one uninfected partner | Using condoms, and limiting sex to one uninfected partner[1] | Abstaining from sexual intercourse | Number of men |
| **Kakira** | | | | | | | | | | |
| Permanent | 100.0 | 96.6 | 96.6 | 86.2 | 29 | 89.5 | 90.8 | 83.0 | 88.2 | 153 |
| Contract | 76.6 | 91.5 | 70.2 | 76.6 | 47 | 80.8 | 93.1 | 77.8 | 80.8 | 203 |
| Casual | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| All | 85.5 | 93.4 | 80.3 | 80.3 | 76 | 84.6 | 92.1 | 80.1 | 84.0 | 356 |
| | | | | | | | | | | |
| **Tilda** | | | | | | | | | | |
| Permanent | 85.7 | 100.0 | 85.7 | 85.7 | 7 | 88.0 | 92.0 | 84.0 | 92.0 | 50 |
| Contract | 71.7 | 89.1 | 67.4 | 84.8 | 46 | 83.1 | 87.0 | 74.0 | 83.1 | 77 |
| Casual | 81.8 | 94.5 | 80.0 | 78.2 | 55 | 83.5 | 86.1 | 77.2 | 87.3 | 79 |
| All | 77.8 | 92.6 | 75.0 | 81.5 | 108 | 84.5 | 87.9 | 77.7 | 86.9 | 206 |
| | | | | | | | | | | |
| **Kaweri** | | | | | | | | | | |
| Permanent | 78.9 | 89.5 | 73.7 | 78.9 | 19 | 90.6 | 95.3 | 87.5 | 89.1 | 64 |
| Contract | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Casual | 86.8 | 92.1 | 82.9 | 84.2 | 76 | 89.3 | 90.5 | 84.0 | 85.2 | 169 |
| All | 85.3 | 91.6 | 81.1 | 83.2 | 95 | 89.7 | 91.8 | 85.0 | 86.3 | 233 |
| | | | | | | | | | | |
| **Wilmar** | | | | | | | | | | |
| Permanent | 100.0 | 100.0 | 100.0 | 100.0 | 1 | 100.0 | 100.0 | 100.0 | 80.0 | 15 |
| Contract | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Casual | 87.5 | 92.5 | 81.3 | 86.3 | 80 | 86.3 | 92.7 | 82.4 | 85.9 | 262 |
| All | 87.7 | 92.6 | 81.5 | 86.4 | 81 | 87.0 | 93.1 | 83.4 | 85.6 | 277 |
| | | | | | | | | | | |
| **Total** | **83.6** | **92.5** | **79.2** | **82.8** | **360** | **86.3** | **91.5** | **81.5** | **85.4** | **1,072** |

[1]Corresponds to UNAIDS Knowledge Indicator 1 "Knowledge of HIV prevention methods".

## Table 3.2. Knowledge of prevention of mother to child transmission of HIV

Percentage of women and men who know that HIV can be transmitted from mother to child by breastfeeding and that risk of mother to child transmission (MTCT) of HIV can be reduced by mother taking special drugs during pregnancy, by plantation and form of employment

| | WOMEN | | | | MEN | | | |
|---|---|---|---|---|---|---|---|---|
| | Percentage who know that: | | | | Percentage who know that: | | | |
| Name of Plantation/ Form of Employment | HIV can be transmitted by breastfeeding | Risk of MTCT can be reduced by mother taking special drugs during pregnancy | HIV can be transmitted by breastfeeding and risk of MTCT can be reduced by mother taking special drugs during pregnancy[1] | Number of women | HIV can be transmitted by breastfeeding | Risk of MTCT can be reduced by mother taking special drugs during pregnancy | HIV can be transmitted by breastfeeding and risk of MTCT can be reduced by mother taking special drugs during pregnancy[1] | Number of men |
| **Kakira** | | | | | | | | |
| Permanent | 89.7 | 86.2 | 75.9 | 29 | 67.3 | 70.6 | 51.0 | 153 |
| Contract | 72.3 | 55.3 | 44.7 | 47 | 64.5 | 47.8 | 37.4 | 203 |
| Casual | NA | NA | NA | NA | NA | NA | NA | NA |
| All | 78.9 | 67.1 | 56.6 | 76 | 65.7 | 57.6 | 43.3 | 356 |
| **Tilda** | | | | | | | | |
| Permanent | 85.7 | 42.9 | 42.9 | 7 | 60.0 | 68.0 | 42.0 | 50 |
| Contract | 65.2 | 60.9 | 45.7 | 46 | 72.7 | 66.2 | 50.6 | 77 |
| Casual | 67.3 | 52.7 | 43.6 | 55 | 74.7 | 78.5 | 59.5 | 79 |
| All | 67.6 | 55.6 | 44.4 | 108 | 70.4 | 71.4 | 51.9 | 206 |
| **Kaweri** | | | | | | | | |
| Permanent | 84.2 | 68.4 | 63.2 | 19 | 68.8 | 78.1 | 51.6 | 64 |
| Contract | NA | NA | NA | NA | NA | NA | NA | NA |
| Casual | 85.5 | 78.9 | 71.1 | 76 | 71.6 | 61.5 | 47.9 | 169 |
| All | 85.3 | 76.8 | 69.5 | 95 | 70.8 | 66.1 | 48.9 | 233 |
| **Wilmar** | | | | | | | | |
| Permanent | 100.0 | 100.0 | 100.0 | 1 | 80.0 | 80.0 | 66.7 | 15 |
| Contract | NA | NA | NA | NA | NA | NA | NA | NA |
| Casual | 87.5 | 71.3 | 66.3 | 80 | 67.6 | 63.4 | 46.2 | 262 |
| All | 87.7 | 71.6 | 66.7 | 81 | 68.2 | 64.3 | 47.3 | 277 |
| | | | | | | | | |
| **Total** | **79.2** | **67.2** | **58.6** | **360** | **68.4** | **63.8** | **47.2** | **1,072** |

[1]Corresponds to UNAIDS Knowledge Indicator 5 "Knowledge of prevention of mother to child transmission of HIV".

## Table 3.3 Knowledge of a source for condoms

Percentage of respondents who know at least one source of condoms

| Background characteristic | WOMEN | | MEN | | TOTAL | |
|---|---|---|---|---|---|---|
| | Know a source for condoms [1] | Number of women | Know a source for condoms [1] | Number of men | Know a source for condoms [1] | Number |
| Plantation | | | | | | |
| Kakira Sugar | 77.6 | 76 | 83.1 | 356 | 82.2 | 432 |
| Tilda Rice | 59.3 | 108 | 85.9 | 206 | 76.8 | 314 |
| Kaweri Coffee | 78.9 | 95 | 95.3 | 233 | 90.5 | 328 |
| Wilmar Palm Oil | 61.7 | 81 | 85.9 | 277 | 80.4 | 358 |
| Form of Employment | | | | | | |
| Permanent | 83.9 | 56 | 94.0 | 282 | 92.3 | 338 |
| Contract | 61.3 | 93 | 77.9 | 280 | 73.7 | 373 |
| Casual | 68.2 | 211 | 88.2 | 510 | 82.4 | 721 |
| Age | | | | | | |
| 15-19 | 44.0 | 25 | 78.5 | 65 | 68.9 | 90 |
| 20-24 | 81.6 | 76 | 89.0 | 254 | 87.3 | 330 |
| 25-29 | 70.1 | 67 | 89.6 | 279 | 85.8 | 346 |
| 30-34 | 75.9 | 58 | 89.3 | 177 | 86.0 | 235 |
| 35-39 | 63.3 | 60 | 89.2 | 111 | 80.1 | 171 |
| 40-44 | 76.7 | 30 | 85.2 | 81 | 82.9 | 111 |
| 45-49 | 60.0 | 30 | 78.0 | 59 | 71.9 | 89 |
| 50-54 | 38.5 | 13 | 75.9 | 29 | 64.3 | 42 |
| 55-59 | 0.0 | 1 | 70.6 | 17 | 66.7 | 18 |
| Marital status | | | | | | |
| Never married | 77.8 | 36 | 83.3 | 293 | 82.7 | 329 |
| Married | 62.9 | 167 | 88.4 | 584 | 82.7 | 751 |
| Living together | 79.6 | 54 | 88.4 | 129 | 85.8 | 183 |
| Divorced/Separated | 74.3 | 74 | 90.0 | 60 | 81.3 | 134 |
| Widowed | 58.6 | 29 | 83.3 | 6 | 62.9 | 35 |
| Education | | | | | | |
| Nursery | 0.0 | 2 | 100.0 | 2 | 50.0 | 4 |
| Primary | 63.6 | 206 | 82.3 | 564 | 77.3 | 770 |
| Post Primary/Vocational | 100.0 | 14 | 97.6 | 41 | 98.2 | 55 |
| Secondary/'A' Level | 83.1 | 71 | 93.6 | 326 | 91.7 | 397 |
| College | 94.7 | 19 | 98.5 | 67 | 97.7 | 86 |
| University | 100.0 | 3 | 100.0 | 21 | 100.0 | 24 |
| Not Stated | 51.1 | 45 | 68.6 | 51 | 60.4 | 96 |
| Religion | | | | | | |
| Roman Catholic | 69.8 | 149 | 85.1 | 477 | 81.5 | 626 |
| Protestant/Other Christian | 71.3 | 136 | 90.2 | 428 | 85.6 | 564 |
| Muslim | 73.0 | 37 | 90.1 | 101 | 85.5 | 138 |
| No Religion | 66.7 | 3 | 20.0 | 5 | 37.5 | 8 |
| Other | 51.4 | 35 | 80.3 | 61 | 69.8 | 96 |
| Distance to former place of residence | | | | | | |
| Born in that area | 73.6 | 53 | 94.2 | 86 | 86.3 | 139 |
| Less than 10 KM | 62.5 | 32 | 86.5 | 96 | 80.5 | 128 |
| 10 - 29 KM | 75.0 | 44 | 88.9 | 81 | 84.0 | 125 |
| 30 - 49 KM | 76.7 | 30 | 91.4 | 58 | 86.4 | 88 |
| 50 - 99 KM | 88.5 | 52 | 91.0 | 100 | 90.1 | 152 |
| 100 KM and above | 57.9 | 145 | 84.8 | 643 | 79.8 | 788 |
| Not Stated | 75.0 | 4 | 100.0 | 8 | 91.7 | 12 |
| **Total** | **68.9** | **360** | **87.0** | **1,072** | **82.5** | **1,432** |

[1] The following sources are not considered sources for condoms in this Table: friends, family members, and home.

## Table 3.4. Comprehensive Knowledge about HIV/AIDS

| Background characteristic | Women (15 - 49) | | Men (15 - 49) | | Total (15 - 49) | |
|---|---|---|---|---|---|---|
| | Comprehensive Knowledge[1] | Number of women | Comprehensive Knowledge[1] | Number of men | Comprehensive Knowledge[1] | Number of respondents |
| **Plantation** | | | | | | |
| Kakira Sugar | 56.3 | 71 | 38.6 | 347 | 41.6 | 418 |
| Tildar Rice | 25.0 | 104 | 32.6 | 190 | 29.9 | 294 |
| Kaweri Coffee | 35.5 | 93 | 31.8 | 220 | 32.9 | 313 |
| Wilmar Palm Oil | 42.3 | 78 | 30.1 | 269 | 32.9 | 347 |
| **Form of Employment** | | | | | | |
| Permanent | 59.2 | 49 | 50.8 | 260 | 52.1 | 309 |
| Contract | 30.8 | 91 | 28.9 | 273 | 29.4 | 364 |
| Casual | 36.4 | 206 | 27.6 | 493 | 30.2 | 699 |
| **Age** | | | | | | |
| 15-19 | 44.0 | 25 | 27.7 | 65 | 32.2 | 90 |
| 20-24 | 39.5 | 76 | 25.6 | 254 | 28.8 | 330 |
| 25-29 | 43.3 | 67 | 33.0 | 279 | 35.0 | 346 |
| 30-34 | 39.7 | 58 | 40.1 | 177 | 40.0 | 235 |
| 35-39 | 26.7 | 60 | 37.8 | 111 | 33.9 | 171 |
| 40-44 | 40.0 | 30 | 49.4 | 81 | 46.8 | 111 |
| 45-49 | 36.7 | 30 | 32.2 | 59 | 33.7 | 89 |
| **Marital status** | | | | | | |
| Never married | 44.4 | 36 | 26.7 | 292 | 28.7 | 328 |
| Married | 39.8 | 161 | 37.8 | 547 | 38.3 | 708 |
| Living together | 33.3 | 54 | 32.8 | 125 | 33.0 | 179 |
| Divorced/Separated | 29.6 | 71 | 33.3 | 57 | 31.3 | 128 |
| Widowed | 54.2 | 24 | 40.0 | 5 | 51.7 | 29 |
| **Education** | | | | | | |
| Nursery | 0.0 | 1 | 100.0 | 2 | 66.7 | 3 |
| Primary | 33.0 | 203 | 25.0 | 541 | 27.2 | 744 |
| Post Primary/Vocational | 75.0 | 12 | 57.5 | 40 | 61.5 | 52 |
| Secondary/'A' Level | 42.6 | 68 | 40.7 | 317 | 41.0 | 385 |
| College | 84.2 | 19 | 68.3 | 63 | 72.0 | 82 |
| University | 33.3 | 3 | 55.0 | 20 | 52.2 | 23 |
| Not Stated | 25.0 | 40 | 9.3 | 43 | 16.9 | 83 |
| **Religion** | | | | | | |
| Roman Catholic | 39.2 | 143 | 29.1 | 453 | 31.5 | 596 |
| Protestant/Other Christian | 45.4 | 130 | 39.5 | 410 | 40.9 | 540 |
| Muslim | 21.6 | 37 | 30.6 | 98 | 28.1 | 135 |
| No Religion | 33.3 | 3 | 40.0 | 5 | 37.5 | 8 |
| Other | 24.2 | 33 | 35.0 | 60 | 31.2 | 93 |
| **Total 15-49** | 38.2 | 346 | 33.8 | 1,026 | 34.9 | 1,372 |
| **Total 15-59** | 37.5 | 360 | 34.0 | 1,072 | 34.8 | 1,432 |

[1] Percentage who say that people can reduce the risk of getting the AIDS virus by using a condom every time they have sex and by having sex with just one partner who is not infected and who has no other partners, who say that people cannot get the AIDS virus from mosquito bites or from sharing food with a person who has AIDS, and who say that a healthy-looking person can have the AIDS virus.

# CHAPTER 4: HIV RELATED ATTITUDES

## 4.1. Key Findings

Misconception about HIV/AIDS is low.

- About ninety percent of both women and men know that a healthy-looking person can have the virus that causes AIDS.
- Much fewer respondents understand that the AIDS virus cannot be transmitted by mosquito bites: 56 percent of women and 60 percent of men know that AIDS cannot be transmitted by mosquito bites.
- The proportions of women and men who know that people cannot get the AIDS virus by sharing food with a person who has AIDS are 68.6 and 65.2 percent, respectively.
- The vast majority of plantation workers say that witchcraft is not a means of transmission of HIV, with 81.1 percent of women and 84.4 percent of men saying so.

The majority of respondents have a caring attitude.

- Over ninety percent of women and men say they would be willing to care for a relative who is sick with AIDS in their own household.
- About seventy seven percent of respondents agree that a female teacher who has the AIDS virus but is not sick should be allowed to continue teaching in the school.
- About 77 percent of women and men say they would buy sugar or fresh vegetables from a vendor if they knew that he/she is HIV positive
- About 48 percent of women and 63 percent of men say that if a member of their family got infected with the AIDS virus, they would not necessarily want it to remain a secret.
- The proportion of women and men who express positive attitudes on all four indicators are 31.5 and 40.4 percent, respectively.

## 4.2. Introduction

Getting to know the attitudes of the public towards PLWH is important in fighting stigma and discrimination. It is also important to facilitate the designing of the key strategies for HIV/AIDS care and support services. This survey reports some information on HIV-related attitudes among plantation workers.

To assess the level of stigma, the survey respondents who had heard of AIDS were asked a set of four questions, namely; a; if they would be willing to care for a relative sick with AIDS in their own households, b; if they would be willing to buy sugar, fresh vegeTables, or other food from a market vendor who had the AIDS virus, c; whether respondents thought that a female teacher who has the AIDS virus but is not sick should be allowed to continue teaching, and d; if a member of their family got infected with the virus that causes AIDS, whether they would they want it to remain secret or not. The specific variables assessed included the proportion of respondents who knows that a healthy-looking person can have HIV, proportion who knows that HIV cannot be transmitted by mosquitoes, proportion who knows that HIV cannot be acquired by sharing food with a person having AIDS, proportion who knows that a healthy looking person can have HIV/AIDS, proportion who would allow female teacher with AIDS to continue teaching, proportion who would buy fresh vegetables from a shopkeeper or vendor if knows that the person has the AIDS virus, proportion who would be willing to care for a relative with AIDS, proportion who would not

want to keep HIV-positive status of a family member secret and the proportion who says that a wife is justified to refuse sex if suspects that the husband has sexually transmitted infections (STI).

### 4.3. Stigma Related Attitudes

Table 4.1 shows the results, indicating that about eighty seven percent of both women and men know that a healthy-looking person can have the virus that causes AIDS. On the other hand, much fewer respondents understand that the AIDS virus cannot be transmitted by mosquito bites: 56 percent of women and 60 percent of men know that AIDS cannot be transmitted by mosquito bites. The proportions of women and men who know that people cannot get the AIDS virus by sharing food with a person who has AIDS are 68.6 and 65.2 percent, respectively. When analysis is done looking at all three beliefs together, 68.6 percent of women and 38.7 percent of men have correct knowledge on all these issues. Respondents were also asked if they thought that people could get the AIDS virus because of witchcraft or other supernatural means. The vast majority of plantation workers reject this idea, with 81.1 percent of women and 84.4 percent of men saying witchcraft is not a means of transmission. Across all the four plantations, the levels of the above indicators appear to be similar.

### 4.4. Willingness to Care for a Family Member with AIDS

Table 4.2 shows that overall, 92.5 and 90.7 percent of women and men say they would be willing to care for a relative who is sick with AIDS in their own household, respectively. Additionally, 76.9 and 77 percent of women and men say they would buy sugar or fresh vegetables from a vendor if they knew that he/she is HIV positive, respectively. On whether to allow a female teacher who has the AIDS virus but is not sick to continue teaching in the school, 77.2 percent of women and 76.7 percent of men agrees with this position. About 48 percent of women and 63 percent of men say that if a member of their family got infected with the AIDS virus, they would not necessarily want it to remain a secret.

Analysis was also done on a composite indicator which combines all four of these attitudes. The result shows that 31.5 percent of women and 40.4 percent of men express positive attitudes on all four indicators. Comparing women to men, the result shows that for all four indicators, women are less likely than men to express accepting attitudes towards people with HIV/AIDS. The composite measure of accepting attitudes shows some differences across the four plantations. For example, in Kakira, 48.7 percent of respondents express accepting attitudes on all four issues examined, whereas in all the remaining three plantations less than 30 percent of respondents express accepting attitudes on all four issues.

## Table 4.1 Beliefs about AIDS: Women

**Percentage of women who, in response to a prompted question, correctly reject local misconceptions about AIDS transmission or prevention, and who know that a healthy-looking person can have the AIDS virus, by background characteristics, [COUNTRY, YEAR]**

| Name of Plantation/ Form of Employment | Percentage of women who know that : A healthy-looking person can have the AIDS virus | AIDS cannot be transmitted by mosquito bites (Country specific) | AIDS cannot be transmitted by supernatural means (Country specific) | A person cannot become infected by sharing utensils with someone who has AIDS | Percentage who reject the two most common local misconceptions and say that a healthy-looking person can have the AIDS virus[1] | Number of women |
|---|---|---|---|---|---|---|
| Kakira | | | | | | |
| Permanent | 96.6 | 86.2 | 79.3 | 89.7 | 79.3 | 29 |
| Contract | 91.5 | 57.4 | 87.2 | 80.9 | 46.8 | 47 |
| Casual | NA | NA | NA | NA | NA | NA |
| All | 93.4 | 68.4 | 84.2 | 84.2 | 59.2 | 76 |
| Tilda | | | | | | |
| Permanent | 57.1 | 71.4 | 85.7 | 28.6 | 14.3 | 7 |
| Contract | 78.3 | 41.3 | 60.9 | 52.2 | 26.1 | 46 |
| Casual | 83.6 | 45.5 | 78.2 | 67.3 | 34.5 | 55 |
| All | 79.6 | 45.4 | 71.3 | 58.3 | 29.6 | 108 |
| Kaweri | | | | | | |
| Permanent | 89.5 | 52.6 | 94.7 | 52.6 | 36.8 | 19 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 89.5 | 48.7 | 84.2 | 68.4 | 39.5 | 76 |
| All | 89.5 | 49.5 | 86.3 | 65.3 | 38.9 | 95 |
| Wilmar | | | | | | |
| Permanent | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 1 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 86.3 | 66.3 | 85.0 | 71.3 | 45.0 | 80 |
| All | 86.4 | 66.7 | 85.2 | 71.6 | 45.7 | 81 |
| **Total** | **86.7** | **56.1** | **81.1** | **68.6** | **41.9** | **360** |

[1]Corresponds to UNAIDS Knowledge Indicator 2 "No incorrect beliefs about AIDS". The two most common local misconceptions involve transmission by mosquito bites and sharing utensils with someone who has AIDS (both country specific).

## Table 4.2 Beliefs about AIDS: Men

**Percentage of men who, in response to a prompted question, correctly reject local misconceptions about AIDS transmission or prevention, and who know that a healthy-looking person can have the AIDS virus, by background characteristics, [COUNTRY, YEAR]**

| Name of Plantation/ Form of Employment | Percentage of men who know that: A healthy-looking person can have the AIDS virus | AIDS cannot be transmitted by mosquito bites | AIDS cannot be transmitted by supernatural means | A person cannot become infected by sharing utensils with someone who has AIDS | Percentage who reject the two most common local misconceptions and say that a healthy-looking person can have the AIDS virus[1] | Number of men |
|---|---|---|---|---|---|---|
| Kakira | | | | | | |
| Permanent | 96.1 | 76.5 | 90.2 | 73.2 | 58.8 | 153 |
| Contract | 78.8 | 59.6 | 74.9 | 68.0 | 35.5 | 203 |
| Casual | NA | NA | NA | NA | NA | NA |
| All | 86.2 | 66.9 | 81.5 | 70.2 | 45.5 | 356 |
| Tilda | | | | | | |
| Permanent | 96.0 | 72.0 | 82.0 | 66.0 | 56.0 | 50 |
| Contract | 89.6 | 63.6 | 84.4 | 67.5 | 40.3 | 77 |
| Casual | 86.1 | 50.6 | 91.1 | 62.0 | 26.6 | 79 |
| All | 89.8 | 60.7 | 86.4 | 65.0 | 38.8 | 206 |
| Kaweri | | | | | | |
| Permanent | 95.3 | 59.4 | 95.3 | 73.4 | 45.3 | 64 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 87.0 | 52.1 | 86.4 | 58.6 | 29.6 | 169 |
| All | 89.3 | 54.1 | 88.8 | 62.7 | 33.9 | 233 |
| Wilmar | | | | | | |
| Permanent | 100.0 | 93.3 | 100.0 | 66.7 | 60.0 | 15 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 81.3 | 53.8 | 82.1 | 60.7 | 32.4 | 262 |
| All | 82.3 | 56.0 | 83.0 | 61.0 | 33.9 | 277 |
| **Total** | **86.6** | **60.1** | **84.4** | **65.2** | **38.7** | **1,072** |

[1]Corresponds to UNAIDS Knowledge Indicator 2 "No incorrect beliefs about AIDS". The two most common local misconceptions involve transmission by mosquito bites and sharing utensils with someone who has AIDS (both country specific).

## Table 4.3. Accepting attitudes toward those living with HIV: Women

**Among women who have heard of HIV/AIDS, percentage expressing accepting attitudes toward people with HIV, by plantation and form of employment**

| Name of Plantation/ Form of Employment | Percentage of women who : | | | | | |
|---|---|---|---|---|---|---|
| | Are willing to care for a family member with HIV at home | Would buy fresh vegeTables or fish from a vendor who has HIV | Believe HIV positive female teacher should be allowed to keep teaching | Would not want HIV+ status of a family member to remain a secret | Percentage expressing accepting attitudes on all four measures[1] | Number of women who have heard of HIV/AIDS |
| Kakira | | | | | | |
| Permanent | 100.0 | 93.1 | 93.1 | 69.0 | 62.1 | 29 |
| Contract | 93.6 | 80.9 | 83.0 | 48.9 | 40.4 | 47 |
| Casual | NA | NA | NA | NA | NA | NA |
| All | 96.1 | 85.5 | 86.8 | 56.6 | 48.7 | 76 |
| Tilda | | | | | | |
| Permanent | 100.0 | 85.7 | 85.7 | 42.9 | 42.9 | 7 |
| Contract | 87.0 | 65.2 | 69.6 | 37.0 | 23.9 | 46 |
| Casual | 89.1 | 78.2 | 69.1 | 40.0 | 25.5 | 55 |
| All | 88.9 | 73.1 | 70.4 | 38.9 | 25.9 | 108 |
| Kaweri | | | | | | |
| Permanent | 94.4 | 77.8 | 83.3 | 44.4 | 33.3 | 18 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 92.1 | 73.7 | 76.3 | 48.7 | 25.0 | 76 |
| All | 92.6 | 74.5 | 77.7 | 47.9 | 26.6 | 94 |
| Wilmar | | | | | | |
| Permanent | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 1 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 93.8 | 76.3 | 76.3 | 51.3 | 27.5 | 80 |
| All | 93.8 | 76.5 | 76.5 | 51.9 | 28.4 | 81 |
| **Total** | **92.5** | **76.9** | **77.2** | **47.9** | **31.5** | **359** |

[1]Corresponds to Emergency Plan Policy and Systems Strengthening (Capacity Building) Indicator 2 "Percent of the general population with accepting attitudes toward persons living with HIV/AIDS"
and to UNAIDS Stigma and Discrimination Indicator 1 "Accepting attitudes toward those living with HIV".

## Table 4.4. Accepting attitudes toward those living with HIV: Men

**Among men who have heard of HIV/AIDS, percentage expressing accepting attitudes toward people with HIV, by Plantation and form of employment**

| Name of Plantation/ Form of Employment | Percentage of men who : Are willing to care for a family member with HIV at home | Would buy fresh vegeTables or fish from a vendor who has HIV | Believe HIV positive female teacher should be allowed to keep teaching | Would not want HIV+ status of a family member to remain a secret | Percentage expressing accepting attitudes on all four measures[1] | Number of men who have heard of HIV/AIDS |
|---|---|---|---|---|---|---|
| Kakira | | | | | | |
| Permanent | 91.4 | 81.6 | 84.9 | 72.4 | 52.6 | 152 |
| Contract | 87.9 | 71.9 | 70.9 | 64.3 | 35.7 | 199 |
| Casual | NA | NA | NA | NA | NA | NA |
| All | 89.5 | 76.1 | 76.9 | 67.8 | 43.0 | 351 |
| Tilda | | | | | | |
| Permanent | 92.0 | 80.0 | 82.0 | 64.0 | 46.0 | 50 |
| Contract | 88.3 | 76.6 | 70.1 | 66.2 | 41.6 | 77 |
| Casual | 91.1 | 82.3 | 81.0 | 45.6 | 35.4 | 79 |
| All | 90.3 | 79.6 | 77.2 | 57.8 | 40.3 | 206 |
| Kaweri | | | | | | |
| Permanent | 93.8 | 85.9 | 85.9 | 64.1 | 46.9 | 64 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 89.9 | 78.0 | 76.8 | 62.5 | 38.7 | 168 |
| All | 90.9 | 80.2 | 79.3 | 62.9 | 40.9 | 232 |
| Wilmar | | | | | | |
| Permanent | 80.0 | 100.0 | 93.3 | 73.3 | 66.7 | 15 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 93.1 | 72.0 | 72.8 | 60.2 | 34.9 | 261 |
| All | 92.4 | 73.6 | 73.9 | 60.9 | 36.6 | 276 |
| **Total** | **90.7** | **77.0** | **76.7** | **63.0** | **40.4** | **1,065** |

[1]Corresponds to Emergency Plan Policy and Systems Strengthening (Capacity Building) Indicator 2 "Percent of the general population with accepting attitudes toward persons living with HIV/AIDS"
and to UNAIDS Stigma and Discrimination Indicator 1 "Accepting attitudes toward those living with HIV".

# CHAPTER 5: HIV RELATED BEHAVIOURS

## 5.1. Key Findings

- Over 96 percent of the respondents said that they have ever had sex. Compared to men, a slightly higher proportion of women reported that they have ever had sex.
- The median ages at first sex for women and men were 16 and 18 years, respectively.
- Overall, 37 percent of women and 24.5 percent of men initiated sex before the age of 15 years.
- Primary abstinence was more common among men (12.9 percent) than in women (3 percent).
- Overall, only 0.5 percent of respondents reported that they had no sex during the last 12 months. Secondary abstinence was more common among women (1 percent) than in men (0.4 percent).
- There is a widespread acceptance of the ability of women to negotiate safer sex with their husbands. About 96 percent of women and 92 percent of men agree that a wife is justified in refusing to have sex with her husband if she knows he has a sexually transmitted disease and/or believe that a wife is justified in asking that he uses a condom if she knows that her husband has a sexually transmitted infection.
- Of those who were sexually active in the 12 months preceding the survey, the proportions that were in multiple sexual relationships were higher in men (27.1 percent) than in women (9.1 percent).
- Compared to women, men had a higher mean number of sexual partners. The mean number of lifetime sexual partners was 6.3 in men compared to 3.2 in women.
- Higher risk sex was more common in men than in women.
- Condom use during the last higher risk sexual encounter was higher in men than in women. Similarly, in all the four surveyed plantations, women were less likely to report consistent condom use during higher risk sex than men.
- About 7 percent of the respondents reported that they had had paid sex in the 12 months preceding the survey. Of these people who reported paid sex, 52 percent said they had used condoms.

## 5.2. Introduction

In Uganda, heterosexual contact is the most predominant route of HIV transmission. This route of transmission is largely driven by risky sexual behaviours. Due to this, the national HIV prevention programme promotes reduction of risky sexual behaviours while encouraging uptake of preventive sexual behaviours by the general population and specific high risk groups. The major strategies comprises risk reduction and risk avoidance measures including promotion of abstinence among youth, fidelity in marriage and condom use with non-regular sexual partners. The programme discourages high risky sexual practices including multiple and casual sexual partnerships, cross generation, transactional and commercial sex as well. Moreover, available evidences support that HIV risk-avoidance is associated with reduction trends in HIV prevalence. On the other hand,

risk-taking has been shown to be associated with increased risk of HIV transmission. Therefore, it is crucial to determine HIV-related behavioural indicators among populations. In this respect, it is important to determine whether people are practicing positive behaviour change through adoption of risk reduction behaviours such as abstinence, reduction in premarital sex, avoiding non-spousal sex, and condom use during non-spousal sex.

In this survey, the key HIV-related behavioural variables examined included primary abstinence, median age at sexual debut, secondary abstinence, premarital sex, casual sex, multiple sex partnership and condom use. Primary abstinence was defined as the proportion of youth (age 15-24) who have never had sex. Median age at first sexual intercourse was defined as the age by which 50% of the respondents had initiated sex, calculated from cumulative single-year percent distribution of age at first sexual intercourse. Secondary abstinence was defined as the proportion of youth who have ever had sex but not in the past 12 months. Cross-generational sex was defined as non-spousal sex by a woman age 15-19 years with a man 10 or more years older. Other variables studied consisted of the number of sex partners in last 12 months (among those who had sex in last 12 months aged 15-49 years old), non-spousal sex: Proportion who engaged in sex with non-marital, non-cohabiting partner in the past 12 months (who had sex in last 12 months, aged 15-49), proportion who used condom at last sex (15-49 years old, who had sex in last 12 months), proportion who used condoms during last non-spousal sex (15-49 years old who had non-spousal sex in last 12 months), proportion who reported consistent condom use in the last 12 months (15-49 years old, who had sex in last 12 months), proportion who had sex in exchange for money or fish or sugar in the last 12 months.

### 5.3. Age at First Sexual Intercourse

Sexual intercourse is the most common mode of HIV transmission in sub-Saharan Africa. Looking at age at first sex is one way to understand when individuals are first exposed to the risk of infection with the virus. Table 5.1 shows the percentage of respondents who have ever had sex. Table 5.2 shows the median age at first sex and the percentage of respondents who had sex by specific ages.

The results on Table 5.1 show that over 96 percent of the respondents said that they have ever had sex. Compared to men, a slightly higher proportion of women reported that they have ever had sex. Looking at all the four surveyed plantations, there was little variation in the indicator across the plantations.

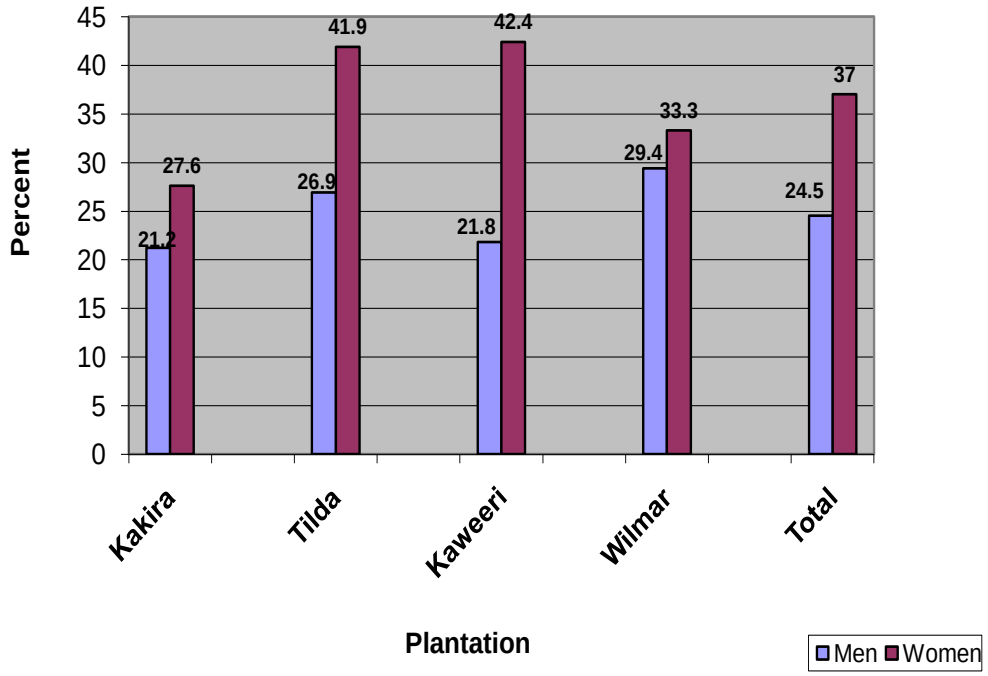
As shown in Tables 5.2 and 5.3, median age at first sex for women and men were 16 and 18 years, respectively. Among women, median age at first sex was 16 years in both Tilda and Kaweri; and 17 years in Kakira and Wilmar; in men, it was 17 years in Wilmar and 18 years in the rest of the plantations.

### 5.4. Initiation of Sex before age 15 years

As shown on Figure 5.1; overall, 37 percent of women and 24.5 percent of men reported that they had sex before age 15 years. In addition, 76 percent of women and 65 percent of men had initiated sex by age 18 years. Across all the surveyed plantations, a similar pattern was seen; a higher proportion of women than men reported to have initiated sex

before the ages 15 and 18. Specifically, the proportions of women who initiated sex before age 15 were 27.6 percent in Kakira, 41.9 percent in Tilda, 42.4 percent in Kaweri and 33.3 percent in Wilmar. For men, the proportions were 21.2 percent in Kakira, 26.9 percent in Tilda, 21.3 percent in Kaweri and 29.4 percent in Wilmar.

**Figure 5.1. Percentage who had sex by age 15 by sex**




Analysis was also done to determine the magnitude of cross-generational sex among young women. The results show that the practice was minimal; only a total of 9 respondents reported this (Table 5.1.2). The percentage of women aged 15-19 who have had sexual intercourse with non-marital non-cohabiting partners (higher risk sex) who was 10 years or older than themselves in the last 12 months is 11 percent. However, given the small denominator, the interpretation of this information is unreliable.

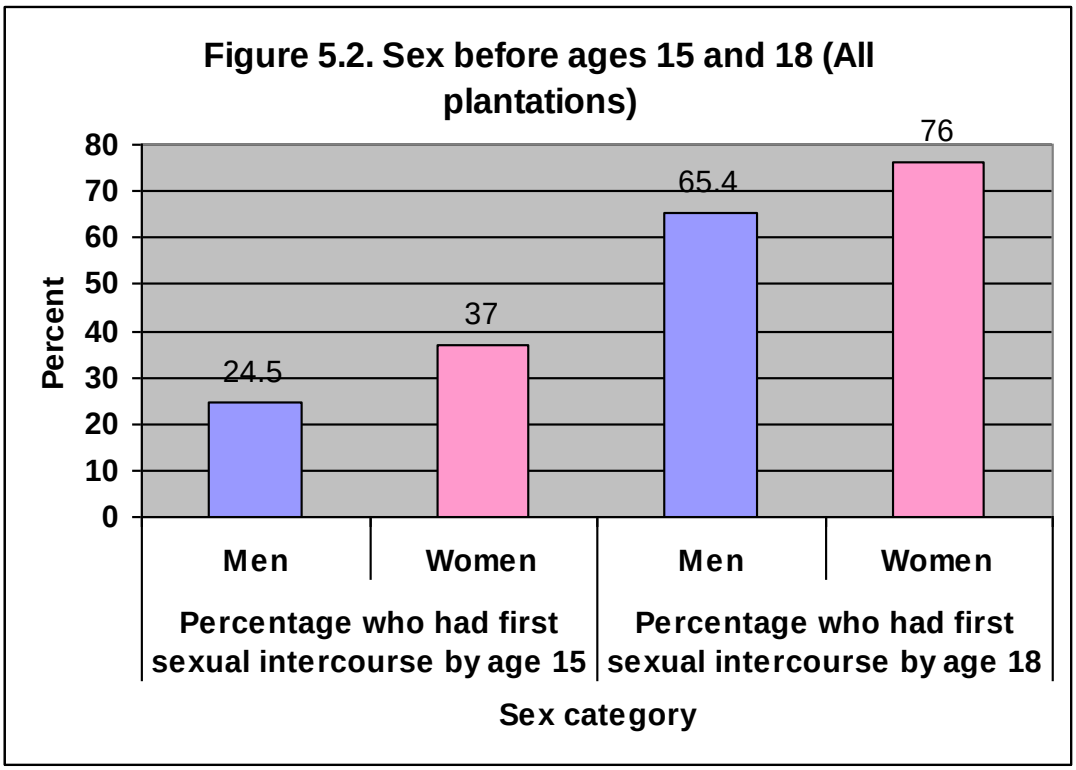



**Table 5.1.1: Respondents that have ever played sex**

| Name of Plantation | WOMEN | | | MEN | | | TOTAL | | |
|---|---|---|---|---|---|---|---|---|---|
| | Never Had Sexual Intercourse | Ever Had Sexual Intercourse | | Never Had Sexual Intercourse | Ever Had Sexual Intercourse | | Never Had Sexual Intercourse | Ever Had Sexual Intercourse | |
| | Percentage | Percentage | Number of women | Percentage | Percentage | Number of men | Percentage | Percentage | Total Number |
| Kakira | 0.0 | 100.0 | 76 | 5.6 | 94.4 | 356 | 4.6 | 95.4 | 432 |
| Tilda | 2.8 | 97.2 | 108 | 2.4 | 97.6 | 206 | 2.5 | 97.5 | 314 |
| Kaweri | 0.0 | 100.0 | 95 | 3.0 | 97.0 | 233 | 2.1 | 97.9 | 328 |
| Wilmar | 0.0 | 100.0 | 81 | 7.2 | 92.8 | 277 | 5.6 | 94.4 | 358 |
| **Total** | **0.8** | **99.2** | **360** | **4.9** | **95.1** | **1,072** | **3.8** | **96.2** | **1,432** |

## Table 5.1.2. Age-mixing in sexual relationships

Percentage of women age 15-19 who have had sexual intercourse with a non-marital non-cohabiting partner (higher risk sex) who was 10 years or more older than themselves in the last 12 months, by background characteristics

| Background characteristic | Percentage who had higher risk sex with a man 10+ years older[1] | Number of women 15-19 having higher risk sex in the last 12 months |
|---|---|---|
| Plantation | | |
| Kakira Sugar | - | - |
| Tildar Rice | 33.3 | 3 |
| Kaweri Coffee | 0 | 3 |
| Wilmar Palm Oil | 0 | 3 |
| Form of Employment | | |
| Permanent | 0 | 1 |
| Contract | - | - |
| Casual | 12.5 | 8 |
| Age | | |
| 15-17 | 0 | 5 |
| 18-19 | 25.0 | 4 |
| Marital status | | |
| Never married | 11.1 | 9 |
| Ever married | - | - |
| Education | | |
| Nursery | 100.0 | 1 |
| Primary | 0 | 4 |
| Post Primary/Vocational | 0 | 1 |
| Secondary/'A' Level | 0 | 3 |
| College | - | - |
| University | - | - |
| Religion | | |
| Roman Catholic | 0 | 5 |
| Protestant/Other Christian | 0 | 1 |
| Muslim | - | - |
| Other | 33.3 | 3 |
| Total 15-19 | 11.1 | 9 |

[1]Corresponds to UNAIDS Young People's Sexual Behavior Indicator "Age-mixing in sexual relationships" (Among the last three partners in the last 12 months). This is an Additional Indicator.

**Table 5.1.3: Mean and median age at sexual debut in those aged 19-24 years**

| Name of Plantation | WOMEN | | | | MEN | | | | TOTAL | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mean Age at Sexual Debut | Standard Deviation | Median Age at Sexual Debut (50% Mark) | Number Reporting Age At First Sex | Mean Age at Sexual Debut | Standard Deviation | Median Age at Sexual Debut (50% Mark) | Number Reporting Age At First Sex | Mean Age at Sexual Debut | Standard Deviation | Median Age at Sexual Debut (50% Mark) | Number Reporting Age At First Sex |
| Kakira | 18.0 | 0.0 | 18 | 2 | 17.5 | 2.7 | 17 | 47 | 17.5 | 2.7 | 18 | 49 |
| Tilda | 16.8 | 2.9 | 18 | 20 | 16.8 | 2.9 | 17 | 40 | 16.8 | 2.9 | 17 | 60 |
| Kaweri | 15.2 | 3.5 | 17 | 24 | 17.3 | 3.1 | 17 | 65 | 16.7 | 3.3 | 17 | 89 |
| Wilmar | 16.1 | 2.6 | 18 | 35 | 16.6 | 2.5 | 17 | 95 | 16.5 | 2.5 | 16 | 130 |
| **Total** | **16.0** | **3.0** | **16** | **81** | **17.0** | **2.8** | **17** | **247** | **16.8** | **2.8** | **17** | **328** |

**Table 5.2: Age at first sexual intercourse among women**

Percentage of women who had first sexual intercourse by specific exact ages and median age at first intercourse, according to plantation

| Name of Plantation | Percentage who had first sexual intercourse by age: | | | | | Mean Age at Sexual Debut (Years) | Standard Deviation (Years) | Median Age at Sexual Debut (50% Mark in years ) | 75% Mark (Years) | Number Reporting Age At First Sex |
|---|---|---|---|---|---|---|---|---|---|---|
| | 10 | 15 | 18 | 20 | 25 | | | | | |
| Kakira | 0.0 | 27.6 | 69.7 | 89.5 | 96.1 | 18.1 | 5.5 | 17.0 | 19.0 | 76 |
| Tilda | 1.0 | 41.9 | 80.0 | 91.4 | 99.0 | 16.6 | 3.3 | 16.0 | 18.0 | 105 |
| Kaweri | 1.1 | 42.4 | 76.1 | 91.3 | 100.0 | 16.5 | 3.0 | 16.0 | 18.0 | 92 |
| Wilmar | 2.5 | 33.3 | 76.5 | 92.6 | 98.8 | 16.8 | 2.9 | 17.0 | 18.0 | 81 |
| **Total** | **1.1** | **37.0** | **76.0** | **91.2** | **98.6** | **16.9** | **3.8** | **16.0** | **18.0** | **354** |

**Table 5.3: Age at first sexual intercourse among men**

Percentage of men who had first sexual intercourse by specific exact ages and median age at first intercours e, according to plantation

| Name of Plantation | Percentage who had first sexual intercourse by age: | | | | | Mean Age at Sexual Debut (Years) | Standard Deviation (Years) | Median Age at Sexual Debut (50% Mark in years ) | 75% Mark (Years) | Number Reporting Age At First Sex |
|---|---|---|---|---|---|---|---|---|---|---|
| | 10 | 15 | 18 | 20 | 25 | | | | | |
| Kakira | 0.9 | 21.2 | 59.7 | 79.4 | 96.7 | 18.3 | 3.5 | 18.0 | 20.0 | 335 |
| Tilda | 2.5 | 26.9 | 67.0 | 88.8 | 97.0 | 17.5 | 3.2 | 18.0 | 19.0 | 197 |
| Kaweri | 1.8 | 21.8 | 65.5 | 85.9 | 99.1 | 17.7 | 3.2 | 18.0 | 20.0 | 220 |
| Wilmar | 2.0 | 29.4 | 71.8 | 88.2 | 98.8 | 17.2 | 3.2 | 17.0 | 19.0 | 255 |
| **Total** | **1.7** | **24.5** | **65.4** | **84.9** | **97.8** | **17.7** | **3.4** | **18.0** | **20.0** | **1,007** |

## 5.5. Primary and Secondary Abstinence

Analysis was done to determine what proportion of youth was practicing primary and secondary abstinence. Secondary abstinence was defined as the proportion of youth who have ever had sex but not in the past 12 months. Premarital sex was defined as the proportion of never married men and women who ever have had sex. Tables 5.4.1 and 5.4.2 show that among the age group 15-24 years, 10.5 percent had never had sexual intercourse. Primary abstinence was more common among men (12.9 percent) than in women (3 percent). Overall, only 0.5 percent of respondents reported that they had no sex during the last 12 months. Secondary abstinence was more common among women (1 percent) than in men (0.4 percent).

**Table 5.4.1: Primary Abstinence: Respondents aged 15-24 years, that have never played sex**

| Name of Plantation | WOMEN | | | MEN | | | TOTAL | | |
|---|---|---|---|---|---|---|---|---|---|
| | Never Had Sexual Intercourse | Ever Had Sexual Intercourse | Number of women age 15-24 | Never Had Sexual Intercourse | Ever Had Sexual Intercourse | Number of men age 15-24 | Never Had Sexual Intercourse | Ever Had Sexual Intercourse | Total Number age 15-24 |
| | Percentage | Percentage | | Percentage | Percentage | | Percentage | Percentage | |
| Kakira | 0.0 | 100.0 | 2 | 21.0 | 79.0 | 62 | 20.3 | 79.7 | 64 |
| Tilda | 10.7 | 89.3 | 28 | 6.1 | 93.9 | 49 | 7.8 | 92.2 | 77 |
| Kaweri | 0.0 | 100.0 | 30 | 8.6 | 91.4 | 81 | 6.3 | 93.7 | 111 |
| Wilmar | 0.0 | 100.0 | 41 | 14.2 | 85.8 | 127 | 10.7 | 89.3 | 168 |
| Total | 3.0 | 97.0 | 101 | 12.9 | 87.1 | 319 | 10.5 | 89.5 | 420 |

**Table 5.4.2: Secondary Abstinence: Sexually experienced respondents aged 15-24 years, that did not have sex in the past 12 months**

| Name of Plantation | WOMEN | | | MEN | | | TOTAL | | |
|---|---|---|---|---|---|---|---|---|---|
| | Had no sex during last 12 months | Had sex during last 12 months | Number of women age 15-24 | Had no sex during last 12 months | Had sex during last 12 months | Number of men age 15-24 | Had no sex during last 12 months | Had sex during last 12 months | Total Number age 15-24 |
| | Percentage | Percentage | | Percentage | Percentage | | Percentage | Percentage | |
| Kakira | 0.0 | 100.0 | 2 | 0.0 | 100.0 | 49 | 0.0 | 100.0 | 51 |
| Tilda | 4.0 | 96.0 | 25 | 0.0 | 100.0 | 46 | 1.4 | 98.6 | 71 |
| Kaweri | 0.0 | 100.0 | 30 | 1.4 | 98.6 | 74 | 1.0 | 99.0 | 104 |
| Wilmar | 0.0 | 100.0 | 41 | 0.0 | 100.0 | 109 | 0.0 | 100.0 | 150 |
| Total | 1.0 | 99.0 | 98 | 0.4 | 99.6 | 278 | 0.5 | 99.5 | 376 |

### 5.5.1. Condom use during first sex

Analysis was done to determine condom use at first sex among young women and men (age 15-24) who have ever had sex. Overall, about one third (36 percent) of the respondents aged 15-24 said that they used condoms during their first sexual encounters. There was no significant difference in condom use between women and men.

Analysis was also conducted involving disaggregating data by marital status, forms of employment, knowledge of at least one source of condoms and age of the respondent. The results show that condom use is higher among the never married, those who know at least one source of condoms, staff in permanent category and younger respondents, compared to the ever married, those who do not know at least one source of condoms, staff in casual/contract categories and older respondents, respectively.

When the individual plantations are considered, the data show that the proportion of both men and women who used condoms at first sex is 42 percent in Kakira, 37.3 percent in Wilmar, 35.8 percent in Tilda and 29.4 percent in Kaweri.

**Table 5.4.3.** Condom use at first sex among young women and men

Among women and men age 15-24 who have ever had sex, percentage who used a condom the first time they ever had sex, by background characteristics, [COUNTRY, YEAR]

| | WOMEN | | MEN | | TOTAL | |
|---|---|---|---|---|---|---|
| Background characteristic | Used a condom at first sex[1] | Number of women age 15-24 who have ever had sex | Used a condom at first sex[1] | Number of men age 15-24 who have ever had sex | Used a condom at first sex[1] | Number of respondents age 15-24 who have ever had sex |
| Plantation | | | | | | |
| Kakira Sugar | 0.0 | 2 | 43.8 | 48 | 42.0 | 50 |
| Tildar Rice | 28.0 | 25 | 40.5 | 42 | 35.8 | 67 |
| Kaweri Coffee | 40.0 | 30 | 25.0 | 72 | 29.4 | 102 |
| Wilmar Palm Oil | 41.5 | 41 | 35.8 | 109 | 37.3 | 150 |
| Form of Employment | | | | | | |
| Permanent | 33.3 | 6 | 57.9 | 19 | 52.0 | 25 |
| Contract | 10.0 | 10 | 36.8 | 57 | 32.8 | 67 |
| Casual | 40.2 | 82 | 32.3 | 195 | 34.7 | 277 |
| Age | | | | | | |
| 15-19 | | | | | | |
| 15-17 | 55.6 | 9 | 33.3 | 9 | 44.4 | 18 |
| 18-19 | 28.6 | 14 | 36.1 | 36 | 34.0 | 50 |
| 20-24 | | | | | | |
| 20-22 | 32.6 | 43 | 31.2 | 125 | 31.5 | 168 |
| 23-24 | 40.6 | 32 | 39.6 | 101 | 39.8 | 133 |
| Marital status | | | | | | |
| Never married | 44.8 | 29 | 38.8 | 160 | 39.7 | 189 |
| Ever married | 33.3 | 69 | 29.7 | 111 | 31.1 | 180 |
| Know condom source [2] | | | | | | |
| Yes | 40.3 | 72 | 36.3 | 248 | 37.2 | 320 |
| No | 26.9 | 26 | 21.7 | 23 | 24.5 | 49 |
| Total 15-24 | 36.7 | 98 | 35.1 | 271 | 35.5 | 369 |

[1] Corresponds to UNAIDS Young People's Sexual Behavior Indicator 6 "Condom use at first sex".

[2] The following sources are not considered sources for condoms in this table: friends, family members, and home.

## 5.6. Attitudes towards Negotiating Safer Sex

Power of people to negotiate for safer sex with their partners is very important in HIV prevention. If a person is powerless to negotiate safer sex with their partners, knowledge about HIV transmission and ways to prevent it will be less useful. Given this, during the survey, some questions were asked to gauge the attitudes towards safer sex. The respondents were asked if they think a wife is justified in refusing to have sex with her husband if she knows he has a disease that can be transmitted through sexual contact. They were also asked if they think that a woman in the same circumstances is justified in asking her husband to use a condom.

As shown in Table 5.2 and Figure 5.1, among the plantation workers, 85.3 percent of women and 78.8 percent of men feel that a wife is justified in refusing to have sex with her husband if she knows he has a sexually transmitted disease, while 92.2 percent of women and 88.5 percent of men believe that a wife is justified in asking that they use a condom if she knows that her husband has a sexually transmitted infection. About 96 percent of women and 92 percent of men agree with at least one statement, indicating widespread acceptance of the ability of women to negotiate safer sex with their husbands. Men are somewhat less likely than women to feel that a wife is justified in negotiating safer sex.

## 5.7. Multiple Sexual Partnerships

Examination of the number of sexual partners of sexually people is important because having many sexual partners widens sexual network and increases the risk of HIV transmission. Each new partner is expected to bring with it new risk of HIV transmission. Therefore, it was deemed necessary to ask questions on multiple sexual relationships during this survey. Related to this, condom use among respondents who engage in multiple sexual relationships was also examined. This was done in recognition of the fact that use of condoms during this act reduces the risk of HIV transmission.

From the analysis, the results indicate that over 95 percent of respondents reported that they were sexually active in the last 12 months preceding the survey. Overall, women were more sexually active (98.6 percent) compared to men (94.4 percent). However, of those who were sexually active, the proportions that were in multiple sexual relationships were higher in men (27.1 percent) than in women (9.1 percent). Furthermore, compared to women, men had a higher mean number of sexual partners. The mean number of sexual partners was 6.3 in men compared to 3.2 in women. When data was disaggregated by work category and the individual surveyed plantations, a similar trend was seen. Specifically, among men, the proportion that engaged in multiple sexual relationship is 18.5 percent in Kakira, 40.8 percent in Tilda, 32.5 percent in Kaweri and 23.8 percent in Wilmar. In respect to mean number of lifetime sexual partners among men, Tilda had the highest number (7.8) while Kakira has the lowest number (5.1). Among women, Kaweri has the highest number (3.7) while Kakira has the lowest number (2.9).

## Table 5.6: Attitudes toward negotiating safer sex with husband

Percentage of women and men who believe that, if a husband has a sexually transmitted disease, his wife is justified in either refusing to have sex with him or asking that he uses a condom, by plantation and form of employment

| Name of Plantation/ Form of Employment | WOMEN | | | | MEN | | | |
|---|---|---|---|---|---|---|---|---|
| | Woman is justified to: | | | | Woman is justified to: | | | |
| | Refuse sex | Propose condom use | Refuse sex or propose condom use[1] | Number of women | Refuse sex | Propose condom use | Refuse sex or propose condom use[1] | Number of men |
| Kakira | | | | | | | | |
| Permanent | 79.3 | 93.1 | 96.6 | 29 | 83.7 | 90.2 | 94.1 | 153 |
| Contract | 89.4 | 87.2 | 95.7 | 47 | 68.5 | 77.3 | 85.2 | 203 |
| Casual | NA | NA | NA | NA | NA | NA | NA | NA |
| All | 85.5 | 89.5 | 96.1 | 76 | 75.0 | 82.9 | 89.0 | 356 |
| Tilda | | | | | | | | |
| Permanent | 100.0 | 85.7 | 100.0 | 7 | 84.0 | 96.0 | 96.0 | 50 |
| Contract | 76.1 | 82.6 | 89.1 | 46 | 68.8 | 89.6 | 90.9 | 77 |
| Casual | 72.7 | 94.5 | 94.5 | 55 | 87.3 | 92.4 | 96.2 | 79 |
| All | 75.9 | 88.9 | 92.6 | 108 | 79.6 | 92.2 | 94.2 | 206 |
| Kaweri | | | | | | | | |
| Permanent | 84.2 | 94.7 | 94.7 | 19 | 79.7 | 93.8 | 96.9 | 64 |
| Contract | NA | NA | NA | NA | NA | NA | NA | NA |
| Casual | 94.7 | 97.4 | 98.7 | 76 | 87.6 | 92.3 | 95.9 | 169 |
| All | 92.6 | 96.8 | 97.9 | 95 | 85.4 | 92.7 | 96.1 | 233 |
| Wilmar | | | | | | | | |
| Permanent | 100.0 | 100.0 | 100.0 | 1 | 80.0 | 86.7 | 100.0 | 15 |
| Contract | NA | NA | NA | NA | NA | NA | NA | NA |
| Casual | 88.8 | 93.8 | 97.5 | 80 | 77.5 | 89.7 | 92.0 | 262 |
| All | 88.9 | 93.8 | 97.5 | 81 | 77.6 | 89.5 | 92.4 | 277 |
| **Total** | **85.3** | **92.2** | **95.8** | **360** | **78.8** | **88.5** | **92.4** | **1,072** |

[1]Corresponds to UNAIDS Sexual Negotiation Indicator 1 "Women's ability to negotiate safer sex with husband".

**Table 5.7.1: Multiple sexual partnerships among women**

Percentage of women age 15-49 who had sexual intercourse in the last 12 months, and among them, the percentage who have had intercourse with more than one partner in the last 12 months, and mean number of lifetime sexual partners among those who have had intercourse, by plantation and form of employment

| | WOMEN | | | | | |
|---|---|---|---|---|---|---|
| Name of Plantation/ Form of Employment | Percentage who had sex in last 12 months | Number of women 15-49 | Percentage who had 2+ partners in the last 12 months[1] | Number of women who had sex in last 12 months | Mean number of lifetime sexual partners | Number of women 15-49 who ever had sex |
| Kakira | | | | | | |
| Permanent | 100.0 | 25 | 0.0 | 25 | 2.9 | 25 |
| Contract | 100.0 | 46 | 6.5 | 46 | 2.9 | 46 |
| Casual | NA | NA | NA | NA | NA | NA |
| All | 100.0 | 71 | 4.2 | 71 | 2.9 | 71 |
| Tilda | | | | | | |
| Permanent | 100.0 | 5 | 0.0 | 5 | 2.6 | 5 |
| Contract | 95.6 | 45 | 9.3 | 43 | 2.9 | 44 |
| Casual | 94.4 | 54 | 5.9 | 51 | 3.1 | 52 |
| All | 95.2 | 104 | 7.1 | 99 | 3.0 | 101 |
| Kaweri | | | | | | |
| Permanent | 100.0 | 18 | 11.1 | 18 | 2.9 | 18 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 100.0 | 75 | 12.0 | 75 | 3.9 | 75 |
| All | 100.0 | 93 | 11.8 | 93 | 3.7 | 93 |
| Wilmar | | | | | | |
| Permanent | 100.0 | 1 | 100.0 | 1 | 5.0 | 1 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 100.0 | 77 | 11.7 | 77 | 3.0 | 77 |
| All | 100.0 | 78 | 12.8 | 78 | 3.0 | 78 |
| **Total 15-49** | **98.6** | **346** | **9.1** | **341** | **3.2** | **343** |

[1] Corresponds to Emergency Plan Core Prevention Indicator 4 "Percent of women and men aged 15-49 who had sex with more than one partner in the last 12 months"

## 5.8. Higher Risk Sex

Analysis was conducted to determine the magnitude of “higher risk sex” among women and men who were sexually active in the 12 months preceding the survey. Higher risk sex was defined as sex with a nonmarital, noncohabiting partner in the 12 months preceding the survey. By this definition, all premarital sex is higher-risk sex. Since condom use is an important HIV prevention method especially during higher risk sex, additional analysis was conducted to determine condom use during the last higher risk sex (Table 5.6).

The results show that higher risk sex was more common in men than in women. The proportion of male respondents who engaged in higher-risk sex ranges from 42.9 percent in both Tilda and Wilmar to 44.4 percent in Kakira. In women, it ranges from 11.8 percent in

**Table 5.7.2. Multiple sexual partnerships among men**

Percentage of men age 15-49 who had sexual intercourse in the last 12 months, and among them, the percentage who have had intercourse with more than one partner in the last 12 months, and mean number of lifetime sexual partners among those who have had intercourse, by plantation and form of employment

| | MEN | | | | | |
|---|---|---|---|---|---|---|
| Name of Plantation/ Form of Employment | Percentage who had sex in last 12 months | Number of men 15-49 | Percentage who had 2+ partners in the last 12 months[1] | Number of men who had sex in last 12 months | Mean number of lifetime sexual partners | Number of men 15-49 who ever had sex |
| Kakira | | | | | | |
| Permanent | 95.9 | 147 | 28.4 | 141 | 7.3 | 143 |
| Contract | 92.0 | 200 | 10.9 | 184 | 3.5 | 184 |
| Casual | NA | NA | NA | NA | NA | NA |
| All | 93.7 | 347 | 18.5 | 325 | 5.1 | 327 |
| Tilda | | | | | | |
| Permanent | 100.0 | 41 | 51.2 | 41 | 9.4 | 41 |
| Contract | 95.9 | 73 | 37.1 | 70 | 8.1 | 69 |
| Casual | 96.1 | 76 | 38.4 | 73 | 6.6 | 75 |
| All | 96.8 | 190 | 40.8 | 184 | 7.8 | 185 |
| Kaweri | | | | | | |
| Permanent | 100.0 | 57 | 28.1 | 57 | 4.8 | 57 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 95.1 | 163 | 34.2 | 155 | 6.6 | 156 |
| All | 96.4 | 220 | 32.5 | 212 | 6.1 | 213 |
| Wilmar | | | | | | |
| Permanent | 93.3 | 15 | 7.1 | 14 | 7.3 | 14 |
| Contract | NA | NA | NA | NA | NA | NA |
| Casual | 92.1 | 254 | 24.8 | 234 | 7.0 | 235 |
| All | 92.2 | 269 | 23.8 | 248 | 7.0 | 249 |
| **Total 15-49** | **94.4** | **1,026** | **27.1** | **969** | **6.3** | **974** |

[1] Corresponds to Emergency Plan Core Prevention Indicator 4 "Percent of women and men aged 15-49 who had sex with more than one partner in the last 12 months"

Kakira to 41.1 percent in Kaweri. In regard to condom use, the proportion of respondents who used a condom during their last sexual encounter with nonmarital, noncohabiting partner was higher in men than in women. This trend was also maintained when the data was analyzed by individual plantations and work categories.

## 5.9. Consistent Condom Use During Higher Risk Sex

Correct and consistent condom use is one of the important means of preventing HIV transmission among sexually active people. The intervention is especially important for the prevention of HIV transmission during higher risk sex. To examine the magnitude of condom use during higher risk sex, respondents who were sexually active in the preceding 12 months were asked whether they used a condom every time they had sexual intercourse with a non-marital, non-cohabiting partner.

Table 5.8 shows the percentage of respondents who say they used a condom every time they had sexual intercourse with a non-marital, non-cohabiting partner in the last 12 months. The results show that among all women and men reporting higher risk sex, the percentage of respondents who say they used a condom every time they had sexual intercourse with such partners was 23 percent in women and 43 percent in women (Figure 5.3). Among both women and men, the percentage that reported consistent condom use was about 38 percent. In all the four surveyed plantations, women were less likely to report consistent condom use during higher risk sex than men (Figure 5.4). The percentage of women who reported consistent condom use during higher risk sex in the last 12 months was 33 percent in Kakira, 14 percent in Tilda, 26 percent in Kaweri and 21 percent in Wilmar. On the other hand, percentage of men who reported consistent condom use during higher risk sex in the last 12 months was 46 percent in Kakira, 34 percent in Tilda, 36 percent in Kaweri and 50 percent in Wilmar.

### 5.10. Paid Sex (Commercial Sex)

Paid sex was defined as having sex in exchange for money or gift (sugar, fish, favour and so forth). Paid sex may be related to a higher risk for contracting HIV/AIDS and other sexually transmitted infections and then passing them on to subsequent partners because it usually leads to multiple sexual partnership. During this survey, the respondents who were sexually active in the last 12 months preceding the survey were asked about paid sex. Men were asked, “In the past 12 months, did you pay anyone to have sex?” Women were asked, “In the past 12 months, did any man pay you to have sex?” As a follow up, for those who answered in affirmative, they were asked whether they used condoms during the last such act. In response, 6.6 percent of all the respondents reported that they had had paid sex. Of these people who reported paid sex, 52 percent said they had used condoms. The above indicates that almost half of the respondents did not use condoms during the last paid sex. Furthermore, although the total number of men who had paid for sex was low (71), disaggregating the data by individual plantations showed that paid sex varied from place to place; being highest in Wilmar (9.4 percent) and lowest in Kakira (2.8 percent). Paid sex also varied with age, marital status, educational background and employment type. Paid sex was lowest in the age category 45-59 (3.4 percent) and highest among the younger respondents aged 15-19 (12.3 percent) and 20-24 (11.4 percent). When marital status was considered, paid sex was found to be most common in unmarried people (11.6 percent) followed by those who had been divorced or separated (8.3 percent). Those respondents who were married/living together were least likely to report engagement in paid sex (4.6 and 3.9 percent, respectively). Considering educational background, there was a higher proportion of reported paid sex among respondents who had attained less than secondary education.

Similarly, condom use during the last paid sex varied with the areas surveyed, educational attainment, marital status, age and religion. Among the four surveyed plantations, condom use was 30.8 percent in Tilda, 36 percent in Kaweri, 40 percent in Kakira and 80.8 percent in Wimar. In the different age groups, condom use was most common in the age groups 20-29 (62 percent) and 25-29 (56 percent).

## Table 5.8. Consistent condom use in higher risk sex during past 12 months

Among all women and men reporting high risk sex (had sex with a non-marital, non-cohabiting partner) in the last 12 months, percentage who say they used a condom every time they had sexual intercourse with such partners, by background characteristics

| | WOMEN | | MEN | | TOTAL | |
|---|---|---|---|---|---|---|
| Background characteristic | % consistently using condom at higher risk sex in last 12 months | Number of women with higher risk sex in the last 12 months | % consistently using condom at higher risk sex in last 12 months | Number of men with higher risk sex in the last 12 months | % consistently using condom at higher risk sex in last 12 months | Number with higher risk sex in the last 12 months |
| Plantation | | | | | | |
| Kakira Sugar | 33.3 | 9 | 46.0 | 63 | 44.4 | 72 |
| Tilda Rice | 14.3 | 21 | 34.0 | 53 | 28.4 | 74 |
| Kaweri Coffee | 25.6 | 39 | 36.0 | 89 | 32.8 | 128 |
| Wilmar Palm Oil | 21.4 | 14 | 49.6 | 113 | 46.5 | 127 |
| Form of Employment | | | | | | |
| Permanent | 45.5 | 11 | 39.4 | 66 | 40.3 | 77 |
| Contract | 14.3 | 14 | 36.4 | 44 | 31.0 | 58 |
| Casual | 20.7 | 58 | 44.7 | 208 | 39.5 | 266 |
| Age | | | | | | |
| 15-19 | 33.3 | 9 | 35.3 | 34 | 34.9 | 43 |
| 20-24 | 15.0 | 20 | 53.7 | 108 | 47.7 | 128 |
| 25-29 | 20.0 | 15 | 39.5 | 81 | 36.5 | 96 |
| 30-34 | 33.3 | 15 | 33.3 | 42 | 33.3 | 57 |
| 35-39 | 27.3 | 11 | 41.7 | 24 | 37.1 | 35 |
| 40-44 | 0.0 | 5 | 23.5 | 17 | 18.2 | 22 |
| 45-49 | 28.6 | 7 | 55.6 | 9 | 43.8 | 16 |
| 50-54 | 0.0 | 1 | 0.0 | 1 | 0.0 | 2 |
| 55-59 | - | 0 | 0.0 | 2 | 0.0 | 2 |
| Marital status | | | | | | |
| Never married | 28.0 | 25 | 47.4 | 152 | 44.6 | 177 |
| Married | 11.1 | 9 | 41.8 | 110 | 39.5 | 119 |
| Living together | 0.0 | 5 | 29.6 | 27 | 25.0 | 32 |
| Divorced/Separated | 25.8 | 31 | 33.3 | 27 | 29.3 | 58 |
| Widowed | 23.1 | 13 | 0.0 | 2 | 20.0 | 15 |
| Education | | | | | | |
| Nursery | 0.0 | 1 | - | 0 | 0.0 | 1 |
| Primary | 21.2 | 52 | 40.1 | 172 | 35.7 | 224 |
| Post Primary/Vocational | 50.0 | 2 | 53.8 | 13 | 53.3 | 15 |
| Secondary/'A' Level | 27.8 | 18 | 41.6 | 101 | 39.5 | 119 |
| College | 50.0 | 4 | 46.7 | 15 | 47.4 | 19 |
| University | - | 0 | 62.5 | 8 | 62.5 | 8 |
| Not Stated | 0.0 | 6 | 55.6 | 9 | 33.3 | 15 |
| Religion | | | | | | |
| Roman Catholic | 22.7 | 44 | 46.3 | 134 | 40.4 | 178 |
| Protestant/Other Christian | 38.1 | 21 | 36.4 | 129 | 36.7 | 150 |
| Muslim | 12.5 | 8 | 47.4 | 38 | 41.3 | 46 |
| No Religion | 0.0 | 2 | 50.0 | 2 | 25.0 | 4 |
| Other | 0.0 | 8 | 46.7 | 15 | 30.4 | 23 |
| Distance to former place of residence | | | | | | |
| Born in that area | 31.6 | 19 | 35.7 | 28 | 34.0 | 47 |
| Less than 10 KM | 33.3 | 3 | 51.6 | 31 | 50.0 | 34 |
| 10 - 29 KM | 20.0 | 15 | 25.0 | 24 | 23.1 | 39 |
| 30 - 49 KM | 0.0 | 4 | 41.7 | 12 | 31.3 | 16 |
| 50 - 99 KM | 20.0 | 15 | 37.5 | 24 | 30.8 | 39 |
| 100 KM and above | 22.2 | 27 | 44.9 | 196 | 42.2 | 223 |
| Not Stated | - | 0 | 33.3 | 3 | 33.3 | 3 |
| **Total** | **22.9** | **83** | **42.5** | **318** | **38.4** | **401** |

## Table 5.9: Paid sex in last year and condom use at last paid sex

Percentage of men reporting sex with a commercial sex worker in the last 12 months and, among men reporting sex with a commercial sex worker in the last 12 months, percentage reporting condom use the last time they had sex with a commercial sex worker, by background characteristics

| Background characteristic | Percentage reporting sex with a commercial sex worker in the last 12 months[1] | Number of men | Percentage reporting condom use at last sex with a commercial sex worker[2] | Number of men reporting sex with a commercial sex worker in the last 12 months |
|---|---|---|---|---|
| Plantation | | | | |
| Kakira Sugar | 2.8 | 356 | 40.0 | 10 |
| Tilda Rice | 6.3 | 206 | 30.8 | 13 |
| Kaweri Coffee | 9.4 | 233 | 36.4 | 22 |
| Wilmar Palm Oil | 9.4 | 277 | 80.8 | 26 |
| Form of Employment | | | | |
| Permanent | 3.2 | 282 | 22.2 | 9 |
| Contract | 3.2 | 280 | 33.3 | 9 |
| Casual | 10.4 | 510 | 60.4 | 53 |
| Age | | | | |
| 15-19 | 12.3 | 65 | 37.5 | 8 |
| 20-24 | 11.4 | 254 | 62.1 | 29 |
| 25-29 | 5.7 | 279 | 56.3 | 16 |
| 30-34 | 4.0 | 177 | 42.9 | 7 |
| 35-39 | 3.6 | 111 | 50.0 | 4 |
| 40-44 | 6.2 | 81 | 0.0 | 5 |
| 45-49 | 3.4 | 59 | 100.0 | 2 |
| 50-54 | 0.0 | 29 | NA | 0 |
| 55-59 | 0.0 | 17 | NA | 0 |
| Marital status | | | | |
| Never married | 11.6 | 293 | 58.8 | 34 |
| Married | 4.6 | 584 | 48.1 | 27 |
| Living together | 3.9 | 129 | 40.0 | 5 |
| Divorced/Separated | 8.3 | 60 | 40.0 | 5 |
| Widowed | 0.0 | 6 | NA | 0 |
| Education | | | | |
| Nursery | 0.0 | 2 | NA | 0 |
| Primary | 8.3 | 564 | 44.7 | 47 |
| Post Primary/Vocational | 12.2 | 41 | 80.0 | 5 |
| Secondary/'A' Level | 4.0 | 326 | 53.8 | 13 |
| College | 1.5 | 67 | 100.0 | 1 |
| University | 0.0 | 21 | NA | 0 |
| Not Stated | 9.8 | 51 | 80.0 | 5 |
| Religion | | | | |
| Roman Catholic | 7.5 | 477 | 47.2 | 36 |
| Protestant/Other Christian | 5.6 | 428 | 58.3 | 24 |
| Muslim | 7.9 | 101 | 62.5 | 8 |
| No Religion | 0.0 | 5 | NA | 0 |
| Other | 4.9 | 61 | 33.3 | 3 |
| Distance to former place of residence | | | | |
| Born in that area | 11.6 | 86 | 10.0 | 10 |
| Less than 10 KM | 12.5 | 96 | 41.7 | 12 |
| 10 - 29 KM | 6.2 | 81 | 20.0 | 5 |
| 30 - 49 KM | 1.7 | 58 | 100.0 | 1 |
| 50 - 99 KM | 7.0 | 100 | 57.1 | 7 |
| 100 KM and above | 5.6 | 643 | 69.4 | 36 |
| Not Stated | 0.0 | 8 | NA | 0 |
| **Total** | **6.6** | **1,072** | **52.1** | **71** |

[1] Corresponds to UNAIDS Sexual Behavior Indicator 3 "Commercial sex in the last year". [2] Corresponds to Emergency Plan Core Prevention Indicator 6 "Percent of men reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse" and to UNAIDS Sexual Behavior Indicator 4 "Condom use at last commercial sex, client report".

**Figure 5.3. Consistent condom use during higher risk sex over last 12 months**

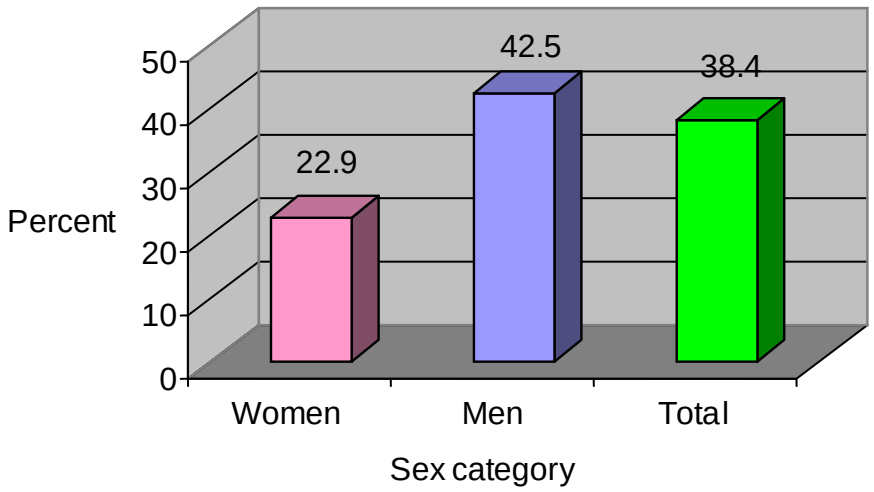
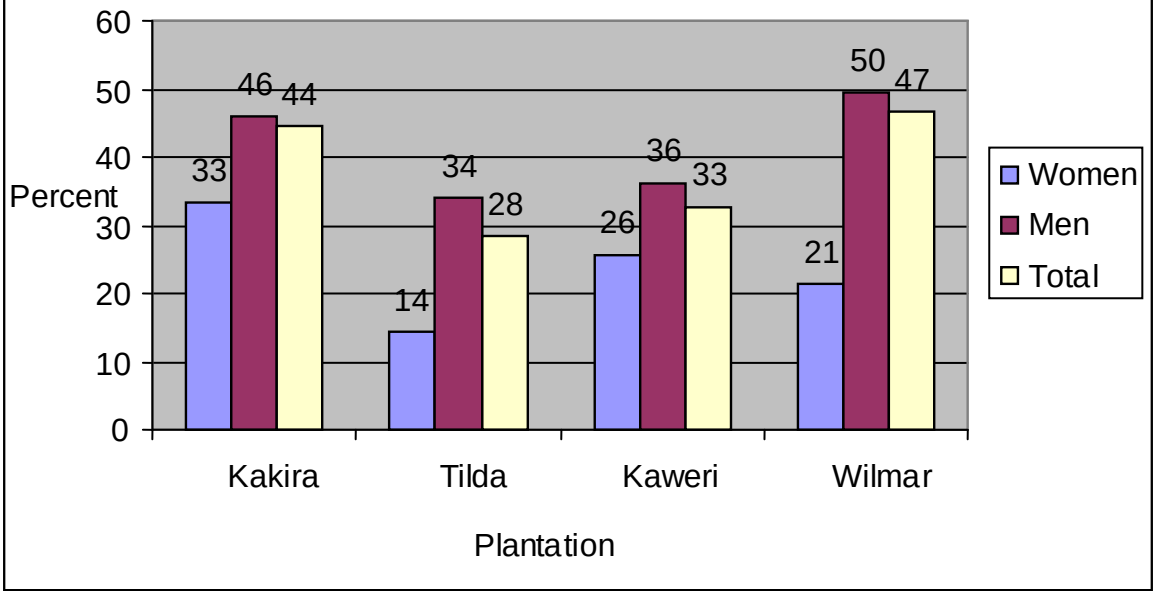



**Figure 5.4. Consistent condom use during higher risk sex by plantation**



# CHAPTER 6: HIV PREVALENCE

## 6.1. Key Findings

- About seven percent of plantation workers aged 15-49 years are infected with HIV; and HIV prevalence among women is higher (13.4%) than among men (4.5%).
- Kaweri coffee plantation has the highest HIV prevalence (8.3%) while Tilda rice plantation has the lowest HIV prevalence (5.1%).
- Across all the 4 plantations, HIV prevalence is highest among widows/widowers (28.6 percent) followed by that among divorced people (14.2 percent).
- Overall, HIV prevalence is highest among respondents with higher number of living children.
- There is no clear pattern of the distribution of HIV prevalence by forms of employment, educational or religious background.
- Higher-risk sex was associated with increased risk of HIV infection. Overall, HIV prevalence was 7.3 percent among those who had higher-risk sex compared to 6.2 percent among those had sex, but not higher-risk sex.
- HIV prevalence increases as the number of lifetime sexual partners rises. Among all the plantation workers (both women and men), HIV prevalence ranges from 3.3 percent in those respondents with 1 lifetime sexual partner to 8.3 percent in those with 3 or more lifetime sexual partners.
- Age at sexual debut is associated with HIV infection. Generally, those respondents who initiated sex at the age of 18-19 years have the lowest HIV prevalence. On the other hand, initiation of sex at the age of 20 and above is associated with increased risk of HIV infection.
- There is a paradoxical association between condom use and HIV infection. In both women and men, respondents who did not use condoms are found to have lower HIV prevalence.

## 6.2. Introduction

Comprehensive HIV information is vital to inform HIV policy formulation, planning and programming. The above information can be generated using a number of methods including cross-sectional studies, prospective studies and mathematical projections. In Uganda, HIV prevalence has mainly been obtained from sentinel surveillance among pregnant women and attendees of sexually transmitted diseases clinic. Other important sources include national and sub-national population based surveys. Generally, the sources referred to do lack of information of the mobile populations (plantation workers and fishing communities). This study was designed to address the above information gap. It has generated information on HIV prevalence and its distribution by plantation and demographic characteristics.

### 6.3. HIV Prevalence by Plantation

The results from this study show that about seven percent of plantation workers aged 15-49 years are infected with HIV. Figure 6.1 shows that HIV prevalence among plantation workers; is 5.2% in Tilda, 6.2% in Wilmar, 7.2% in Kakira and 8.3% in Kaweri. The results further show that HIV prevalence is higher among women than among men (Figure 6.2).

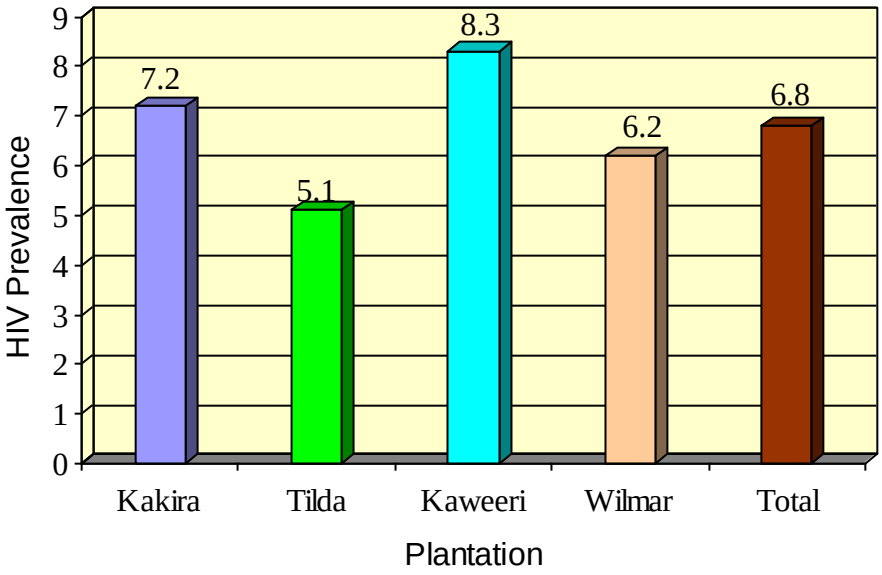
### 6.4. Age Specific HIV Prevalence

Analysis of age-specific HIV prevalence shows that overall; HIV prevalence for both men and women is lowest among the younger age groups. Generally, in both men and women, HIV prevalence increases steadily from the age groups 15-19 until it reaches the peak, which for both men and women is attained at ages 40-44 years (Figures 6.3 and 6.4). Thereafter, HIV prevalence drops steeply. In all age groups, HIV prevalence is higher among women compared to that of men. When data was disaggregated by individual plantations, a similar trend was seen among women in all the surveyed plantations; where HIV prevalence is lowest in the younger age groups (15-19 and 20-24). The prevalence also increases steadily with age reaching a peak at the age group 40-44 and drops thereafter. In Kaweri, the picture was a little different in that, HIV prevalence is lowest in the age group 20-24, and the prevalence increases steadily with age reaching a peak at the age group 30-34 and drops thereafter to zero. The pattern of HIV prevalence among men in individual plantations is different from that of women. In Kakira, there was some unusual pattern in HIV prevalence of 25 and 33 percent among the age groups 15-19 and 55-59, respectively (Figure 6.3.3). This pattern came about due to the small numbers of clients in those age categories, thus rendering the estimates imprecise. The numbers of clients were 4 and 3 in the age groups 15-19 and 55-59, respectively. In Tilda and Wilmar plantations, HIV prevalence increases with age reaching a peak at the age of 45 and above. Among men at Kakira, the peak is reached at the age of 45 and above.

### 6.5. HIV Prevalence by Form of Employment, Educational Background, Religion, Marital Status, and Number of Living Children

Analysis was done to determine the distribution of HIV infection by forms of employment, education, religion, marital status and number of living children. The results show that there was no clear pattern of the distribution of HIV prevalence by work category, education and religion. In respect to the distribution of HIV prevalence by marital status, prevalence is highest among widows/widowers followed by that among those who are married/living together. The results also show that the higher the number of living children, the higher the HIV prevalence.

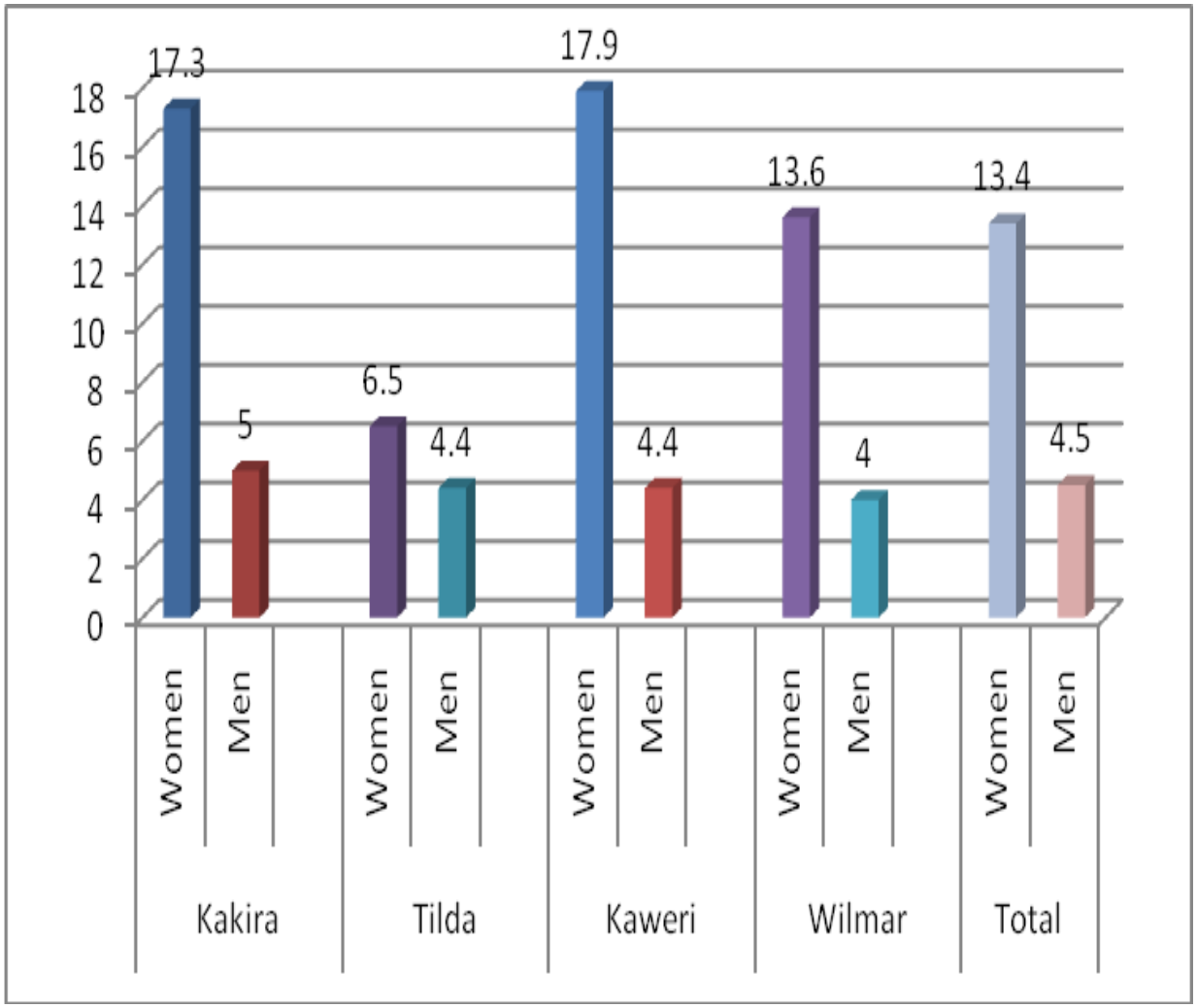
**Figure 6.1.** HIV Prevalence by site




Analysis was also done by cross-tabulation of HIV status by age at sexual debut, higher-risk sex, condom use and number of lifetime sexual partners. The findings show that among those respondents (both women and men) who had sex in the past 12 months preceding the survey, higher-risk sex was associated with increased risk of HIV infection. For instance, HIV prevalence was 7.3 percent among those who had higher-risk sex compared to 6.2 percent among those had sex, but not higher-risk sex. The same trend was seen among women whereby, HIV prevalence was 17.7 percent among those who had higher-risk sex compared to 10.1 percent among those had sex, but not higher-risk sex. In men, there was no difference in HIV prevalence among the two groups.

When the number of sexual partners is considered, the results show that HIV prevalence increases as the number of lifetime sexual partners rises. Among all the plantation workers (both women and men), the results show that, HIV prevalence ranges from 3.3 percent in those respondents with 1 lifetime sexual partner to 8.3 percent in those with 3 or more lifetime sexual partners. When data is disaggregated by sex, data shows that among women, HIV prevalence ranges from 5 percent in those respondents with 1 lifetime sexual partner to 18.5 percent in those with 3 or more lifetime sexual partners. In men, HIV prevalence ranges from 2.5 percent in those respondents with 1 lifetime sexual partner to 5.5 percent in those with 3 or more lifetime sexual partners.

**Figure 6.2. HIV prevalence by sex and site**



The data also show that age at sexual debut is associated with HIV infection. Generally, those respondents who initiated sex at the age of 18-19 years have the lowest HIV prevalence. On the other hand, initiation of sex at the age of 20 and above is associated with increased risk of HIV infection. For example, among all plantation workers, HIV prevalence is 7.9 and 4.9 percent among those who initiated sex before the age of 15 and those who initiated sex at the age of18-19, respectively. A similar pattern is seen among women, whereby, HIV prevalence is 10.7 and 8.5 percent among those who initiated sex at the before the age of 15 and at the age of 18-19, respectively. In men, HIV prevalence is 5.8 percent among those who initiated sex before the age of 15 and 3.8 percent in those who initiated sex at the age of 18-19.

**Figure 6.3.1.** Overall age-specific HIV prevalence

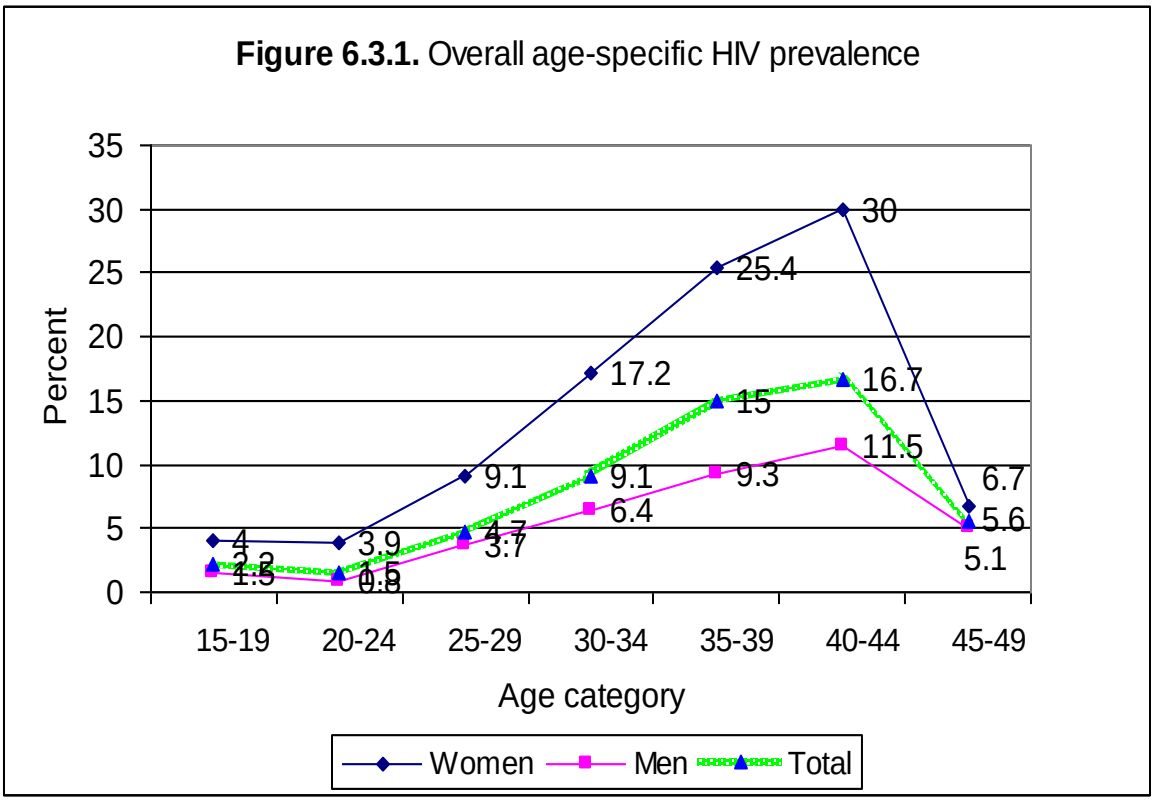



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**Figure 6.3.2 Age-specific HIV prevalence by site (Women)**

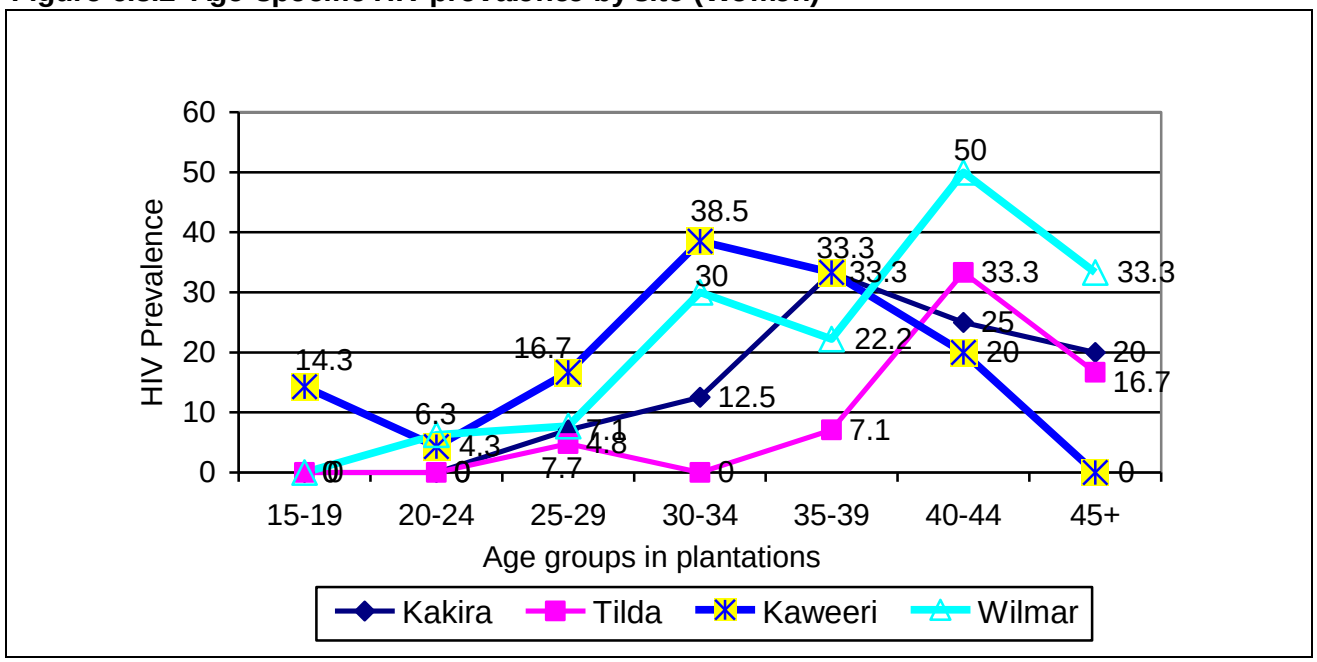
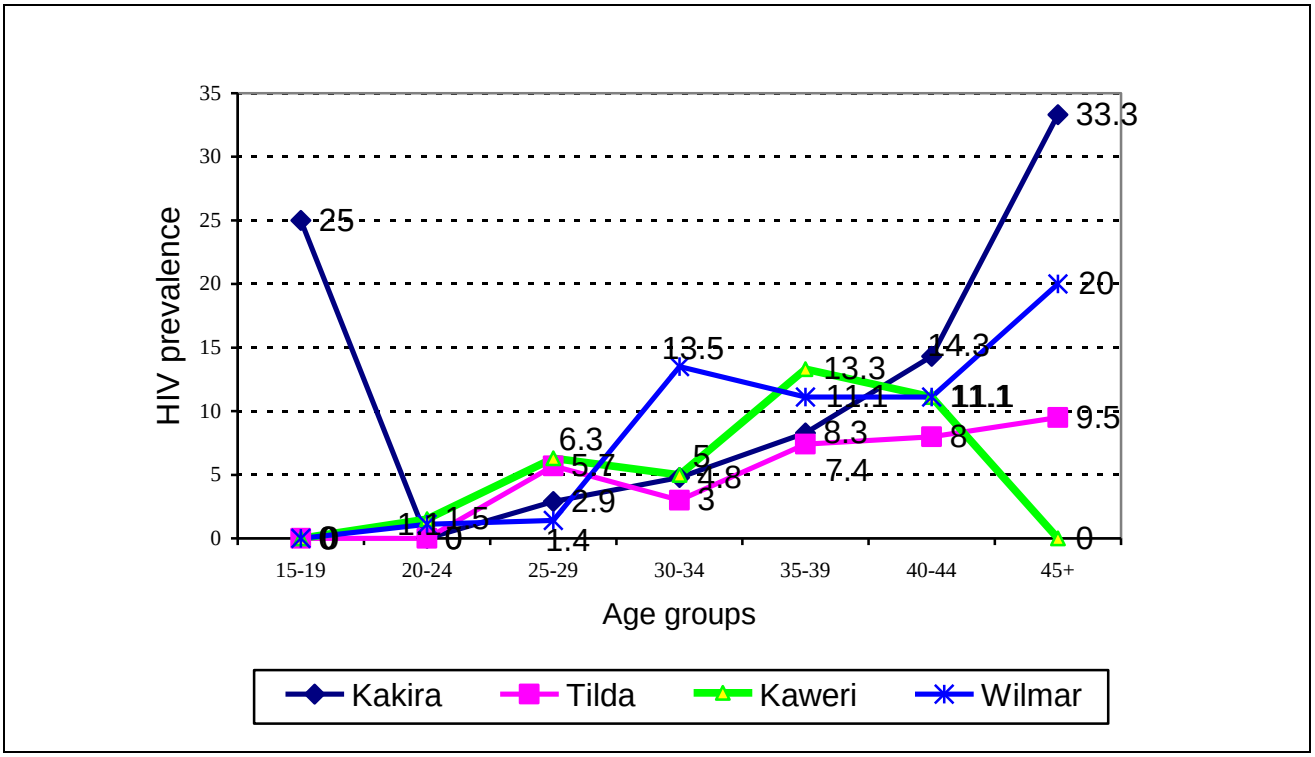


**Figure 6.3.3 Age-specific HIV prevalence by site (Men)**



## Table 6.1. HIV Prevalence by sex, forms of employment, age and marital status (n = 1,407).

| Background characteristic | Women | | Men | | Total | |
|---|---|---|---|---|---|---|
| | Percentage HIV positive | Number Tested | Percentage HIV positive | Number Tested | Percentage HIV positive | Number Tested |
| Form of Employment | | | | | | |
| Permanent | 25.0 | 56 | 6.2 | 273 | 9.4 | 329 |
| Contract | 7.7 | 91 | 4.1 | 271 | 5.0 | 362 |
| Casual | 12.8 | 211 | 3.8 | 505 | 6.4 | 716 |
| Age | | | | | | |
| 15-19 | 4.0 | 25 | 1.5 | 65 | 2.2 | 90 |
| 20-24 | 3.9 | 76 | 0.8 | 250 | 1.5 | 326 |
| 25-29 | 9.1 | 66 | 3.7 | 272 | 4.7 | 338 |
| 30-34 | 17.2 | 58 | 6.4 | 173 | 9.1 | 231 |
| 35-39 | 25.4 | 59 | 9.3 | 108 | 15.0 | 167 |
| 40-44 | 30.0 | 30 | 11.5 | 78 | 16.7 | 108 |
| 45-49 | 6.7 | 30 | 5.1 | 59 | 5.6 | 89 |
| 50-54 | 15.4 | 13 | 0.0 | 27 | 5.0 | 40 |
| 55-59 | 0.0 | 1 | 5.9 | 17 | 5.6 | 18 |
| Marital status | | | | | | |
| Never married | 2.8 | 36 | 1.4 | 289 | 1.5 | 325 |
| Married | 9.6 | 166 | 5.3 | 566 | 6.3 | 732 |
| Living together | 18.9 | 53 | 3.9 | 128 | 8.3 | 181 |
| Divorced/Separated | 18.9 | 74 | 8.3 | 60 | 14.2 | 134 |
| Widowed | 24.1 | 29 | 50.0 | 6 | 28.6 | 35 |
| Education | | | | | | |
| Nursery | 0.0 | 2 | 0.0 | 2 | 0.0 | 4 |
| Primary | 14.6 | 205 | 5.3 | 551 | 7.8 | 756 |
| Post Primary/Vocational | 21.4 | 14 | 5.0 | 40 | 9.3 | 54 |
| Secondary/'A' Level | 9.9 | 71 | 4.0 | 322 | 5.1 | 393 |
| College | 16.7 | 18 | 1.5 | 65 | 4.8 | 83 |
| University | 33.3 | 3 | 0.0 | 18 | 4.8 | 21 |
| Not Stated | 8.9 | 45 | 3.9 | 51 | 6.3 | 96 |
| Religion | | | | | | |
| Roman Catholic | 10.1 | 149 | 5.2 | 466 | 6.3 | 615 |
| Protestant/Other Christian | 18.7 | 134 | 3.6 | 420 | 7.2 | 554 |
| Muslim | 5.4 | 37 | 4.1 | 98 | 4.4 | 135 |
| No Religion | 33.3 | 3 | 0.0 | 5 | 12.5 | 8 |
| Other | 14.3 | 35 | 6.7 | 60 | 9.5 | 95 |
| Number of living children | | | | | | |
| 0 | 4.3 | 46 | 1.7 | 349 | 2.0 | 395 |
| 1-2 | 12.0 | 117 | 5.5 | 291 | 7.4 | 408 |
| 3-4 | 18.4 | 98 | 5.4 | 184 | 9.9 | 282 |
| 5+ | 14.4 | 97 | 6.7 | 225 | 9.0 | 322 |
| **Total** | **13.4** | **358** | **4.5** | **1,049** | **6.8** | **1,407** |

## Table 6.2 (a). HIV Prevalence by site, sex, forms of employment, age and marital status.

| Background characteristic | Kakira | | | | | | Tilda | | | | | | Kaweri | | | | | | Wilmar | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Women | | Men | | Total | | Women | | Men | | Total | | Women | | Men | | Total | | Women | | Men | | Total | |
| | W | NW | M | NM | P | N | W | NW | M | NM | P | N | W | NW | M | NM | P | N | W | NW | M | NM | P | N |
| Form of Employment | | | | | | | | | | | | | | | | | | | | | | | | |
| Permanent | 27.6 | 29 | 6.8 | 146 | 10.3 | 175 | 0.0 | 7 | 6.0 | 50 | 5.3 | 57 | 31.6 | 19 | 6.5 | 62 | 12.3 | 81 | 0.0 | 1 | 0.0 | 15 | 0.0 | 16 |
| Contract | 10.9 | 46 | 3.6 | 194 | 5.0 | 240 | 4.4 | 45 | 5.2 | 77 | 4.9 | 122 | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Casual | NA | NA | NA | NA | NA | NA | 9.1 | 55 | 2.6 | 78 | 5.3 | 133 | 14.5 | 76 | 3.6 | 167 | 7.0 | 243 | 13.8 | 80 | 4.2 | 260 | 6.5 | 340 |
| Age | | | | | | | | | | | | | | | | | | | | | | | | |
| 15-19 | 0.0 | 0 | 25.0 | 4 | 25.0 | 4 | 0.0 | 9 | 0.0 | 9 | 0.0 | 18 | 14.3 | 7 | 0.0 | 15 | 4.5 | 22 | 0.0 | 9 | 0.0 | 37 | 0.0 | 46 |
| 20-24 | 0.0 | 2 | 0.0 | 56 | 0.0 | 58 | 0.0 | 19 | 0.0 | 39 | 0.0 | 58 | 4.3 | 23 | 1.5 | 66 | 2.2 | 89 | 6.3 | 32 | 1.1 | 89 | 2.5 | 121 |
| 25-29 | 7.1 | 14 | 2.9 | 102 | 3.4 | 116 | 4.8 | 21 | 5.7 | 35 | 5.4 | 56 | 16.7 | 18 | 6.3 | 63 | 8.6 | 81 | 7.7 | 13 | 1.4 | 72 | 2.4 | 85 |
| 30-34 | 12.5 | 16 | 4.8 | 63 | 6.3 | 79 | 0.0 | 19 | 3.0 | 33 | 1.9 | 52 | 38.5 | 13 | 5.0 | 40 | 13.2 | 53 | 30.0 | 10 | 13.5 | 37 | 17.0 | 47 |
| 35-39 | 33.3 | 18 | 8.3 | 48 | 15.2 | 66 | 7.1 | 14 | 7.4 | 27 | 7.3 | 41 | 33.3 | 18 | 13.3 | 15 | 24.2 | 33 | 22.2 | 9 | 11.1 | 18 | 14.8 | 27 |
| 40-44 | 25.0 | 12 | 14.3 | 35 | 17.0 | 47 | 33.3 | 9 | 8.0 | 25 | 14.7 | 34 | 20.0 | 5 | 11.1 | 9 | 14.3 | 14 | 50.0 | 4 | 11.1 | 9 | 23.1 | 13 |
| 45-49 | 0.0 | 8 | 0.0 | 24 | 0.0 | 32 | 16.7 | 12 | 9.5 | 21 | 12.1 | 33 | 0.0 | 9 | 0.0 | 9 | 0.0 | 18 | 0.0 | 1 | 20.0 | 5 | 16.7 | 6 |
| 50-54 | 20.0 | 5 | 0.0 | 5 | 10.0 | 10 | 0.0 | 3 | 0.0 | 10 | 0.0 | 13 | 0.0 | 2 | 0.0 | 7 | 0.0 | 9 | 33.3 | 3 | 0.0 | 5 | 12.5 | 8 |
| 55-59 | 0.0 | 0 | 33.3 | 3 | 33.3 | 3 | 0.0 | 1 | 0.0 | 6 | 0.0 | 7 | 0.0 | 0 | 0.0 | 5 | 0.0 | 5 | 0.0 | 0 | 0.0 | 3 | 0.0 | 3 |
| Marital status | | | | | | | | | | | | | | | | | | | | | | | | |
| Never married | 0.0 | 1 | 3.2 | 63 | 3.1 | 64 | 0.0 | 15 | 0.0 | 33 | 0.0 | 48 | 8.3 | 12 | 1.3 | 76 | 2.3 | 88 | 0.0 | 8 | 0.9 | 117 | 0.8 | 125 |
| Married | 14.6 | 41 | 4.7 | 212 | 6.3 | 253 | 8.5 | 59 | 4.7 | 148 | 5.8 | 207 | 11.1 | 27 | 4.9 | 102 | 6.2 | 129 | 5.1 | 39 | 7.7 | 104 | 7.0 | 143 |
| Living together | 8.3 | 12 | 2.4 | 41 | 3.8 | 53 | 16.7 | 6 | 0.0 | 19 | 4.0 | 25 | 20.0 | 15 | 6.7 | 30 | 11.1 | 45 | 25.0 | 20 | 5.3 | 38 | 12.1 | 58 |
| Divorced/Separated | 30.0 | 10 | 13.6 | 22 | 18.8 | 32 | 0.0 | 19 | 0.0 | 3 | 0.0 | 22 | 25.0 | 32 | 10.0 | 20 | 19.2 | 52 | 23.1 | 13 | 0.0 | 15 | 10.7 | 28 |
| Widow ed | 27.3 | 11 | 50.0 | 2 | 30.8 | 13 | 12.5 | 8 | 100 | 2 | 30.0 | 10 | 22.2 | 9 | 0.0 | 1 | 20.0 | 10 | 100 | 1 | 0.0 | 1 | 50.0 | 2 |
| **Total** | **17.3** | **75** | **5.0** | **340** | **7.2** | **415** | **6.5** | **107** | **4.4** | **205** | **5.1** | **312** | **17.9** | **95** | **4.4** | **229** | **8.3** | **324** | **13.6** | **81** | **4.0** | **275** | **6.2** | **356** |

W; Percentage of women positive, NW; Number of women tested, M; Percentage of men positive, NM; Number of men tested

P; Percentage of women and men positive, N; Number of women and men tested and NA; Not Applicable

## Table 6.2 (b). HIV Prevalence by site, sex, education, religion and number of living children.

| Background characteristic | Kakira | | | | | | Tilda | | | | | | Kaweri | | | | | | Wilmar | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Women | | Men | | Total | | Women | | Men | | Total | | Women | | Men | | Total | | Women | | Men | | Total | |
| | W | NW | M | NM | P | N | W | NW | M | NM | P | N | W | NW | M | NM | P | N | W | NW | M | NM | P | N |
| Education | | | | | | | | | | | | | | | | | | | | | | | | |
| Nursery | NA | NA | NA | NA | NA | NA | 0.0 | 2 | 0.0 | 2 | 0.0 | 4 | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Primary | 8.8 | 34 | 6.2 | 178 | 6.6 | 212 | 9.0 | 67 | 4.3 | 92 | 6.3 | 159 | 26.9 | 52 | 3.2 | 125 | 10.2 | 177 | 13.5 | 5 | 6.4 | 156 | 8.2 | 208 |
| Post Primary/Vocational | 25.0 | 4 | 11.1 | 18 | 13.6 | 22 | 0.0 | 3 | 0.0 | 6 | 0.0 | 9 | 33.3 | 3 | 0.0 | 9 | 8.3 | 12 | 25.0 | 4 | 0.0 | 7 | 9.1 | 11 |
| Secondary/'A' Level | 27.3 | 11 | 4.0 | 99 | 6.4 | 110 | 0.0 | 19 | 5.2 | 77 | 4.2 | 96 | 4.3 | 23 | 5.5 | 73 | 5.2 | 96 | 16.7 | 18 | 1.4 | 73 | 4.4 | 91 |
| College | 22.2 | 9 | 0.0 | 24 | 6.1 | 33 | 0.0 | 4 | 7.1 | 14 | 5.6 | 18 | 25.0 | 4 | 0.0 | 11 | 6.7 | 15 | 0.0 | 1 | 0.0 | 16 | 0.0 | 17 |
| University | 50.0 | 2 | 0.0 | 8 | 10.0 | 10 | 0.0 | 0 | 0.0 | 2 | 0.0 | 2 | 0.0 | 0 | 0.0 | 3 | 0.0 | 3 | 0.0 | 1 | 0.0 | 5 | 0.0 | 6 |
| Not Stated | 20.0 | 15 | 0.0 | 13 | 10.7 | 28 | 8.3 | 12 | 0.0 | 12 | 4.2 | 24 | 0.0 | 13 | 25.0 | 8 | 9.5 | 21 | 0.0 | 5 | 0.0 | 18 | 0.0 | 23 |
| Religion | | | | | | | | | | | | | | | | | | | | | | | | |
| Roman Catholic | 16.1 | 31 | 6.3 | 175 | 7.8 | 206 | 3.2 | 31 | 4.1 | 74 | 3.8 | 105 | 9.3 | 54 | 3.3 | 91 | 5.5 | 145 | 12.1 | 33 | 5.6 | 126 | 6.9 | 159 |
| Protestant/Other Christian | 20.0 | 35 | 3.2 | 125 | 6.9 | 160 | 9.3 | 43 | 3.3 | 91 | 5.2 | 134 | 31.0 | 29 | 5.8 | 103 | 11.4 | 132 | 18.5 | 27 | 2.0 | 101 | 5.5 | 128 |
| Muslim | 0.0 | 6 | 3.4 | 29 | 2.9 | 35 | 7.7 | 13 | 4.8 | 21 | 5.9 | 34 | 0.0 | 1 | 0.0 | 15 | 0.0 | 16 | 5.9 | 17 | 6.1 | 33 | 6.0 | 50 |
| No Religion | NA | NA | NA | NA | NA | NA | 0.0 | 2 | 0.0 | 1 | 0.0 | 3 | 100 | 1 | 0.0 | 0 | 100 | 1 | 0.0 | 0 | 0.0 | 4 | 0.0 | 4 |
| Other | 33.3 | 3 | 9.1 | 11 | 14.3 | 14 | 5.6 | 18 | 11.1 | 18 | 8.3 | 36 | 20.0 | 10 | 5.0 | 20 | 10.0 | 30 | 25.0 | 4 | 0.0 | 11 | 6.7 | 15 |
| Number of living children | | | | | | | | | | | | | | | | | | | | | | | | |
| 0 | 0.0 | 5 | 2.3 | 86 | 2.2 | 91 | 0.0 | 17 | 0.0 | 41 | 0.0 | 58 | 15.4 | 13 | 3.4 | 87 | 5.0 | 100 | 0.0 | 11 | 0.7 | 135 | 0.7 | 146 |
| 1-2 | 23.5 | 17 | 4.1 | 97 | 7.0 | 114 | 0.0 | 25 | 7.3 | 41 | 4.5 | 66 | 14.3 | 35 | 7.0 | 71 | 9.4 | 106 | 12.5 | 40 | 4.9 | 82 | 7.4 | 122 |
| 3-4 | 21.1 | 19 | 5.2 | 77 | 8.3 | 96 | 6.3 | 32 | 5.4 | 37 | 5.8 | 69 | 29.6 | 27 | 0.0 | 34 | 13.1 | 61 | 20.0 | 20 | 11.1 | 36 | 14.3 | 56 |
| 5+ | 14.7 | 34 | 8.8 | 80 | 10.5 | 114 | 15.2 | 33 | 4.7 | 86 | 7.6 | 119 | 10.0 | 20 | 5.4 | 37 | 7.0 | 57 | 20.0 | 10 | 9.1 | 22 | 12.5 | 32 |
| **Total** | **17.3** | **75** | **5.0** | **340** | **7.2** | **415** | **6.5** | **107** | **4.4** | **205** | **5.1** | **312** | **17.9** | **95** | **4.4** | **229** | **8.3** | **324** | **13.6** | **81** | **4.0** | **275** | **6.2** | **356** |

W; Percentage of women positive, NW; Number of women tested, M; Percentage of men positive, NM; Number of men tested

P; Percentage of women and men positive, N; Number of women and men tested and NA; Not Applicable

**Table 6.3.1. HIV prevalence by sexual behaviour characteristics; All sites**

| Background characteristic | Women aged 15-49 who ever had sex | | Men aged 15-49 who ever had sex | | Total aged 15-49 who ever had sex | |
|---|---|---|---|---|---|---|
| | Percentage HIV positive | Number | Percentage HIV positive | Number | Percentage HIV positive | Number |
| Age at first sex | | | | | | |
| <15 | 10.7 | 75 | 5.8 | 103 | 7.9 | 178 |
| 15-17 | 15.5 | 142 | 6.2 | 355 | 8.9 | 497 |
| 18-19 | 8.5 | 71 | 3.8 | 234 | 4.9 | 305 |
| 20+ | 20.0 | 50 | 3.6 | 250 | 6.3 | 300 |
| Higher-risk sex in past 12 months | | | | | | |
| Had higher-risk sex | 17.7 | 79 | 4.6 | 306 | 7.3 | 385 |
| Had sex, not higher-risk | 10.1 | 207 | 4.5 | 507 | 6.2 | 714 |
| No sex in past 12 months | 21.2 | 52 | 7.0 | 129 | 11.0 | 181 |
| Number of life time partners | | | | | | |
| 1 | 5.0 | 60 | 2.5 | 121 | 3.3 | 181 |
| 2 | 6.3 | 95 | 1.4 | 140 | 3.4 | 235 |
| 3+ | 18.5 | 178 | 5.5 | 655 | 8.3 | 833 |
| Not stated | 80.0 | 5 | 19.2 | 26 | 29.0 | 31 |

**Table 6.3.2. HIV prevalence by sexual behaviour characteristics; Kakira**

| Background characteristic | Women aged 15-49 who ever had sex | | Men aged 15-49 who ever had sex | | Total aged 15-49 who ever had sex | |
|---|---|---|---|---|---|---|
| | Percentage HIV positive | Number | Percentage HIV positive | Number | Percentage HIV positive | Number |
| Age at first sex | | | | | | |
| <15 | 7.7 | 13 | 10.7 | 28 | 9.8 | 41 |
| 15-17 | 23.1 | 26 | 5.6 | 107 | 9.0 | 133 |
| 18-19 | 10.5 | 19 | 2.5 | 81 | 4.0 | 100 |
| 20+ | 25.0 | 12 | 5.2 | 97 | 7.3 | 109 |
| Higher-risk sex in past 12 months | | | | | | |
| Had higher-risk sex | 22.2 | 9 | 6.9 | 58 | 9.0 | 67 |
| Had sex, not higher-risk | 12.8 | 47 | 3.6 | 196 | 5.3 | 243 |
| No sex in past 12 months | 28.6 | 14 | 8.5 | 59 | 12.3 | 73 |
| Number of life time partners | | | | | | |
| 1 | 17.6 | 17 | 1.8 | 57 | 5.4 | 74 |
| 2 | 18.2 | 11 | 3.8 | 53 | 6.3 | 64 |
| 3+ | 15.0 | 40 | 5.2 | 192 | 6.9 | 232 |
| Not stated | 50.0 | 2 | 27.3 | 11 | 30.8 | 13 |

**Table 6.3.3. HIV prevalence by sexual behaviour characteristics; Tilda**

| Background characteristic | Women aged 15-49 who ever had sex | | Men aged 15-49 who ever had sex | | Total aged 15-49 who ever had sex | |
|---|---|---|---|---|---|---|
| | Percentage HIV positive | Number | Percentage HIV positive | Number | Percentage HIV positive | Number |
| Age at first sex | | | | | | |
| <15 | 9.5 | 21 | 0.0 | 26 | 4.3 | 47 |
| 15-17 | 8.2 | 49 | 9.8 | 61 | 9.1 | 110 |
| 18-19 | 5.6 | 18 | 6.4 | 47 | 6.2 | 65 |
| 20+ | 0.0 | 12 | 0.0 | 46 | 0.0 | 58 |
| Higher-risk sex in past 12 months | | | | | | |
| Had higher-risk sex | 10.0 | 20 | 6.0 | 50 | 7.1 | 70 |
| Had sex, not higher-risk | 7.7 | 65 | 4.2 | 120 | 5.4 | 165 |
| No sex in past 12 months | 0.0 | 15 | 10.0 | 10 | 4.0 | 25 |
| Number of life time partners | | | | | | |
| 1 | 0.0 | 27 | 0.0 | 18 | 0.0 | 45 |
| 2 | 0.0 | 27 | 0.0 | 25 | 0.0 | 52 |
| 3+ | 15.2 | 46 | 6.8 | 133 | 8.9 | 179 |
| Not stated | - | 0 | 0.0 | 4 | 0.0 | 4 |

**Table 6.3.4. HIV prevalence by sexual behaviour characteristics; Kaweri**

| Background characteristic | Women aged 15-49 who ever had sex | | Men aged 15-49 who ever had sex | | Total aged 15-49 who ever had sex | |
|---|---|---|---|---|---|---|
| | Percentage HIV positive | Number | Percentage HIV positive | Number | Percentage HIV positive | Number |
| Age at first sex | | | | | | |
| <15 | 17.4 | 23 | 0.0 | 19 | 9.5 | 42 |
| 15-17 | 20.0 | 35 | 5.0 | 80 | 9.6 | 115 |
| 18-19 | 10.5 | 19 | 6.3 | 48 | 7.5 | 67 |
| 20+ | 30.8 | 13 | 5.3 | 57 | 10.0 | 70 |
| Higher-risk sex in past 12 months | | | | | | |
| Had higher-risk sex | 24.3 | 37 | 4.7 | 85 | 10.7 | 122 |
| Had sex, not higher-risk | 10.3 | 39 | 6.0 | 100 | 7.2 | 139 |
| No sex in past 12 months | 28.6 | 14 | 0.0 | 19 | 12.1 | 33 |
| Number of life time partners | | | | | | |
| 1 | 0.0 | 8 | 4.0 | 25 | 3.0 | 33 |
| 2 | 4.0 | 25 | 0.0 | 28 | 1.9 | 53 |
| 3+ | 24.1 | 54 | 5.4 | 149 | 10.3 | 203 |
| Not stated | 100.0 | 3 | 50.0 | 2 | 80.0 | 5 |

**Table 6.3.5. HIV prevalence by sexual behaviour characteristics; Wilmar**

| Background characteristic | Women aged 15-49 who ever had sex | | Men aged 15-49 who ever had sex | | Total aged 15-49 who ever had sex | |
|---|---|---|---|---|---|---|
| | Percentage HIV positive | Number | Percentage HIV positive | Number | Percentage HIV positive | Number |
| Age at first sex | | | | | | |
| <15 | 5.6 | 18 | 10.0 | 30 | 8.3 | 48 |
| 15-17 | 15.6 | 32 | 5.6 | 107 | 7.9 | 139 |
| 18-19 | 6.7 | 15 | 1.7 | 58 | 2.7 | 73 |
| 20+ | 23.1 | 13 | 2.0 | 50 | 6.3 | 63 |
| Higher-risk sex in past 12 months | | | | | | |
| Had higher-risk sex | 7.7 | 13 | 2.7 | 113 | 3.2 | 126 |
| Had sex, not higher-risk | 10.7 | 56 | 5.5 | 91 | 7.5 | 147 |
| No sex in past 12 months | 33.3 | 9 | 7.3 | 41 | 12.0 | 50 |
| Number of life time partners | | | | | | |
| 1 | 0.0 | 8 | 4.8 | 21 | 3.4 | 29 |
| 2 | 9.4 | 32 | 0.0 | 34 | 4.5 | 66 |
| 3+ | 18.4 | 38 | 5.0 | 181 | 7.3 | 219 |
| Not stated | - | 0 | 11.1 | 9 | 11.1 | 9 |

# CHAPTER 7: HIV CARE SERVICES

## 7.1. Key Findings

- Overall, women were more likely than men to have received HIV testing; about 71 of women and 58 percent of men reported that they have ever had HIV tests.
- Fifty seven percent of pregnant women who gave birth in the last two years were counseled during antenatal care.
- Among those women who were offered and accepted HIV test during antenatal care, 27.2 percent received their results.
- About one fifth (18.4 percent) of pregnant women who were offered HIV test during antenatal care accepted an offer for HIV testing, and know their results.

## 7.2. Introduction

Understanding the coverage of HIV care and support services is important. Services such as HIV counseling and testing (HCT) and prevention of mother-to-child-transmission (PMTCT) are important in the reduction of HIV transmission. Knowing one's HIV sero-status is an entry point for prevention and care. According to UNAIDS/WHO, counseling and testing eases acceptance of sero-status and coping, facilitates behavior change, reduces mother-to-child transmission, promotes management of opportunistic infections, enables preventive therapy and contraceptive advice, facilitates referral to social and per support, normalizes HIV/AIDS and reduces stigma; and promotes planning and orphan care. On the other hand, a number of factors act as barriers to HIV testing; including denial of HIV risk, fear of positive results, lack of perceived benefits from knowing sero-status, lack of affordability, lack of treatment availability, not knowing where to test from, clinic location being inconvenient, lack of time, repeated HIV negative test results, reluctance to provide blood samples and having been bled many times.

In this survey, a number of variables were assessed. The variables that were assessed included the proportion of respondents aged 15-49 who reported having ever tested for HIV (15-49 year olds), proportion of pregnant women aged 15-49 who received HIV counseling during antenatal care (among women who had one or more births within last 2 years and received ANC) and proportion of pregnant women aged 15-49 who received HIV testing during antenatal care (among women who had one or more births within last 2 years and received ANC).

## 7.3. HIV Counselling and Testing in the Study Population

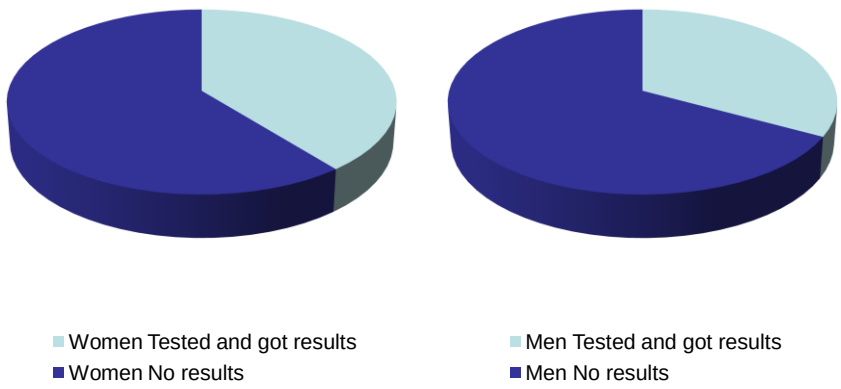
Table 7.1 shows the proportion of respondents who have ever had HIV tests and those that obtained their test results. The results show that, overall, about 71 and 58 percent of women and men reported that they have ever had HIV tests, respectively. Therefore, women were more likely than men to have received HIV testing. There is variation in the proportion of respondents who reported having ever tested for HIV among the 4 surveyed plantations. Looking at women and men, the proportion of respondents who reported that they have ever tested for HIV is highest at 80 percent in Kakira, 78 percent in Wilmar, 69 percent in Kaweri and 51 percent in Tilda. When data is disaggregated by sex of the respondents and individual plantation, the same pattern is seen; women were more likely than men to have received HIV testing.

The results further show that the percentage of women who were tested and received results in the last 12 months was 36.8 percent in Kakira, 25.9 percent in Tilda, 51.6 percent in Kaweri and 44.4 percent in Wilmar. In men, the percentage was 30.0 percent in Kakira, 32.5 percent in Tilda, 35.6 percent in Kaweri and 35.6 percent in Wilmar. Overall, 39.2 percent of women and 32.9 percent said that were tested and received results in the last 12 months preceding the survey.

### 7.4. HIV Counselling and Testing in Pregnancy

Analysis was conducted to determine the practice of HIV counseling and testing (HCT) among women who gave birth in the two years preceding the survey (Table 7.2). Overall, the results show that 57 percent of percent of pregnant women who gave birth in the last two years were counseled during antenatal care. A woman is considered to have received counseling only if she was spoken to about all three of the following topics: transmission of the virus to babies, preventing the virus, and getting tested for the virus. Among those women who were offered and accepted HIV test during antenatal care, 27.2 received their results. Additionally, 18.4 percent of pregnant women who were offered HIV test during antenatal care accepted an offer for HIV testing, and know their results. Only women who were offered the test are included here; women who were either required or asked for the test are excluded from this measure. The results also show that the indicator varies from plantation to plantation; it was highest in Kaweri (29.2 percent) followed by Kakira (28 percent), then Tilda (11 percent) and Wilmar (10.3 percent).

**Figure 7.1.** Tested and received results in the last 12 months



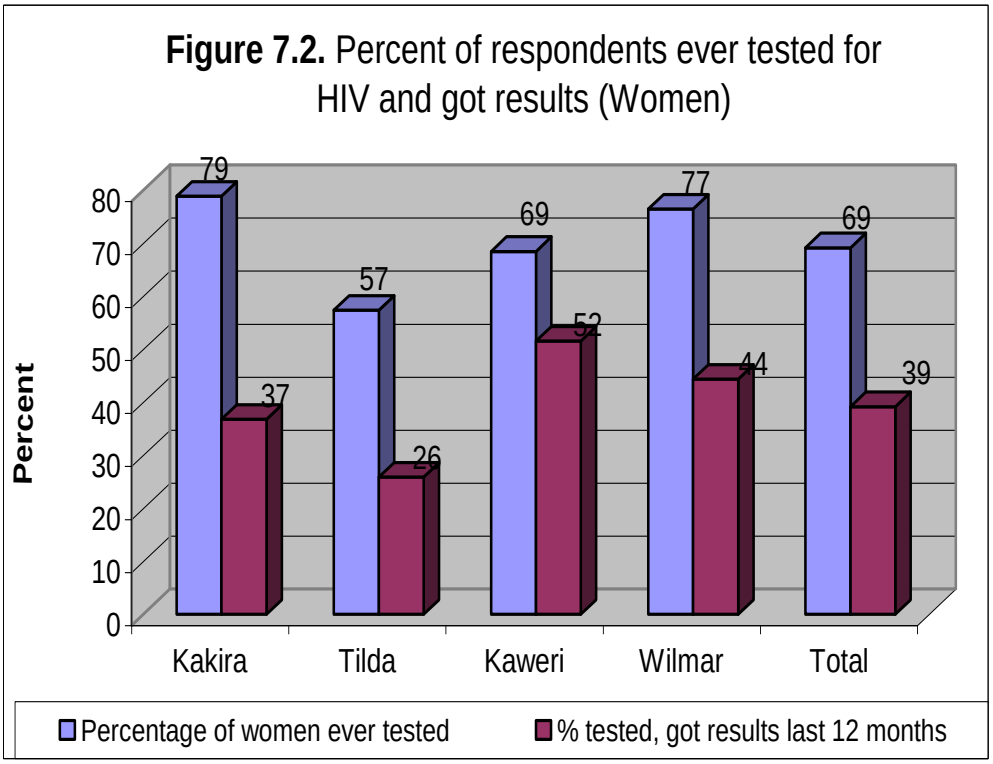


Figure 7.2. Percent of respondents ever tested for HIV and got results (Women)
Percent
80
70
60
50
40
30
20
10
0
79
37
57
26
69
52
77
44
69
39
Kakira
Tilda
Kaweri
Wilmar
Total
Percentage of women ever tested
% tested, got results last 12 months

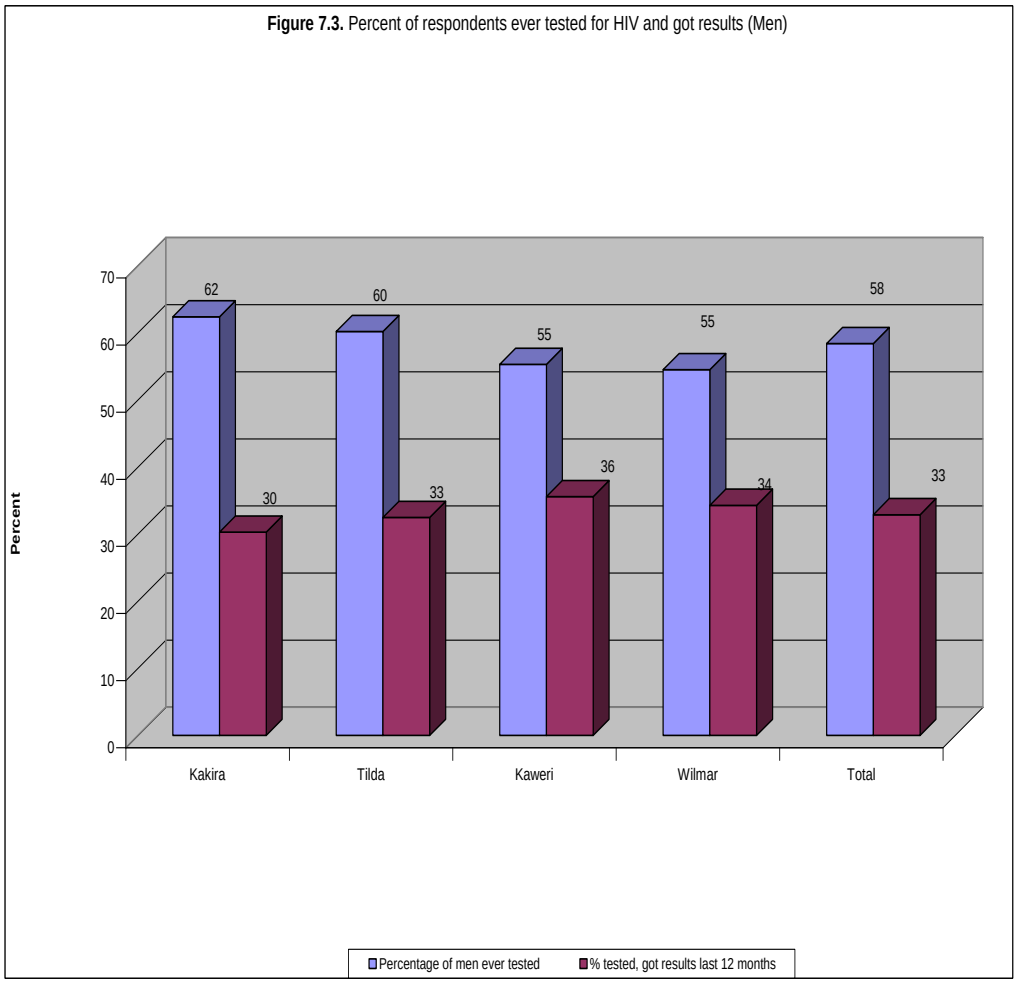


Figure 7.3. Percent of respondents ever tested for HIV and got results (Men)
Percent
70
60
50
40
30
20
10
0
62
30
60
33
55
36
55
34
58
33
Kakira
Tilda
Kaweri
Wilmar
Total
Percentage of men ever tested
% tested, got results last 12 months

**Figure 7.4.** Pregnant women who gave birth in the last 2 years who were counseled during ANC

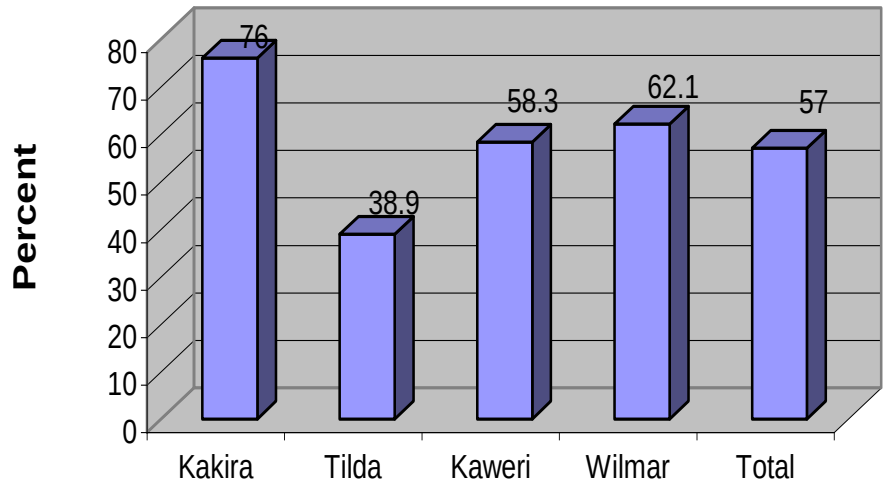
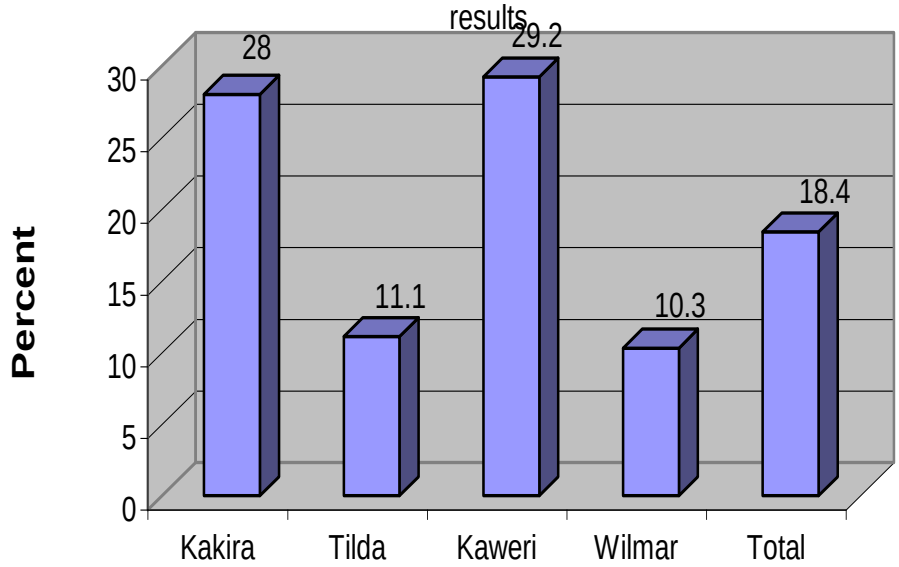



**Figure 7.5**. Pregnant women who gave birth in the last 2 years who were counseled, accepted an offer for HIV testing, and know results



## Table 7.1. Population who had an HIV test and received test results

Percent distribution of women and men by status of HIV testing, and percentage of women and men who were tested for HIV and received test results 12 months prior the survey, by plantation and form of employment

| | WOMEN | | | | | | | MEN | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Ever tested | | | | | | | Ever tested | | | | | | |
| Name of Plantation/ Form of Employment | Received results | No results | Never tested | DK/ Missing | Total | Percentage who were tested and received results in the last 12 months[1] | Number of women | Received results | No results | Never tested | DK/ Missing | Total | Percentage who were tested and received results in the last 12 months[1] | Number of men |
| Kakira | | | | | | | | | | | | | | |
| Permanent | 82.8 | 0.0 | 17.2 | 0.0 | 100.0 | 37.9 | 29 | 69.9 | 5.2 | 24.2 | 0.7 | 100.0 | 39.9 | 153 |
| Contract | 72.3 | 4.3 | 21.3 | 2.1 | 100.0 | 36.2 | 47 | 43.8 | 8.9 | 44.8 | 2.5 | 100.0 | 23.2 | 203 |
| Casual | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| All | 76.3 | 2.6 | 19.7 | 1.3 | 100.0 | 36.8 | 76 | 55.1 | 7.3 | 36.0 | 1.7 | 100.0 | 30.3 | 356 |
| Tilda | | | | | | | | | | | | | | |
| Permanent | 71.4 | 0.0 | 28.6 | 0.0 | 100.0 | 28.6 | 7 | 80.0 | 6.0 | 14.0 | 0.0 | 100.0 | 48.0 | 50 |
| Contract | 54.3 | 4.3 | 37.0 | 4.3 | 100.0 | 28.3 | 46 | 50.6 | 6.5 | 41.6 | 1.3 | 100.0 | 27.3 | 77 |
| Casual | 50.9 | 3.6 | 45.5 | 0.0 | 100.0 | 23.6 | 55 | 41.8 | 5.1 | 53.2 | 0.0 | 100.0 | 27.8 | 79 |
| All | 53.7 | 3.7 | 40.7 | 1.9 | 100.0 | 25.9 | 108 | 54.4 | 5.8 | 39.3 | 0.5 | 100.0 | 32.5 | 206 |
| Kaweri | | | | | | | | | | | | | | |
| Permanent | 63.2 | 0.0 | 31.6 | 5.3 | 100.0 | 47.4 | 19 | 48.4 | 1.6 | 50.0 | 0.0 | 100.0 | 29.7 | 64 |
| Contract | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Casual | 68.4 | 1.3 | 30.3 | 0.0 | 100.0 | 52.6 | 76 | 55.6 | 1.8 | 42.0 | 0.6 | 100.0 | 37.9 | 169 |
| All | 67.4 | 1.1 | 30.5 | 1.1 | 100.0 | 51.6 | 95 | 53.6 | 1.7 | 44.2 | 0.4 | 100.0 | 35.6 | 233 |
| Wilmar | | | | | | | | | | | | | | |
| Permanent | 100.0 | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 | 1 | 93.3 | 0.0 | 6.7 | 0.0 | 100.0 | 66.7 | 15 |
| Contract | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Casual | 68.8 | 7.5 | 22.5 | 1.3 | 100.0 | 43.8 | 80 | 46.2 | 6.1 | 47.3 | 0.4 | 100.0 | 32.4 | 262 |
| All | 69.1 | 7.4 | 22.2 | 1.2 | 100.0 | 44.4 | 81 | 48.7 | 5.8 | 45.1 | 0.4 | 100.0 | 34.3 | 277 |
| **Total** | **65.6** | **3.6** | **29.4** | **1.4** | **100.0** | **39.2** | **360** | **53.0** | **5.4** | **40.8** | **0.8** | **100.0** | **32.9** | **1,072** |

[1]Corresponds to Emergency Plan Counselling and Testing Indicator 1 "Percentage of women and men who have been tested for HIV in the last 12 months and received their test results the last time they were tested".

## Table 7.2. Pregnant women counselled and tested for HIV.

Among women who gave birth in the two years preceding the survey, percentage who received HIV counseling during antenatal care for their most recent birth, and percentage who accepted an offer of HIV testing, whether or not they received their test results, by plantation

| Name of Plantation | Counselled during antenatal care [1] | Offered and accepted an HIV test during antenatal care | | Counseled, accepted an offer for HIV testing, and know results [3] | Number of women who gave birth in the last 2 years |
|---|---|---|---|---|---|
| | | Received results [2] | No results [2] | | |
| Kakira | 76.0 | 32.0 | 0.0 | 28.0 | 25 |
| Tilda | 38.9 | 16.7 | 0.0 | 11.1 | 36 |
| Kaweri | 58.3 | 50.0 | 0.0 | 29.2 | 24 |
| Wilmar | 62.1 | 17.2 | 3.4 | 10.3 | 29 |
| **Total** | **57.0** | **27.2** | **0.9** | **18.4** | **114** |

[1] A woman is considered to have received counseling only if she was spoken to about all three of the following topics: transmission of the virus to babies, preventing the virus, and getting tested for the virus.

[2] Only women who were offered the test are included here; women who were either required or asked for the test are excluded from this measure.

[3] Corresponds to UNAIDS Mother to Child Transmission Indicator 1 "Pregnant women counseled and tested for HIV".

# CHAPTER 8: KEY INFORMANT INTERVIEWS AND FOCUS GROUP DISCUSSION

## 8.1. Key Findings

- Virtually all participants of the KI interviews and FGDs hold a common viewpoint that HIV/AIDS is still a big problem in Uganda.
- The key factors cited by the key informants to be influencing the spread of HIV infection included: poverty; low female-to-male ratio, inadequate information on HIV/AIDS among plantation workers, low risk perceptions, the practice of commercial sex work as a means of supplementing income, non-pecuniary benefits like favours, the practice of widow inheritance, negative beliefs on condoms and negative cultures/values.
- Apart from Kakira, the surveyed plantations do not have written HIV policies and guidelines. However, all the other 3 plantations have unwritten workplace policies which are being implemented. In all the plantations, HIV testing is not a requirement for recruitment and HIV infected staff were generally allowed to continue working.
- HIV prevention and control services are available at the plantations and are being accessed by the workers. The breadth of services are however variable; of the four plantations, only Kakira Sugar Works is offering a full package of HIV services. The services included: Chronic care for HIV/AIDS, anti-retroviral treatment, provision of safe water and mosquito nets, HCT, PMTCT, management of TB and other opportunistic infections.
- There exists some stigma related to service utilization. Some of the plantation workers fear to access HIV services especially when they are provided by people who know them.
- Overall, the quality of HIV prevention and control services was found to be highest in Kakira, a situation which could be attributed to the availability of a hospital.
- The interviews revealed that a number of partners are providing HIV services. Kakira had many partners compared to the other three plantations.
- In most of the plantations, coordination of HIV prevention and control services is not well organized. Generally, there are no clear coordination structures. The function of HIV/AIDS coordination was largely twinned with human resource departments in all the surveyed plantations.

## 8.2. Introduction

The key informant interviews and focus group discussions (FGDs) were organized in all the four surveyed plantations to provide opportunity to get insights into, obtain deeper understanding of and generate explanations for the key behavioural indicators that the survey revealed; as well as the policy environment of the plantations. The samples were purposively selected, and involved plantation workers of different categories.

The FGDs were conducted in all the four surveyed plantations. On the average, each of the FGDs was comprised of 8 people drawn from the general plantation population. To facilitate triangulation of information, deliberate efforts were made to collect information from various categories of staff; including those of top level management, senior level management, middle level management and support staff.

The Key informant (KI) interviews were conducted at the national level, in all the four plantations and the host districts to the plantations. The people interviewed were mainly the policy makers and programme officers at central level, as well as the managerial staff of the different levels of the plantations and the respective districts.

The above interviews generated information on the magnitude of the HIV/AIDS epidemic; HIV related behaviours, knowledge and attitudes; and also, the availability of HIV services and policies. Some suggestions were also made by the people interviewed by proposing the strategies they felt could be used to improve HIV-related services.

## 8.2. Magnitude of HIV/AIDS and Factors Promoting HIV Transmission

The KI interviews also considered the manifestations of the HIV/AIDS epidemic and the factors fueling the epidemic. This section presents overview information on the perceived magnitude of HIV problem in the plantations and the key factors fueling the epidemic in these settings. The study participants were asked to give their informed opinion about the HIV problem.

In all the study areas, the key informants emphasized that the HIV problem exists and that its magnitude is great. The participants said that the manifestations were in form of the high numbers of people who have died of AIDS and the burden due to the high cost of treating HIV infected employers.

The key factors cited to be influencing the epidemic included: poverty; low female-to-male ratio, inadequate information on HIV/AIDS among plantation workers, low risk perceptions, the practice of commercial sex work as a means of supplementing income, non-pecuniary benefits like favours, the practice of widow inheritance and negative beliefs on condoms. In addition, the key informants

reported that there are different populations with different cultures, values and economic status some of which promote HIV transmission. Cross generational sex was also reported to be of concern and that it was mainly initiated by men. Other factors cited included the availability of free time for some staff that keep them redundant, lack of empowerment and the limited disclosure of HIV ser-status of staff.

The above findings are reflected in the following statements/quotations abstracted from the interviews:

> *We note that many of the plantation communities are closed in nature yet they employ mainly men who don't move with their spouses and this is likely to promote sharing of the few women in the community. These people may be away from their homes for a long time so they are prone to have sex with those close to them.*
> ***(PM STD/ACP)***
>
> *In most of these communities health or HIV prevention is not a priority there area of interest is making money and enjoying it. After making money what follows is reckless sex and in my opinion money and poverty are co-factors to HIV infection.*
> ***( PM STD/ACP)***
>
> *The burden of HIV/AIDS is higher in these communities and this is driven by many factors which include inadequate knowledge and empowerment.*
> *There is low level of knowledge on prevention messages and options like condoms and other technologies.*
> *The ABC strategy is not working well because in these communities sharing women is an acceptable way of life. The people live on day to day basis with a lot of cash and a low risk perception so many sex workers target these communities for money like pay days for plantation workers and daily for fishers.*
> ***(National Programme Officer-HIV/AIDS WHO)***
>
> *The HIV/AIDS problem is quite big and this can be noted from the number of people we are initiating on treatment. This goes on every day.*
> *We also have a problem in that the company employs very few female workers and yet the men do not usually move with their spouses. Therefore, sex workers take advantage and usually come to provide services especially in the camps mostly during the pay-days. There is also a tendency of inheritance of women without knowing their HIV status*.
> *There are also cultural beliefs against protective measures like condoms which are not used in their culture. There is also*

*drunkenness which exposes the workers to the risk of HIV/AIDS. There is also a problem of language barrier in messaging.*
***(HIV/AIDS Coordinator, Kakira Hospital)***

*The burden of HIV/AIDS is big in terms of cost for burial, medical facilities; we also lose labour time and skills gained over time in case of death. This HIV problem is fueled by among other things poverty where some women are forced to have more than one sexual partner to supplement their income. The salary especially for workers in the field who earn about 50,000= monthly is inadequate. The practice of polygamy amongst the Basoga is also common. On top of that, drunkardness is a problem.*
***(Senior Welfare Officer, Kakira Sugar Factory)***

*The Wilmar plantation has a big population; sometimes many women time the pay days for the salaries of workers; especially sex workers. Unfortunately, Wilmar is not working closely with the district health office; we have tried to have several meetings but in vain.*
***(District Health Educator, Kalangala)***

*There is a big HIV problem because you have people with different cultures and economic status. There are no strict regulations on time of work on the plantations and people take advantage of this and interact; given that this is natural process. You find that the deployments do not consider the marital status and you may find a wife and husband working in different areas.*
***(Production Officer, Bugiri District)***

*The problem of HIV/AIDS epidemic isn't as big as it was in 1997. It was worrying then; we had four deaths every week and these were skilled workers and the company had invested a lot of money leading to a negative effect on business. At the moment, there is about one death in 6 months and the impact reduced. Although, Ugandans seem to have relaxed, an equal number no longer uses condoms. Reluctance to go for HCT early and beliefs in witch craft still exist.*
*(**Human Resource Manager, Kakira)***

*In my opinion, the problem of HIV/AIDS is big and people should be encouraged to share their HIV sero-status to reduce new infections. These days, mature men fear their age mates so they resort to young girls because of money. It is easier for elderly men who have money to go for young girls. Likewise, the elderly women also go for the young male contract workers. The drivers and their*

*assistants stay throughout the night at the cane yard and they may be tempted in this environment.*
***(Organizing Secretary Union, Kakira Sugar Plantation)***

*The HIV/AIDS problem is big; for example, we have tested about 200 people and about 50 people tested positive. The infections are fueled by the fact that most people left their spouses back home and engage in casual sex while they are here.*
*The marriages are occupational because once the staff leaves, the marriages also end.*
*Some women get into relationships for food rations to save their own provisions.*
***(Nursing Officer Wilmer, Kalangala)***

*The other factor which promotes infection is the low ratio of women compared to men in this community. There is also limited disclosure of HIV sero-status. To me, I feel the PHAs need to be more responsible to ensure reduction in HIV infection. They need to act like Philly Lutaya who openly shared his HIV sero-status.*
*(**Human Resource Manager, Wilmer)***

*The contract workers don't have wives around and tend to go to "Polota" for sex workers who take advantage by moving around the camps on pay-day in pretence of selling items. The accommodation of plantation workers is also not very convenient because they share rooms and yet one of them may bring a girlfriend late in the night. Some people also have a negative attitude; they tend to give up on life and feel they shouldn't die alone so decide to infect others with HIV.*
*(**Welfare Assistants FGD, Kakira)***

*Poverty is a problem; some women engage in sex to supplement their incomes, while others do it for favors like promotion or to be assigned less strenuous tasks. Sometimes, women provide sex to fellow workers for assistance in finalizing the tasks given to them.*
*House-wives also do have extramarital sex as revenge to what the husbands have done or as compensation for lost love.*
***(Welfare Assistants FGD, Kakira)***

*The HIV problem exists and this is influenced by people having many sexual partners and a tendency of sex for survival. The girls have a lot of love for easy money. High level of school dropouts with the girls ending up in early marriages is also a problem. Some parents marry off their children to get dowry. Discos and watching of blue movies are common. Alcohol abuse and gang rape is also reported.*

***(Workers FGD, Kakira)***

*When people drink, they do things they wouldn't do. The people get courage after drinking and get involved in risky sex. There is a high influence of people from other areas. This is a big problem because new people come in the area. In addition, if a beautiful girl comes in a community, many men strive for that single girl. You get one girl with over five boy friends and either way.*
***(Kaweri Plantation Staff FGD)***

*I cannot believe my HIV results today. With me, I had given up with life. I have been having sexual intercourse with sex workers knowing that I am HIV positive and now I have to change behaviours.*
***(Staff FGD Wilmer)***

### 8.3. Assessment of HIV/AIDS Services

This section describes the available package of HIV/AIDS services in the plantations and surrounding communities. The key informants were requested to list the services that are available and the facilities offering such services.

Overall, the findings show that out of the four plantations, only Kakira Sugar Plantation was offering a full package of HIV services. The services were being offered through the Kakira Hospital and included: Chronic care for HIV/AIDS, anti-retroviral treatment, provision of safe water and mosquito nets, HCT, PMTCT, management of TB and other opportunistic infections.
The other three plantations have health facilities/clinics which are equivalent to HC II and were providing HCT and treatment of minor opportunistic infections. The Government health facilities operating in the nearby areas are also providing services.
The ranges of services being provided are reflected in the following assertions and statements:

*I note that most plantations have a more organized health delivery system compared to fishing communities who don't have any targeted interventions. We don't have sustained interventions in fishing communities.*
***PM STD/ACP)***

***I don't have any great detail but I could say the plantations have some health facilities compared to fishing communities who rely mainly on the general systems.***
***(National Programme Officer-HIV/AIDS WHO)***

*Kakira Hospital provides a full package of HIV/AIDS services and these include: HIV Chronic care, TB management, Provision of Safe water, Mosquito nets, Malaria treatment, PMTCT, HCT and management of other opportunistic infections. Similar services are being provided by Joint Clinical Research Centre clinic which is located in the Kakira community.*
***(HIV/AIDS Coordinator, Kakira Hospital)***

*We provide HCT services with assistance of the Ministry of Health. The hospital is providing medical services with three satellite clinics located in the estate. We also provide recreational services for the staff, including indoor games mainly for men and athletics for the ladies.*
***(Human Resource Manager, Kakira Sugar Plantation)***

*At the clinic, we provide HCT and the HIV positive people are referred to Kalangala HC IV, but they usually complain that it is far. We treat opportunistic infections, STDs especially syphilis which is very common, as well as provide condoms, family planning services and septrin prophylaxis.*
***(Nursing Officer, Wilmer)***

*We have a health facility which is not operating daily; we have a visiting clinician who comes to provide services including HIV/AIDS but at a limited level. Services like septrin provision and referrals for those who need further managemen are also being providedt.*
***(Human Resource Manger, Kaweri Coffee Plantation)***

*The Wilmer workers depend on our health units in the area for HIV/AIDS services, Unfortunately, they are too many and end up exhausting our drugs.*
***(DHE, Kalangala)***

*We have a clinic which operates daily providing treatment for opportunistic infections and testing for HIV/AIDS. It is managed by a senior nurse.*
***(Personnel Officer, Tilda Rice Plantation)***
*We provide condom to our workers. In addition, there is HIV counseling and testing though the uptake is quite low.*
***(Human Resource Manager Wilmer)***

*There are HIV/AIDS services provided through ICOBI and JCRC clinic which is stationed in Mubende, but this is quite far. The company provides limited services at its clinic where condoms are provided at a limited level.*
***(FGD-Kaweri Coffee Plantation)***

### 8.4. HIV/AIDS Service Utilization

The respondents were asked whether the available services are being utilized. In response, there were reports of some staff preferring to get services from outside the plantation environment; mainly because of the attributed stigma of seeking HIV-related treatment from fellow staff. It was noted that there is low uptake of services by men compared to women. Condom use is also limited despite the availability. The statements that follow indicate the viewpoints of the respondents on service utilization.

> *On utilization of services, I am not very sure but I observe that people fear to get services at the hospital. They prefer getting services away from the hospital because of stigma.*
> ***(Senior Welfare Officer, Kakira Sugar Factory)***

> *Many workers are utilizing services though there are a few still in the denial stage; those few are reluctant to go for testing because of negative beliefs. The management usually realizes this too late.*
> ***(Human Resource Manager, Kakira Sugar Plantation)***

> *These things are tricky, everybody cannot respond positively to services but they are operational. People fear, like HCT somebody can fear to know his/her test result because of stigma.*
> *(**General Secretary Workers Union, Kakira)***

> *Generally, the staff and community members utilize the available services. We have not had any problem with the utilization of these HIV services.*
> ***(Personnel Officer, Tilda Rice Plantation)***

> *Men are usually not keen in joining HIV/AIDS programmes. Then they shun community sensitization and yet they are expected to escort their wives for programmes like PMTCT. Very few people test for HIV because they are not comforTable being tested by fellow staff; they tend to prefer outsiders for HCT because these don't know their computer number since there is fear of follow-up.*
> ***(Welfare Assistants-FGD-Kakira)***

> *Some people don't have money for buying condoms and some girls don't like condoms because they would not enjoy sex with condoms. Some men don't like condom because whenever they put them on they lose erection. Some people don't like to use condoms because of the "western jazz" style of playing sex; this affects condom use. They fear condom would disturb them.*
> ***(Kaweri Plantation Staff FGD)***

### 8.5. Quality of Services

The respondents were asked about the quality of HIV/AIDS services which are delivered and in response, they noted that the quality of services was noted to be good. Overall, the quality of services was highest in Kakira, which situation could be attributed to the availability of a hospital. However, some gaps were noted and these included: Stock outs of supplies especially HIV test kits, limited supervision, lack of transport for outreach services at the camps, limited confidentiality and limited support for PHAs. Statements related to quality are presented below:

> *I am not very satisfied with what is going on in these communities and I have no single report from the districts and I would propose we need to have an opportunity to supervise HIV/AIDS interventions in these sectors*.
> **(PM-STD.ACP-MOH)**

> *Somehow, people are satisfied. However, there are some gaps like lack of allowances and transport to reach camps for outreach services, limited support supervision, and stock outs of HIV test kits, limited training and lack of a CD4 count machine. Nutrition service is also not very strong.*
> ***(HIV/AIDS Coordinator, Kakira Hospital)***

> *There is lack of confidentiality in the HIV services. The employees are not 100% sure of confidentiality and this has affected the utilization of services at the Hospital.*
> *There is a problem of monitoring; especially in the field, where you do not know the effect of the messages disseminated. The HIV treatment programme (Care) leaves out the dependants and covers only 4 children yet most people on average have over 6 children. Shortage of condoms is also reported and people prefer protector or trust condoms; engabu is not accepted.*
> ***(Senior Welfare Officer, Kakira Sugar Factory)***

> *Inability of the system to ensure adherence e.g. somebody who is a PHA and who is a drunkard; monitoring is a problem in such a case. There is no system to follow up clients on drugs. We also note that the nutritional component is not strong; most of the PHAs may not afford a basic balanced diet yet as a company, we cannot do much.*
> ***(Human Resource Manager, Kakira Sugar Plantation)***

> *There are some gaps in this service. We do not have PMTCT, health education and promotion of positive living. Feeding programme is non-existent. The company rules provide for only*

*treatment of company workers; and not for the spouse and other family members.*
*(**Nursing Officer, Wilmer)***

*We are satisfied by the HIV/AIDS services which they offer. The only concern is that they provide the services to only their staff; outside people are not utilizing these services*
***(Senior Nursing Officer, Jinja District)***

*In the company, there are no HIV services, the only service is at the clinic which is supplying some condoms at a limited level. There is no regular supply of condoms. The company makes arrangements for HIV/AIDS workshops (FUE).*
*(**Staff FGD, Kaweri Coffee Plantation)***

### 8.6. Existence of HIV-related Partners

The study participants were requested to list the partners which are available to provide HIV-related services. The interviews revealed that a number of partners are providing HIV services. Kakira had many partners compared to the other three plantations. For Kakira, the partners included: HIPPS that is providing training in peer-education; AIC providing HCT services and training; TASO providing HIV/AIDS care services and health education; JCRC providing comprehensive HIV care; local government conducting mobilization and training; PACE providing family planning services. On the other hand, Tilda had HIPPS and PACE, Kaweri had ICOBI and Wilmer was reported to be only partnering with Government (Kalangala District Health Office). The statements below indicate the kind of services that are available.

*We have some partners like HIPPS who work with support from USAID operating in some plantation communities.*
***(PM-STD.ACP-MOH)***

*We have some partners like HIPPS supporting peer education, AIC providing mainly HCT and training, JCRC-providing HIV/AIDS care and local governments who do mainly mobilization.*
***(Senior Welfare Officer, Kakira Sugar Factory).***

*The partners I am aware of are URHB and BUNASO doing some work mainly in HIV education.*
***(Production Officer, Bugiri District)***

*It is only ICOBI providing community HCT and No NGOs currently providing services. We are looking forward to LVBC. We hope to sign a memo of understanding*

***(Human Resource Manager, Kaweri Coffee Plantation)***

*The only partner we have been working with is the District Health Office who provides us with condoms and we also use their health facilities.*
***(Nursing Officer, Wilmer)***

## 8.7. HIV/AIDS Related Policies

HIV policies and guidelines at plantation level were largely not well developed. Comparatively, Tilda and Kakira had relatively well developed policy compared to Wilmar and Kaweri Plantations.
Despite the fact that there were no clear HIV policies in some of the plantations, HIV testing wasn't a requirement for recruitment and HIV infected staff were generally allowed to continue working. HIV treatment was provided free of charge to staff in Kakira and Tilda; while only limited treatment was provided at Wilmer and Kaweri plantations. Implementation of national guidelines wasn't clear at national level. These scenarios are reflected in statements below:

*We have general guidelines which need to be implemented but as a programme we have not had a deliberate effort to supervise the facilities like Kakira hospital and they are operating fairly independently.*
***(PM-STD.ACP-MOH)***

*I am not aware of national policy guidelines focusing on MARPs. However globally there are guidelines which we could use nationally. The National HIV/AIDS strategic plan recognizes some MARPs but not all of them. In Uganda we haven't done much to address MARPs.*
***(National Programme Officer-HIV/AIDS WHO)***

*In Kakira Hospital, treatment is free for all workers and outsiders. Testing is not a requirement for recruitment and HIV infected staff members are allowed to continue to work without any problem*
***(HIV/AIDS Coordinator Kakira Hospital)***

*We have an HIV/AIDS Policy and HCT is not a requirement for recruitment .The HIV infected staff members are allowed to continue working and are provided free treatment including a refund for treatment expenses up to some levels. However, they may be allowed to retire early on the recommendation of their supervisors.*
***(Senior Welfare Officer, Kakira Sugar Plantation)***

*There are no policy guidelines on management of HIV in plantations which I am aware of.*

***(DHE, Kalangala)***

*The workplace policy was disseminated to Tilda. HCT is not a requirement for recruitment. I also believe they allow people to continue working even when they are HIV positive. I know they don't discriminate PHAs.*
***(Production Officer, Bugiri District)***

*We have an HIV/AIDS workplace policy which doesn't discriminate PHAs. Those who are unfortunate to have HIV are allowed to work and are provided with medical services until it is very clear that they are coming to their end of life and relatives take action and take them home. The company pays for their medical bills.*
***(Human Resource Manager, Kakira Sugar Plantation)***
*There is an HIV/AIDS Policy and we participated as a union. In this policy, HIV testing is not a requirement for recruitment and an HIV positive employee is allowed to continue working unless this person becomes extremely weak. HIV infected workers are not deleted from the payroll; their treatment bills at the hospital and at referral sites are paid by the company.*
***(Organizing Secretary, Workers Union Kakira)***

*In Wilmar, the HIV policy is not clear. I saw some papers on policies on HIV but it is not clear. HCT is not a requirement for recruitment although it is provided at the factory. The staff members said that if they are found to be HIV positive, they feel that they may not be recruited. We provide treatment at the level of the health facility for those conditions that we can manage and refer the rest. The company doesn't stop them (HIV infected people) from working. There is no special treatment for PHAs*
***(Nursing Officer, Wilmar Clinic).***

*We don't have a clear HIV policy .However, we provide them sick leaves and continue paying them. We planned to have a partnership with JCRC. For the other services, the employees have to pay. We provide free services at the clinic but when referred to other health facilities, the employees usually meet the costs. We also refer them to professionals there.*
*(**Human Resource Manager, Kaweri Plantation)***

*They (Kakira Sugar Workers) follow the national HIV policies and in addition, they have an HIV workplace policy. In this policy, HCT is not a requirement for employment, and there is no termination of work after one is found to be HIV positive; and treatment is provided free of charge for PHAs.*
***(Senior Nursing Officer, Jinja District)***

*We do not have any specific policies on HIV; we only use the labour policy. We normally test for HIV but the workers are allowed to continue to work though we don't pay them if they don't work. If you don't work, we don't pay you. The company provides free treatment only through the clinic and we have a visiting Doctor who works two days a week, that is, on Monday and Sunday. Referral costs are normally met by workers.*
***(Human Resource Manager, Wilmer)***

*We have a policy which we use and we normally encourage HCT and those who are found to be positive are provided with appropriate treatment at our cost; and the management is very supportive.*
*(**Personnel officer, Tilda)***

*People are allowed to continue working even after they are found to have HIV infection. For casual workers, they end up losing out of their work, because most of the jobs require energy.*
***(Kaweri Staff, FGD)***

### 8.8. Coordination of HIV Services

In most of the plantations, the coordination of HIV prevention and control services is quite adhoc; generally, there are no clear and streamlined coordination structures. The function of HIV/AIDS coordination was largely twinned with human resource departments in all the surveyed plantations. Overall, coordination was more organized in Kakira and Tilda plantations compared to the other two plantations.

*There is a Kakira AIDS Committee but not very active these days. It normally has refresher courses. We also have an HIV coordinator at the Hospital.*
***(HIV/AIDS Coordinator Kakira Hospital)***

*Coordination is normally not wholly formalized but the welfare department handles its coordination in conjunction with the hospital. The Welfare Officer is also the focal point for HIV/AIDS. During the HIV/AIDS policy development, we had representatives from all sections and the Human Resource Manager was the Chairperson.*
***(Senior Welfare Officer, Kakira Sugar Plantation).***

*We don't have any HIV/AIDS Committee. We just work with the Human Resource Manager if any HIV/AIDS related thing comes by. Therefore, for HIV/AIDS, it is normally the clinic and the human resource department.*

***(Nursing officer, Wilmer Clinic)***

*There is no active committee on HIV. No clear coordination system is in place. Most of the communication is through the administration.*
***(Staff FGD Kaweri)***

*We are not aware of any committee handling HIV/AIDS issues .It is normally the personnel officer who coordinates most of those activities.*
***(FGD Tilda Rice Plantation)***

## 8.9. Suggestions for Improvement

The respondents were requested to make some suggestions for improvement. In response, the common suggestions made included: Deliver the drugs and supplies in time; Scale up the peer education programmes; Initiate income generation programmes for PHAs; Strengthen HIV prevention education; Regular support supervision; Strengthen monitoring and evaluation of HIV programmes; Scale up HCT; Provide regular supplies of condoms; Establish fully functional hospitals in the plantations where they do not exist and integrate HIV/AIDS in other production programmes; Need for nutritional support for PHAs; Improve the staff accommodation especially for the contract staff. The following are some statements in regard to the way forward. Need to establish MARPs Desk at STD/ACP;More generation and dissemination of strategic information.

*We need to work more closely with the responsible sectors on the workplace policy and other interventions. This could be done through review meetings. The Uganda AIDS Commission needs to do more coordination* ***and we need to work with Federation (PM-STD.ACP-MOH*)**

*We need to conduct more supervision in these sectors and was will provide feedback on the findings.*
*(**Programme Manager- STD.ACP-MOH)***

*As a country we need to generate more evidence on all the MARPS.We need to rely on more evidence as opposed to the use of models which are good but with limitations.*
*We don't need to shy away from some MARPs like MSMs,IDU as these may be a source of new infections even if we have a generalized HIV epidemic.*
*We cannot continue to leave in denial and we should make a distinction between moral and public health issues.*
***(National Programme Officer-HIV/AIDS WHO)***

*In my opinion the Ministry of Health should establish a desk to coordinate civil society effortsof addressing MARPs. Some of the NGOs need capacity enhancing to effectively have interventions for MARPs.We need to be more proactive and avoid phobia of starting interventions for particular groups like MSM. .*
***(National Programme Officer-HIV/AIDS WHO)***

*Given the population of Wilmer, there is need to establish a hospital rather than a health unit which works only half day that is 2 pm-4pm only on Wednesdays. The Wilmer population is very big and these people use the government health facilities as such consuming a lot of drugs which we didn't plan for. They need to make some contributions to the purchase of drugs. Wilmer needs to send representatives to the District Health Team meetings.*
***(District Health Eductor, Kalangala)***

*Tilda Company needs to scale-up HCT services .Since this is a big company, we need the presence of regular counselors or even peer educators. There is need to improve the networking with CBOs and NGOs which are working in the area of HIV/AIDS. Whenever we go there, we normally discuss issues of production and we never raise issues of HIV/AIDS; in future, we need to integrate.*
***(Production Officer, Bugiri District)***

*I suggest that there should be improvement in the monitoring and evaluation; continuous supply of condoms and IEC/BCC materials and regular film shows on HIV/AIDS.*
***(Senior Welfare Officer, Kakira Sugar Plantation).***

*Governments needs to provide more financial support for management of HIV/AIDS, we need regular supply of drugs rather than offloading this responsibility to the company which is a profit making institution.*
***(Human Resource Manager, Kakira)***

*We need to link up with the Ministry of Health for accreditation for ART centres. We need to link up with TASO groups for Health Education for HIV. The company needs to improve its accommodation policy for e.g. women should have their own blocks and the married should stay separately. There is need to cater for treatment for the immediate family of the worker. There is need for capacity building for clinic staff to provide HIV/AIDS care, counseling, ART provision and positive living services.*
***(Nursing Officer, Wilmer)***

*There is need to sensitize new recruits and the neighboring communities about HIV/AIDS. Working with the Town council on HIV/AIDS initiatives needs to be strengthened.*
***(Welfare Assistants FGD-Kakira)***

*There is a need to provide nutritional support to PHAs and the dependants (orphans) and provide mosquito nets free of charge.*
*(**Staff FGD Kakira)***

# CHAPTER 9: HIV/AIDS WORKPLACE POLICY AND PROGRAMS

## 9.1. Key Findings

- There are national level workplace policies in MoGLSD and MAAIF. Ministry of Gander, Labour and Social Development has workplace policy for HIV/AIDS which specifically highlights what needs to be done in the farming communities, including non-discrimination on the basis of HIV status and confidentiality of HIV information, as well as the provision of HIV/AIDS prevention, treatment, care and support services for workers. This policy is a good framework which can guide other organizations of how to develop their own policies and programmes for the HIV/AIDS prevention, treatment, care and support services for workers.
- Only two plantations (Kakira and Kaweri) have written workplace policies. The one for Kaweri is still in draft form having been drafted in 2008. The other two plantations (Tilda and Wilmar) have unwritten workplace policies.
- All the surveyed plantations are implementing workplace policies and programmes. Emphasis is being put on ensuring non-discrimination of HIV infected workers, gender sensitivity, safer work environment and confidentiality in handling HIV information, greater involvement of PLWH and HIV service provision.
- The HIV/AIDS Committees or plantation clinics are spearheading the delivery of HIV services. The services being offered include awareness creation, health education, HCT, general HIV care and ART services.
- Overall, there is good response to implementing the workplace policies and use of HIV programmes by all plantation workers and management.
- Every plantation has a HIV focal person to coordinate HIV programmes.

## 9.2. Introduction

A desk review was conducted to document any existing HIV/AIDS workplace policy and programmes. Workplace HIV/AIDS policy is crucial to provide a framework for guiding the delivery of HIV-related services targeting workers. The policy usually addresses the multidimensional challenges that face people in the work environment. The policy among others provides for the protection of the rights of workers, their non-discrimination on the basis of their HIV sero-status, confidentiality their HIV sero-status, as well as services for reducing their vulnerability and mitigating the impact of the epidemic at the individual and community levels. It also provides a framework for strengthening the capacity of institutions and communities to overcome the social and economic challenges of the epidemic. Furthermore, the policy also usually provides a framework for strengthening the monitoring and evaluation of workplace HIV/AIDS programmes and for resource mobilization. The policy can however only be meaningful if it is evidence-based. In line with this, this report will be an invaluable source of information for the planning, strengthening and monitoring and evaluation of workplace HIV/AIDS programmes in Uganda and the region.

From the outset of the HIV/AIDS epidemic in Uganda, a national response was initiated to deal with the ensuing morbidity and mortality due to HIV infection; and also the related social impact. The national response consisted of multisectoral strategies for containment of their epidemic, including public health strategies. Notably, the 'ABC' (abstinence, being faithful, and condom use) strategy has been the backbone of HIV prevention and control strategy in the country. The ABC strategy has since been expanded to the ABC Plus, to include voluntary counseling and testing (VCT), prevention of mother-to-child transmission of the virus (PMTCT), antiretroviral treatment (ART), and HIV/AIDS care and support services. It also provides for the incorporation of any new cost-effective intervention such as medical male circumcision for HIV prevention. The above strategies have led to declining trends in HIV prevalence in Uganda during the period early 1990s to the early 2000s. Since then, there has been a stabilization of the rate of HIV infection, and in some instances there have been indications of a rising trend. This latest trend has underscored the need to re-examine the current interventions and target groups. Arising from this, it has been recommended that the HIV prevention strategies should be re-invigorated, and that populations that are not traditionally targeted should be reached. These populations include the most-at-risk-populations (MARPs). The mobile populations such plantation workers and fishers fall in this category.

In this study, efforts were made to establish the range, breadth, availability and utilization of HIV and AIDS related services. Also, efforts were made to determine the existence and effectiveness of policies, programs and coordination structures on HIV and AIDS in plantations. The results summarized in Table 10.1 below show that of the four plantations surveyed, only two (Kakira and Kaweri) have written workplace policies. Moreover, the one for Kaweri is still in draft form having been drafted in 2008. The other two plantations (Tilda and Wilmar) have unwritten workplace policies. In terms of practice, all the surveyed plantations are implementing workplace policies and programmes. Emphasis is being put on ensuring non-discrimination of HIV infected workers, gender sensitivity, safer work environment and confidentiality in handling HIV information greater involvement of PLWH and HIV service provision. The HIV/AIDS Committees or plantation clinics are spearheading the delivery of HIV services. The services being offered include awareness creation, health education, HCT, general HIV care and ART services. The demand for HCT is high. Overall, one can conclude that there is good response to implementing the workplace policies and use of HIV programmes by both workers and management. Every plantation has a HIV focal person to coordinate HIV programmes.

At the national level, there is a stand-alone workplace policy in the Ministry of Gender, Labour and Social Development (MoLGSD). The MoLGSD also has workplace HIV-related programmes. The Ministry of Agriculture, Animal Industry and Fisheries (MAAIF) also has workplace policies and programmes for fishing communities and plantations.

Given the current trends of HIV in the country and the region, there is need to implement a multidimensional and multisectoral policy and programmes targeting the general population with emphasis on the most vulnerable groups. The success of this approach however can only be attained through the participation of all stakeholders comprising public organizations, civil society organizations, nongovernmental organizations, private sector, communities, and individuals. Since agriculture is the backbone of the Uganda's economy, the Uganda Government is cognizant of the developmental challenges of the epidemic and has taken concrete steps to address it. HIV control is one of the developmental priorities addressed in the country's Poverty Eradication Action Plan (PEAP) and the National Vision for 2025.

**Table 10.1; Highlights of Plantation-related HIV policies and Programmes at Central and Local Levels**

| Policies and Programmes | Central Level Institutions | Tilda Rice Plantation | Kakira Sugar Works | Kaweri Coffee Plantation | Wilma Palm Oil |
|---|---|---|---|---|---|
| | | | | | |
| **Policies** | | | | | |
| Existence | There is a "National Policy on HIV/AIDS and the World of Work" in the Ministry of Labour, Gender and Social Development (MoLGSD). | There is no written HIV/AIDS workplace policy | Explicit written HIV/AIDS workplace policy is present (1985) | Draft explicit written HIV/AIDS workplace policy is present (2008) | There is no written HIV/AIDS workplace policy |
| Emphasis | 1. HIV/AIDS prevention, management and mitigation activities being present in the world of work.<br>2. Stigma and discrimination on basis of HIV status eliminated from the world of work.<br>3. Effectiveness of measures to combat HIV monitored within the world of work.<br>4. Impact of HIV/AIDS mitigation monitored within the world of work.<br>5. Care, treatment and support provided to people infected and affected by HIV/AIDS within the world of work.<br>6. Greater quantitative knowledge and awareness on HIV/AIDS present within the world of work. | Not applicable | Emphasis is put on ensuring non-discrimination of HIV infected workers, gender sensitivity, safer work environment and confidentiality in handling HIV information. Roles of management, workers and HIV committee have been defined. | Emphasis is put on ensuring non-discrimination of HIV infected workers, confidentiality in handling HIV information, gender sensitivity, greater involvement of PLWH and HIV service provision,. Membership of the HIV/AIDS Committee has been defined. | Not applicable |
| Effectiveness | One objective states that that "To provide a framework for monitoring and evaluating the effectiveness of measures taken to combat HIV/AIDS | Not applicable | Policy seems to be working well. Plantation management is | Policy seems to be working well. Plantation management is | Not applicable |

| Policies and Programmes | Central Level Institutions | Tilda Rice Plantation | Kakira Sugar Works | Kaweri Coffee Plantation | Wilma Palm Oil |
|---|---|---|---|---|---|
| | within the world of work". | | implementing the policy and workers have no issues on the policy | implementing the policy and workers | |
| | | | | | |
| | | | | | |
| **Programmes** | | | | | |
| Existence | The policy defines the roles of the different institutions including that of Office of the President, Office of the Prime Minister, Labour Advisory Board, MOH, UAC, MAAIF, MoPS, MoES, MoJCA, MoLG, MoIA, MoD, UBOS,local authorities, employers, workers, provate sector,, CSOs, international organizations, etc. | Both HIV prevention and treatment programmes exist. Kibimba HC III serves as the main service outlet. | Both prevention and treatment programmes exist. Kakira Hospital serves as the main service outlet. | Both HIV prevention and treatment programmes exist. The plantation clinic run by a Medical officer from Mubende Town serves as the main service outlet. | Both HIV prevention and treatment programmes exist. The plantation clinic run by a Registered Nurse serves as the main service outlet. |
| Range | The policy covers the following areas:<br>1. Non-discrimination on the basis of known or perceived HIV status.<br>2. Confidentiality.<br>3. HIV counseling and testing.<br>4. Greater involvement of people living with HIV/AIDS.<br>5. Promotion of prevention, treatment, care and support.<br>6. Gender concerns in the world of work.<br>Social dialogue. | Awareness creation, health education, HCT and genera health services are being provided. | Awareness creation, health education, HCT and ART services are being provided. | Awareness creation, health education, HCT and ART services are being provided. | Awareness creation, health education, HCT and genera health services are being provided |
| Effectiveness | One of the roles of MAAIF is to develop and implement HIV/AIDS interventions for farming communities to mitigate the impact of HIV/AIDS on agricultural production. | There is good response from both workers and management. | There is good response from both workers and management. | There is good response from both workers and management. | There is good response from both workers and management. |

# CHAPTER 10: DISCUSSION AND RECOMMENDATIONS

## 10.1 Key Recommendations

- Tilda, Kaweri and Wilmar plantations should develop their HIV/AIDS work place policies.
- Coordination structures for HIV prevention and control should be strengthened in the plantation sector.
- Expand the range of HIV services in Tilda, Kaweri and Tilda to make the services comprehensive. This will allow the implementation of comprehensive HIV services in all the plantations.
- To increase the levels of HIV-related knowledge, strengthen programmes for information-education-communication (IEC) in the plantations and surrounding areas.
- Some of the plantation workers are engaging is HIV risk behaviours, namely, multiple sexual relationships, higher-risk sex, paid sex and non-use of condoms during such acts. These acts are likely to promote HIV transmission in the plantations and surrounding areas. To facilitate the adoption of risk-avoidance and risk-reduction HIV-related sexual behaviours, there is need to strengthen programmes for behavior change communication.
- Promote HIV counseling and testing among the general plantation workers. Pregnant women should be particularly targeted.
- Strategies should be designed to address the high level of HIV infection among the plantation workers. The design of these strategies should take into consideration the key factors identified by the KI interview participants and focus group discussions to be responsible for the spread of HIV infection.
- To allow trend analysis, that is, determination of change in the HIV-related variables over time, there is need to and value in repeating the survey in the same populations three to five years later. In addition, efforts should be made to conduct a similar survey in the other plantations that were not covered this round because the varying locations of the plantations may have some unique influences on the risk of HIV transmission.

## 10.2. Introduction

The survey has shown that the plantation sector has not been spared by the HIV/AIDS epidemic. Overall, the HIV prevalence among the plantation workers was found to be 6.8 percent; which is slightly higher than the national HIV prevalence of 6.4 percent among general population people aged 15-49 years. The survey also revealed that HIV-related knowledge is widespread, but not universal. The level of this knowledge varies from plantation to plantation and with different age groups and work categories. Furthermore, while there is generally an accepting attitude among the plantation workers, a good proportion of them still express non-accepting attitudes. Additionally, while the plantation workers are practicing risk-reduction and risk-avoidance measures, the level of HIV-related behavior indicators are still sub-optimal. Quite a significant proportion of plantation workers

are still engaging in multiple sexual partnership, higher risk sex and non-use of condoms during such acts. The survey further revealed that HIV counseling among the plantation workers and female workers who are pregnant is still low. In respect to HIV/AIDS policies and programmes, it was found that only one plantation (Kakira) has a written and approved workplace policy. The HIV/AIDS services though were available in all the four surveyed plantations, their breadth were variable; being well developed and comprehensive in Kakira which has a hospital.

### 10.3. Discussion

The analysis revealed that the key findings on HIV-related knowledge included; knowledge of single HIV prevention methods is widespread among plantation workers across all the plantations; and the knowledge is similar in both women and men; the majority of respondents (79.2 percent of women) and (68.4 percent of men) know that HIV can be transmitted from a mother to her child by breastfeeding; about two thirds of the respondents know that there are special drugs (antiretroviral drugs) that a doctor or nurse can give to a pregnant woman infected with the AIDS virus to reduce the risk of transmitting the virus to the baby; and that kknowledge of at least one source of a condom was widespread; ranging from 77 percent in Tilda to 91 percent in Kaweri. Given that Uganda has had the HIV/AIDS epidemic for close to three decades and a national response as old as two decades and half, the above levels of knowledge are still low. Efforts are therefore required to increase the HIV-related knowledge.

On sexual behaviours, the survey has revealed that most of the respondents (over 96 percent) are sexually experienced; compared to men, a slightly higher proportion of women reported that they have ever had sex. The median ages at first sex for women and men were 16 and 18 years, respectively. Overall, 37 percent of women and 24.5 percent of men initiated sex before the age of 15 years and primary abstinence was more common among men (12.9 percent) than in women (3 percent). Overall, only 0.5 percent of respondents reported that they had no sex during the last 12 months. Secondary abstinence was more common among women (1 percent) than in men (0.4 percent). There is also a widespread acceptance of the ability of women to negotiate safer sex with their husbands. Some respondents who were sexually active in the 12 months preceding the survey are practicing multiple sexual relationships; 27.1 percent of men and of 9.1 percent women. Compared to women, men had a higher mean number of sexual partners. The mean number of lifetime sexual partners was 6.3 in men compared to 3.2 in women. Like for multiple sexual relationships, higher risk sex was more common in men than in women and condom use during the last higher risk sexual encounter was higher in men than in women. Finally, of these people who reported paid sex, 52 percent said they had used condoms.
The above results show that some of the plantation workers are engaging is HIV risk behaviours, namely, multiple sexual relationships, higher-risk sex, paid sex and non-use of condoms during such acts. These acts are likely to promote HIV transmission in the plantations and surrounding areas.

HIV counseling and testing services are important to promote knowledge of HIV sero-status. Knowledge of HIV sero-status is a stepping stone to the uptake of HIV prevention, care and support services. In the surveyed plantations, it was found that about 71 of women and 58 percent of men have ever had HIV tests; and that women were more likely than men to have received HIV testing. In addition, fifty seven percent of pregnant women who gave birth in the last two years were counseled during antenatal care. Furthermore,

among those women who were offered and accepted HIV test during antenatal care, 27.2 percent received their results. The results also showed that about one fifth (18.4 percent) of pregnant women who were offered HIV test during antenatal care accepted an offer for HIV testing, and know their results. The above findings show that HCT is still sub-optimal. Ideally, everybody should know their HIV sero-status; and especially the high-risk groups where plantation workers fall. Action is needed to increase HCT uptake in the plantations.

In regard to HIV infection, the survey has revealed that about seven percent of plantation workers aged 15-49 years are infected with HIV; and that HIV prevalence is higher among women (13.4%) than among men (4.5%). Comparing all the surveyed plantations, it was found out that Kaweri coffee plantation has the highest HIV prevalence (8.3%) while Tilda rice plantation has the lowest HIV prevalence (5.1%). Across all the 4 plantations, HIV prevalence is highest among widows/widowers (28.6 percent) followed by that among divorced people (14.2 percent). Furthermore, the analysis shows that, overall, HIV prevalence is highest among respondents with higher number of living children. These findings show that HIV prevalence among plantation workers is slightly above that among the general population of Uganda which stands at 6.4 percent. Like in the general population, HIV infection was found to be heterogeneous with women and some plantations more disproportionately affected than their counterparts.

During the KI interviews, some of the key factors cited by the key informants to be influencing the spread of HIV infection among plantation workers included: poverty; low female-to-male ratio in the plantations, inadequate information on HIV/AIDS among plantation workers, low risk perceptions, the practice of commercial sex work as a means of supplementing income, non-pecuniary benefits like favours, the practice of widow inheritance, negative beliefs on condoms and negative cultures/values.

It is gratifying to find out that misconception about HIV/AIDS is low among the plantation workers, and that the majority of respondents have a caring attitude. About ninety percent of both women and men know that a healthy-looking person can have the virus that causes AIDS. Much fewer respondents understand that the AIDS virus cannot be transmitted by mosquito bites: 56 percent of women and 60 percent of men know that AIDS cannot be transmitted by mosquito bites. Furthermore, the proportions of women and men who know that people cannot get the AIDS virus by sharing food with a person who has AIDS are 68.6 and 65.2 percent, respectively. Additionally, the vast majority of plantation workers say that witchcraft is not a means of transmission of HIV, with 81.1 percent of women and 84.4 percent of men saying so.
In regard to respondents attitude on providing care to a family member who has AIDS, over ninety percent of women and men say they would be willing to care for a relative who is sick with AIDS in their own household. The results also show that about seventy seven percent of respondents agree that a female teacher who has the AIDS virus but is not sick should be allowed to continue teaching in the school. Furthermore, about 77 percent of women and men say they would buy sugar or fresh vegetables from a vendor if they knew that he/she is HIV positive; and about 48 percent of women and 63 percent of men say that if a member of their family got infected with the AIDS virus, they would not necessarily want it to remain a secret. Last but not least, the proportion of women and men who express positive attitudes on all four indicators are 31.5 and 40.4 percent, respectively.

Given the above findings, some remedial actions need to be taken to address the challenges. The actions should build on the existing opportunities and be implemented in the context of the national policies and programmes. In making the recommendations, the roles of the drivers of the HIV/AIDS epidemic are considered.

### 10.4. General Recommendations

**In view of the findings of the survey, the following are the key recommendations:**

1. Tilda, Kaweri and Wilmar plantations should develop their HIV/AIDS work place policies.
2. Coordination structures for HIV prevention and control should be strengthened in the plantation sector.
3. Expand the range of HIV services in Tilda, Kaweri and Tilda to the services comprehensive. This will allow the implementation of comprehensive HIV services in all the plantations.
4. To increase the levels of HIV-related knowledge, strengthen programmes for information-education-communication (IEC) in the plantations and surrounding areas.
5. Some of the plantation workers are engaging is HIV risk behaviours, namely, multiple sexual relationships, higher-risk sex, paid sex and non-use of condoms during such acts. These acts are likely to promote HIV transmission in the plantations and surrounding areas. To facilitate the adoption of risk-avoidance and reduction HIV-related sexual behaviours, there is need to strengthen programmes for behavior change communication.
6. Promote HIV counseling and testing among the general plantation workers. Pregnant women should be particularly targeted.
7. Strategies should be designed address the high level of HIV infection among the plantation workers. The design of these strategies should take into consideration the key factors identified by the KI interview participants and focus group discussions to be responsible for the spread of HIV infection.
8. Build on the positive finding of low misconception about HIV/AIDS among the plantation workers, and that the widespread caring attitude among the respondents. Plantation workers could be used to extend HIV services among their peers.
9. To allow trend analysis or determination of change over time in HIV-related variables, there is need to and value in repeating a similar survey in the same populations three to five years later. In addition, efforts should be make to conduct a similar survey in the other plantations that were not covered this round because the varying locations of the plantations may have some unique influences on the risk of HIV transmission.

### 10.4. Limitations of the Study

The study had a number of limitations, namely; Only 4 plantations were surveyed. Therefore, the results may not be representative of all plantations in Uganda. In addition, most of the information generated from respondents came from structured individual interviews. Hence, there are inherent biases arising from reported information as opposed to observed behaviors. This type of bias is referred to as “Hawthorne effect” or social desirability effect; it is attributed to the respondents telling you what they think you want to hear. Furthermore, syphilis testing was not performed. This led to missed opportunity to provide some services to the participants. Since sexually transmitted infections are cofactors to HIV infection, syphilis testing in the survey would have provided yet another opportunity to study the link between the two conditions. Finally, due to limited budget, residents of plantations who were not directly involved in plantation work were left out; except for the focus group discussions. This led to a big missed opportunity to study the effect of population mixing on the HIV/AIDS epidemic.

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# Annex 1

## TOPIC GUIDE FOR KEY INFORMANT INTERVIEW

## (PROGRAMME AND KEY PLANTATION STAFF)

---

**Introductory note**

*I would like to thank you for accepting to be interviewed by my team. The interview is going to focus on the following topics:*

1. *The views you have on how big a problem is HIV/AIDS in plantations communities.*
2. *The range, breadth, availability and utilization of HIV/AIDS related services in AIDS in plantations communities.*
3. *The existence and effectiveness of policies, programs and coordination structures on HIV/AIDS services in AIDS in plantations communities.*
4. *Any suggestions on how services for HIV prevention and care can be improved in your community.*

*I would now like to go over them one by one.*

**1. Burden of HIV/AIDS:**

a. In your own assessment, how big a problem is HIV/AIDS in plantations?

b. If it is a big problem, what are the factors that promote the spread of HIV infection in the community?

**2. HIV/AIDS related services:**

a. Are HIV/AIDS related services available in this community?

b. If yes, what services are available, can you enumerate them?

c. Are these services being used?

**3. Policies, programs and coordination structures on HIV/AIDS service in plantations:**

a. Are there specific policies for HIV in your organization?

b. Is HIV testing a requirement before a worker is employed in your organization?

c. How do you handle a worker who is found to have HIV infection? What I mean is, is he/her allowed to continue working?

d. Does the company pay for treatment of people found to suffer from AIDS?

e. What coordination structures for HIV/AIDS services are there?

f. Are there HIV-related NGOs/CBOs in this area?

**4. Quality of services:**

a. Are you satisfied with what is being done on HIV prevention and care in this area?

b. If not, could you please make suggestions on how services can be improved.

**Thank you**

# Annex 2

## CONSENT FORM FOR INDIVIDUAL INTERVIEWS

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**Introduction**

Hello. Good morning/afternoon. My name is…… I am working for the East Africa Lake Victoria Project who is working in collaboration with the Ministry of Health. We are interviewing some people in agricultural plantations and fishing communities. The main aim of the interviews is to find out information about HIV/AIDS and sexual reproductive health of people in these communities. The information collected will help the East Africa Lake Victoria Project and Government to plan for health services which specially target plantation workers and fishing communities. This exercise will cover four plantations and 46 landing sites in 9 districts. A total of about one thousand eight hundred (1800) people both male and female will be interviewed by the end of the exercise in the 4 plantations. In the fish landing sites, approximately 932 respondents will be interviewed by the end of the exercise.

All interested respondents will be provided with free HIV counseling and testing services from their places of work or residences. Those found to be HIV positive will be referred to the nearest health care facility for follow up and care.

**Confidentiality and consent:** During the interview, I will ask you some very personal questions that some people may find difficult to answer. The answers you give will be completely confidential; and your name will not be written on the interview form. In any case, you do not have to answer any questions that you do not want to answer, and you may end this interview at any time you wish to when you become uncomfortable to continue with the interview. However, your honest answers to these questions will help us better understand the HIV/AIDS situation in your community; and what people think, say and do about certain kinds of behaviors. We would greatly appreciate your help in responding to these questions. The interview will take less than one hour to complete.

**Persons to contact**

If you have any additional questions after this interview you may contact the study team or the Ethics Committee at Entebbe:

| | | |
|---|---|---|
| Ministry of Health | Dr Alex Opio | 0414-340874/0414-259669/0414-348278 |
| | Noordin Mulumba | 0414-340874/0414-259669/0414-348278 |
| | Michael Muyonga | 0414-340874/0414-259669/0414-348278 |
| Chair UVRI Science and Ethics Committee | | 0414-321962 |

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Thank you,

Would you be willing to participate in this interview?" Yes…… No……..…

Signature or Thumb print of the interviewee certifying that he/she has provided consent for the interview……..……..……..

Signature of the interviewer…… Date ..……..……

# Annex 3

## CONSENT FORM FOR HIV TESTING AND BLOOD DRAW

Hello. My name is …… and I am also working for the East Africa Lake Victoria Project, an organization which is working with the Ministry of Health. I am part of the survey team which has been talking to you.

As part of this survey earlier mentioned, we are asking you to give a little blood for HIV testing. If you agree to participate, you will be counseled by trained counselors before the blood draw and before receiving your HIV results. You will be able to receive your HIV test results here in the interview place within a period of one hour.

While collecting the blood, we will use only new and sterile needles. You may get some pain where the blood is taken from. If you get any discomfort, some bleeding or swelling at the site which may be of concern to you, please contact our study staff or a nearby health worker.

Some of the blood you provide will also be sent to the National STD Reference Laboratory based at Mulago Hospital; for HIV testing to provide further information about HIV in your community. We will ensure confidentiality. We will put a study number, not your name on the blood tube. That way, we can make sure that nobody can tell to whom the blood belongs from the national laboratory or anywhere else.

In addition the information we shall obtain from this survey will help the East Africa Lake Victoria Project and the Ministry of Health to see how big the HIV/AIDS problem is in your community and will be used for planning and improving the delivery of HIV services.

This study presents a good opportunity for you to know your HIV status and to get advice from our trained counselors on what you can do about it.

At this stage, do you have any questions so far?

It is your choice to accept the blood being taken off or not. There is no problem if your refuse. Do you still have any questions?

May I proceed with the blood draw? Yes……..…….. No……..……

Signature/Thumb print of interviewee certifying that he/she has provided consent for the blood draw……..……..……

Signature of technician……..……..……
Date……..……

# Annex 4

## HIV COUNSELING AND TESTING CLIENT CARD

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### SERO-BEHAVIORAL SURVEY IN PLANTATIONS AND FISHING COMMUNITIES

| | |
|---|---|
| Date …./…./…. | Client ID # (Insert counselors control form number in Col 1) _ _ |
| District……<br>**County**…….. **Sub-county**……<br>**Parish**…… **LC1**…… | Date of Birth \|__\|__\|/\|__\|__\|__\|__\|<br>*mm* *yr*<br>**Sex** M[ ] F[ ] |
| **Marital status**<br>01[ ]Single 02 [ ]Married 03 [ ] Co-habiting<br>04[ ]Divorced/separated 05 [ ] Widowed | **Occupation**<br>01[ ]Peasant 02 [ ]Employed 03[ ] Small-scale trade<br>04[ ] None 04[ ]Other (specify)_____ |

**1. TESTING HISTORY**

**1a. Ever had an HIV test?**
1[ ] Yes *(go to 1c)* 2[ ] No 3[ ] Don't Know

**1b. If No, why?** ***Don't prompt.*** ***Tick all that apply.***
01[ ] No perceived HIV risk 02[ ] VCT services expensive 03[ ] Transport costs 04 [ ] Stigma of going to VCT facility
05[ ] Afraid to know status 06[ ] Not a priority 99[ ] Others (specify) _____ _____

**If No go to 3**

**1c. Date of last HIV test:** \|__\|__\|/\|__\|__\|/\|__\|__\|__\|__\|
***dd mm yr***

**1d. Where did you go for the test the last time?**
01 [ ] AIC 02 [ ] Gov't Hospital/Health Center 03 [ ] Private hospital/clinic
04 [ ] Out reach 99 [ ] Others (specify)_____

**1e. Do you wish to share your results? \|_____\| 01 –Yes 02-No (go to 2)**

**1f. What was the result of this HIV test?**
01 [ ] Positive 02[ ]Negative 03[ ]Don't know

**1g. Have you disclosed your HIV test result to your spouse or partner(s)?**
01 [ ]yes to all 02 [ ]yes to some 03 [ ] No 04[ ] Not applicable *(don't have a spouse or partner)*

**2. Other than the reason that we have offered you testing here today, what is the main reason you would like a test?**

Main Reason: |__|__| (*Tick other reasons applicable)*

01[ ] Current HIV risk 02[ ] HIV risk in past 03[ ] Feel ill/AIDS symptoms
04[ ] STD symptoms 05[ ] HIV+ parent 06[ ] Pregnancy
07[ ] Lost partner/child /parent/co-partner 08[ ] Confirm Prev. HIV status 09[ ] Ill partner/co-partner/child/parent
10[ ] New partner 11[ ] To get Married 12[ ] There is treatment for AIDS these days
99[ ] Others (specify) _____

**3. TYPE OF COUNSELING:**

**3a. How would you like to receive your results?**

01 [ ] Individual 02 [ ]Couple

**34a. Where would you like to receive your results?**

01[ ] Home 02[ ] Nearest HC 03[ ] Outreach 04[ ] Other preferred place (specify)_____

**3a. What time is convenient for you to receive your test result?** ***(min 2 days and max 6 days-period in cluster)***

01[ ] Tomorrow: Time_____ 02 [ ] Other date (specify)_____Time_____

**4. Results** Positive [ ] Negative [ ]

**4a. Results given?** 01[ ] Yes 02[ ] No. **Why not, specify**_____

**4b. Referral made to (specify)** _____

**Counselor's comments:**

Counselor Name . ……

Date dd……/mm……/yyyy……

Signature ……

---

## CLIENT SLIP

**District Code**……/……/……. **Centre Code**……/……/……

**Client Name**…… **Sex** [ ] Male [ ] Female **Age:** ……

Date of HIV test……

**Results** [ ] Positive [ ] Negative

**Reason for referral:** 01[ ] Repeat test 02[ ] Medical Care
03[ ] Psycho-social support 99 [ ]
Other (specify)……

Referral made by: **Counselor name**: ……

# Annex 5

## LIST OF RESEARCH TEAM MEMBERS

**Central Coordination Team (Consultants)**
Dr. Alex Opio – Lead Consultant
Noordin Mulumba – Biostatistician
Michael Muyonga – Behavioral Scientist

**Supervisors**
Patrick Kusemerwa
Nyende Hirone Paul
Samuel Wangalwa
Kasimbi Willy

**Interviewers**
Kirabira Muzafalu
Kyozira Allen
Nangira Evelyn
Businge Jones
Namubiru Mary Josephine
Daniel Byaruhanga
Busuulwa Phillip
Busingye Florence
Nkungwa Ibrahaim
Balwanaki Carol
Byaino Jonathan
Bazaale Jennifer
Kadisi Suzan
David Okimait
Mutambo Fred
Nansambu Ruth

**Counselors**
Robert Kanyike
Janet Nerima
Naluzze Juliet
Nakkazi Aminah Angella

**Laboratory Technicians**
Mirembe Rebecca
Nakayiza Sarah
Agaba Richard
Maziga John

**Plantation site supervisors**
Umaru Mukose – Tilda Rice Plantation
Robinah – Kakira Sugar Plantation

Edward Ssali – Kawrei Coffee Plantation
Joshua Adiba – Wilmar Palm Oil Plantation

**Partners' local liaison team**
Eva Musimenta - AMREF
Noela Kigozi - AMREF

# Annex 6

## QUESTIONNAIRES