"Everyone now knows about ARVs": Findings from a pre and post intervention study of a fishing community in Kazungula District, Southern Province, Zambia

Phillimon Ndubani
Institute of Economic and Social Research, University of Zambia

Fiona Samuels
Overseas Development Institute

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* Disclaimer: The views presented in this paper are those of the authors and do not necessarily represent the views of the International HIV/AIDS Alliance

Overseas Development Institute
111 Westminster Bridge Road
London SE1 7JD
UK

Tel: +44 (0)20 7922 0300 Fax: +44 (0)20 7922 0399
www.odi.org.uk

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Abbreviations

ACER Project	ARVs Community Education and Referral
ART	Anti-retroviral treatment
ARVs	Anti-retrovirals
CBO	Community Based Organization
DAPP	Development Aid from People to People
DHMT	District Health Management Team
DHS	Demographic Health Survey
EHT	Environmental Health Technician
FAO	Food and Agriculture Organization of the United Nations
FAPCAS	Fishmongers HIV/AIDS Prevention Care and Support project
FGDs	Focus Group Discussions
HBC	Home Based Care
IDIs	In-depth Interviews
INESOR	Institute of Economic and Social Research
KAPB	Knowledge, attitudes, practices and behaviours
LGH	Livingstone General Hospital
PMTCT	Prevention of Mother To Child Transmission
MTCT	Mother To Child Transmission
NHC	Neighbourhood Health Committee
NZP+	Network of Zambia People Living with HIV
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
PPAZ	Planned Parenthood Association of Zambia
RHC	Rural Health Centre
STIs	Sexually Transmitted Infections
THAPAZ	Traditional Health Practitioners Association of Zambia
ToTs	Trainer of Trainers
VCT	Voluntary Counseling and Testing
ZDHS	Zambia Demographic Health Survey
ZEN	Zambia Enrolled Nurse

EXECUTIVE SUMMARY

1.0 Introduction

In April 2005 a baseline assessment was carried out in Kabala fishing community in Southern Zambia. The Kabala community was the third and rural site of an operations research project – ACER - carried out in Lusaka and Ndola. Following the baseline assessment, a set of interventions were implemented by the Fishmongers HIV/AIDS Prevention Care and Support project (FAPCAS) and ran for approximately 18 months. This report, whilst focusing mostly on the follow-up study, brings out the change over time in this site. Issues explored in the report essentially focuses on knowledge, attitudes, practices and behaviour (KAPB) around HIV/AIDS and ART among members of Kabala fishing community.

2.0 Background

2.1 Fishing Communities and the HIV/AIDS epidemic

In 2005, an estimated 1,100,000 adults and children were living with HIV in Zambia, with approximately 98,000 adults and children dying of AIDS in 2005. The estimated national adult prevalence rate is 17% (15-49 year olds). The epidemic has affected all sectors of Zambian communities including those of the fishermen and traders. Due to the nature of fishing in which men often have to travel to wherever the catch is most plentiful, fishermen can also be categorized as a mobile population and one, therefore, which is highly vulnerable to HIV/AIDS. However, as in many sub-Saharan African countries where the impact of HIV/AIDS in the fishing communities has been devastating, little efforts have been made towards meaningful intervention activities.

2.2 The HIV situation in Southern Province

The national zero-surveillance data indicates that the Southern province is one of the most severely affected geographical areas in Zambia with the prevalence of 17.6 percent. Contributing factors to these high rates in Southern province includes the fact that Livingstone, the provincial headquarters is a border town and is both a transit point for truckers and a centre for tourism. Fishing and fish mongering are important income generating activities within southern province and fishing activities are associated with a style of life which is likely to lead to risky behaviours.

2.3 The socio-economic and health services context in Kabala

Situated in Kazungula district, are several fishing communities that include Mambova and Kabala. Kabala fishing camp, where this assessment was carried out, is on the western side of Kazungula and has a population of about 300 people and a total of 91 households. During the rainy season, the road leading to Kabala becomes impassable; also during this period, Kabala itself floods so that many of its inhabitants move to the upland villages. The main occupation in the area is fishing and fish mongering; some farming of maize, sorghum, millet and beans is taking place, though it is mostly subsistence farming. Some of the inhabitants own cattle.

The nearest health facility to Kabala, approximately 2 hours walk or 30 minutes drive, is located at Mambova. A major change from the baseline is the scaling up of ART. As of February 2007, the ARVs were brought to Mambova clinic and are now being stocked there. Since February 2006 a medical doctor has been coming to Mambova health centre once a week from Livingstone; he attends to both ART and general cases and sees about 25 patients per visit. Mambova health centre currently has 73 people on ART. A further approximately 50 people are HIV positive but are not yet on ART. The majority of the people on ART are from the fishing camps of Kabala, Ngwezi and Simalaha.

2.4 HIV/AIDS Interventions in Kabala

HIV/AIDS interventions in Kabala were implemented by FAPCAS. Prior to 2005, a number of activities had been already been implemented in Kabala, including sensitization on prevention of HIV, peer education and home based care support for the chronically ill. Several community members were

encouraged to go for VCT, but there had been little in terms of caring for those that are found to be HIV positive and there were no links with the ARV treatment programme based in Livingstone. In 2005, supported by the International HIV/AIDS Alliance, FAPCAS initiated a project which aimed to address the above gaps by educating the community of Kabala on ARV treatment and its benefits and mobilizing people for treatment. In addition, the already existing structures were to be strengthened to support those on treatment to adhere and to actively link in prevention messages into treatment services and structures.

At the time of the follow-up assessment, FAPCAS did not have an executive committee although there was a caretaker committee that was organizing the election of a new executive committee. It was reported that two members of the previous executive embezzled project funds and disappeared leading to the dissolution of the executive committee. In January 2007, the members met and elected a caretaker committee with one member standing in as the Acting Coordinator. There are currently 12 members in the new committee. Each sub-committee from the fishing camps has a representative on the main executive committee which is based in Livingstone.

3.0 Methodology

This was a post-intervention assessment following the baseline assessment conducted in 2005. The post-intervention assessment was carried out to measure change amongst beneficiaries of FAPCAS interventions. The respondents were asked about their knowledge, attitudes and behaviour around HIV/AIDS and ART. The data collection tools consisted of semi-structured interview schedule and documentation of case studies. A total of 21 people were interviewed, 12 males and 9 females: 14 were members of the community, 4 FAPCAS members, one health worker, one NHC member and one community leader. The assessment took place in May 2007.

The researchers, who authored this report, conducted the interviews. Extensive field notes were taken for all the interviews. Data was analysed using qualitative methods; content analysis was used to give a clear picture of the data.

4.0 Key findings

4.1 Interviews with community members

Common Illness and treatment seeking behaviour

The community members felt that Malaria, STI, TB, diarrhea, HIV/AIDS were the most common illnesses in the area. Unlike at baseline, at post-intervention most respondents mentioned that HIV/AIDS was affecting people in the area. Mambova health centre was the only health facility in the area and, as at baseline, most people during the follow-up data collection mentioned going there if they had a health related problem. A few people both at baseline and follow up did mention the existence of community health workers (CHWs). Similarly, as in the baseline study, in the follow-up some people mentioned at first trying African herbs. A number of people during the follow-up data collection mentioned treatment supporters as being people who were turned to when health related problems were being faced. This cadre of health care providers did not exist during the baseline. As at baseline, people in Kabala continue to complain about the long distance to Mambova clinic.

Current health problems

The respondents were asked whether they had a current health problem. A number of respondents had current health problems and included toothache, body rashes, scabies etc. Some of the respondents were living with HIV and were on ART.

Sources of information about HIV/AIDS

A number of people mentioned receiving information from Mambova clinic, with some mentioning specifically the sister-in-charge; they also spoke about the mobile VCT clinics that had taken place as

a location in which they received HIV/AIDS related information. What stood out at follow-up data collection was that fact that FAPCAS members had become a key source of information about HIV/AIDS. Despite this, there was some concern regarding the frequency of the sensitization events, with some respondents saying that, in the last one year, FAPCAS had reduced on these kinds of activities.

Knowledge about HIV/AIDS

During the follow-up interviews, it became apparent that most people had good knowledge about HIV/AIDS and similarly, there appeared to be fewer misconceptions than at baseline. Most people clearly knew how HIV was transmitted and were able to state all the ways of preventing the spread of HIV. The majority of the respondents perceived that all the people were at risk of HIV/AIDS, noting that even married people were at risk of getting HIV especially those who had a tendency of having extramarital relationships. A few, however, said that women were at more risk because they had multiple partners as they were more interested in monetary gains. Others felt that women were at greater risk because they were perceived to be drinking a lot of beer.

Views about condom use

Most respondents believed that, if used correctly, condoms provide protection against HIV. They also noted that these days there were more people using condoms than a few years ago. However, some commented that, although knowledge about condom use was wide spread, it was difficult to tell whether people were actually using them. It was evident that FAPCAS had been doing an effective job of distributing and sensitizing people on the use of condoms. It was observed that Kabala people were now more open and positive towards condoms than they were a few years ago. Although people claimed that condoms were widely available, at the time of the assessment, the FAPCAS members did not have any condoms for distribution neither did the local shops and *tuntemba* have any condoms for sale.

Views about VCT and ART

Most people in Kabala now know about VCT and the need for people to know their status. The main reason given for people to undergo VCT was the availability of ARVs. They noted that since the coming of ARVs, it was important that people know their status so that they can access treatment. However, it was noted that the issue of VCT was still very sensitive among community members. Some felt that not as many people as expected were going for VCT mainly because of perceived lack of confidentiality and stigma.

Knowledge about ART

During the post-intervention assessment, all the respondents were aware that ARVs were being provided at Mambova clinic and that within Kabala there were treatment supporters who were assisting those taking medication. Some respondents reported knowing some people living with HIV/AIDS in the area. They attributed their knowledge of ARV to the interventions by FAPCAS. All respondents knew that to be put on ART they needed to go for VCT. Respondents said that they knew people that had gone for testing, but they did not know their statuses as it was confidential. Some respondents seemed to know people on ART by their looks. In the community anyone who was too sick and had lost weight and suddenly regained it was suspected to be taking ARVs.

ART, pregnancy and sex

At post-intervention, although there some who remained unclear, most respondents felt that pregnant women could take ARVs if they were found to be HIV positive. In addition to knowing about PMTCT, respondents pointed out that babies born from mothers who are HIV should be breastfed for only 6 months and then weaned off.

Regarding sexual intercourse and ART, almost all the respondents pointed out that someone on ART should not engage in indiscriminate sexual activities because of the risk of high multiplication of the virus. Others specified that if they have sex whilst on ART, they must use a condom.

Stigma
There were mixed views about stigma. Some of the respondents felt that stigma was still prevalent whilst others observed that it had greatly reduced. If there was change it was attributed to the FAPCAS interventions. Owing to the availability of ART, for instance, many respondents were aware of people who were living with HIV/AIDS and were on ART. Despite this, stigma and discrimination persist still often resulting in people not wishing to come out in the open about their HIV status.

Views about interventions
Many people felt that FAPCAS had done an effective job of sensitizing people about HIV/AIDS in general and ART in particular. They noted that FAPCAS conducted sensitizations through drama and other events. They also noted that when people were too busy to attend the events, FAPCAS members visited them in their homes. Many said that the messages disseminated by FAPCAS were very effective as most community members had become more open about HIV and many people, mostly young men, were seen buying condoms. There were some respondents, however, who felt that FAPCAS had not done much, acknowledging that whilst they had started well, during the last year they had lost momentum.

4.2 Interviews with FAPCAS members and key informants

ART training and related activities
Five FAPCAS members were trained as ART treatment supporters in 2005. They reported that the sensitization activities had been going on since 2005. As a result, the people of Kabala were now able to access ART from Mambova. Whilst at the beginning people on ART were accompanied by treatment supporters, they were now able to go on their own to the clinic. As treatment supporters, clients come to seek assistance; they also visit clients to ensure that they are taking their ARVs and are feeding properly. They indicated that, as treatment supporters, they got no incentives as their work was voluntary. They reported more people now than in the past going for testing. They also noted that the first people in Kabala commenced ART around August 2005 and observed that these people were doing well although 3 had died.

Condom availability and use
FAPCAS members distributed condoms during their sensitization activities; the condoms were obtained from Mambova health centre. They noticed a reduction in STIs compared to the past when condoms were unpopular. They also noted that through their teaching and supply of condoms people were using condoms more that they did before the interventions.

Stigma
FAPCAS members pointed out that they sensitize the community on stigma and discrimination against people on ART. They however, observed that stigma was still common although it was reducing. They admitted that no one in the area had come out in the open to live positively, mainly due to stigma.

Perceptions about community knowledge and awareness
FAPCAS members felt that peoples' knowledge levels had increased due to the interventions. They noted that people have been changing their sexual behaviour and they have over the past one year seen an increase in condom demand.

Challenges of carrying out the interventions
FAPCAS faced several challenges including accessing people for sensitization activities, as many people had no time to attend meetings. They also mentioned difficulties of looking after people on ART

in an environment like Kabala which was a long way from the nearest health facility, where food was scarce and where people's livelihoods were dependent on the physical fitness of the individual. They noted that many new patients developed side effects. Additionally, some of the clients on ART were old, with no dependants, were unable to go fishing, which, compounded often by severe side-effects, resulted in difficulties in getting food and survival in general.

5.0 RECOMMENDATIONS

Following the baseline assessment, a set of recommendations were made. Some of the recommendations have already been taken on board, relating mostly to wider issues and aspects related to national policy. Other recommendations made at baseline remain largely valid and can, therefore, be reiterated:

5.1 Sensitization and awareness raising strengthened and continued; the following is a list of topics which emerged as being important from the baseline assessment which could be included in sensitization and awareness raising sessions; they are in no order of importance and clearly this is a long list and would have to be prioritized and perhaps topics combined in the same session:

- HIV/AIDS transmission and prevention
- Testing and counselling
- Treatment and adherence
- Alcohol and recreational drug use and links to risky behaviour, prevention, transmission and treatment
- Positive living
- STIs and their relationship to HIV/AIDS and treatment issues
- Links between TB and HIV/AIDS
- Links between TB and HIV treatment
- Links between TB, HIV, Malaria
- Nutrition and HIV/AIDs and treatment

5.2 Masculinity and fishing; linked to the above, some awareness raising and further exploration of the concept of 'Water, Wine and Women'; this may include discussions on:

- gender and sexuality;
- what in means to be a man and a woman in contemporary Zambia
- how masculinity is expressed through the fishing
- implications this has on sexual behaviour

5.3 Careful targeting of messages in terms of content and form; often message reach only reach one category of people (e.g. youth), therefore there is need to take into account the following criteria when developing and carrying out sensitization activities:

- Age and gender of people; carry out separate activities for different age and gender groups, including children and the elderly, facilitated by the appropriate gender/age in order that people are more at ease to ask questions and raise issues
- The livelihood activities and when different categories of people are available to take part in sensitization activities
- Place of residence of people, or where they are in the chain in relation to fishing, i.e. fishing camps, Livingstone, Namibia; ideally sensitization activities need to happen in the fishing camps (to include fishermen from Namibia who play a key role in fishing and transaction sex) but also in Livingstone when many fishmongers and families are based.
- Literacy levels; those who can read and speak English have different requirements than those who cannot; need to consider more visual approaches and methods

5.4 Locally and culturally specific approaches to delivering messages; linked to the above, there is need to ensure that messages have been translated into locally and culturally specific notions and terms. The means of expressing these concepts also need to be acceptable locally and might, therefore, include:

- drama activities,
- story telling events,
- family centred or intergenerational transfer of knowledge, i.e. instead of children being exposed to risky behaviour have this explained to them by their elders,
- other community events organised by the chief or headmen

5.5 Broadening the ToTs base; currently a few people in Kabala have been trained as ToTs; there is a sense that they are the selected few who will benefit; it is important to widen the base, invite others if possible to go through some training, to ensure that there is an equitable selection of people involving FAPCAS but also the headman who is very active and enlightened. There is also the issued raised by those already trained of additional or refresher training.

5.6 Other stakeholder involvement;

- the community school in Kabala could be explored as a possible base for undertaking awareness raising activities amongst school children.
- A number of CBOs and NGOs are working in Mambova and Kabala areas; there is potential overlap in many activities so it is important to ensure there is communication and building on each others work rather than duplicating.

5.7 Rural Health Centres and capacity

- Given the shortages of medical staff in Zambia as a whole, and in particular in rural areas, a wider spectrum of people should be trained to be able to administer treatment and should not just be left to medical doctors as in many RHC these do not exist and therefore there non-existence is one of the reasons for stalling rolling out of treatment to these areas.
- In order to encourage medical staff to go and remain in rural areas an appropriate incentive structure needs to be in place.

In addition to the above, a few additionally recommendations from the post-intervention assessment can be made:

5.8 ***Reporting, monitoring and evaluation*** – in order to measure the effects of the intervention, financial and programmatic reporting, monitoring and, eventually, evaluation are crucial. Support needs to be provided from the onset on these issues. Ongoing support and oversight also needs to be provided to ensure that these activities are taking place.

5.9 Horizontal HIV programming –integrating HIV programming into broader programmes at village level should be considered; this could either be done through one organization carrying out integrated, multi-sectoral programmes or collaborating with other organizations, both NGO and government, to develop these integrated programmes. The benefits of these kinds of programmes may result in reduced stigma and, therefore, generally improved affect of the programmes.

5.10 Appropriate incentive structures – when implementing programmes, in order to ensure sustainability and continuity, appropriate incentive structures need to be instituted, whether they are in rural and urban areas; one cannot expect an individual to carry out unpaid work at the expense of making their own livelihood.

1.0 INTRODUCTION

In April 2005 a baseline assessment was carried out in a fishing community in Southern Zambia (Samuels and Ndubani, 2005). This site was to become the third and rural site of an operations research project, ACER, being carried out in Lusaka and Ndola. Following the baseline assessment, a set of interventions were carried out in this area and ran for approximately 18 months. The same team that carried out the baseline assessment then undertook a follow-up in May 2007. This report, whilst focusing mostly on the follow-up study, will bring out the change over time in this site. Issues explored in both the baseline and follow-up essentially focused on knowledge, attitudes, practices and behaviour (KAPB) around HIV/AIDS and ART among members of Kabala fishing.

The report begins by presenting a general discussion of global empirical literature in order to contextualize this study into the wider debates around HIV/AIDS and the fisheries sector. Following the background, the HIV/AIDS situation in Zambia and southern province in particular is discussed, including a short account of the ACER project and its interventions. This is followed by a presentation of methodology, whilst section four presents the bulk of the findings. Much of these initial sections are based on the baseline report. A discussion of key findings and themes is found in section five with conclusions and recommendations rounding up the paper in section six. Literature review suggest that some of the findings from the studies are in line with the current assessment whilst others are somewhat different as will become evident in the subsequent sections of this paper. It must be pointed out from the onset that this was a rapid assessment conducted to provide a snapshot view of the KAPB around HIV/AIDS and ART in Kabala fishing community.

2.0 BACKGROUND

2.1 Fishing Communities and the HIV/AIDS epidemic

In 2005, an estimated 1,100,000 adults and children were living with HIV, with approximately 98,000 adults and children dying of AIDS in 2005. The estimated national adult prevalence rate is 17% (15-49 year olds); amongst the 15-24 year olds, prevalence rates for women is more than 4 times that of men, i.e. 12.7% compared to 3.8% (WHO, 2006). The epidemic has affected all the sectors of the Zambian communities including those of the fishermen and traders. However, as in many sub-Saharan African countries where the impact of HIV/AIDS in the fishing communities has been devastating, little efforts have been made towards meaningful intervention activities. A recent policy briefing by FAO notes the following: *"The impact of the AIDS epidemic in Africa first became apparent in a fishing village on the Ugandan shores of Lake Victoria in 1982. Since then, the vulnerability of fishing communities to HIV and AIDS has been widely overlooked. The consequence is that they have been left largely beyond the reach of prevention, care and mitigation efforts. This neglect is having devastating consequences" (FAO, 2005).* The report goes on to show evidence that fishing communities throughout the world have HIV prevalence rates of five to ten times higher than those in the general population. This is supported by evidence from in Allison and Seeley (2004) where, for instance, in the mid 1990s, marine fishing boat crews in Thailand had prevalence rates between 13-20 percent while in the general population rates were around 1.5 percent; and, similarly, 24 percent of fisher folk on Lake Albert, Uganda, were HIV-positive in 1992 compared to 4 percent in nearby agricultural villages.

Due to the nature of fishing in which men often have to travel to wherever the catch is most plentiful, fishermen can also be categorized as a mobile population and one, therefore, which is highly vulnerable to HIV/AIDS. Studies have shown a connection between time and frequency of being away from home and engagement in HIV risk associated behaviour. Both being away from home and being left at home increases the likelihood of engaging in high risk sexual behaviour. A study done by FHI in 2000 amongst Cambodian seafarers in Rayong, Thailand, found that 60 percent engage in commercial sex and studies done among the sex worker communities found HIV prevalence rates of

29-34 percent (quoted in Huang, 2002). Similarly, a study carried out by Soskolne (2000) found 15 percent prevalence rates amongst migrant fishers in Thailand, whose average age was 30 years and in which 60 percent spoke about having multiple partners and visiting commercial sex workers whilst away from home. A study in South Africa, in a district in which two thirds of adult men spent most nights away from home, found that among discordant couples "…. in nearly 30 percent of cases, the infected person was the female partner who stayed at home in the rural areas, while her migrant partner was HIV-negative" (Lurie et al, 2003).

Mobile populations may also feel a sense of alienation and isolation by being away from their home, separated from their families, their cultural norms, belief and identity (Seeley and Allison, 2005). This may lead to a lack of social control by peers, a freedom to experience new behaviours, but also a sense of estrangement and loneliness, which are factors likely to increase the likelihood of excessive use of alcohol and practices of unsafe sex (Af-aids list serve discussion on mobile populations, 2005).

Alongside the mobility of fishing populations, and a factor that is both a consequence and a cause of this, is the demographic structure of these populations, which often leads to potentially risky behaviours. Evidence shows that the majority of people are in the sexually active age group and there is often a sexual imbalance in these populations as the majority of people are unmarried and single. Results of a recent study in Uganda (Karukuza and Bob, 2005) shows that the majority of the population (62.8%) was between the ages of 18-30 and 58.9 percent of respondents were female. "This influenced sexual networking and the majority (70.2%) of female respondents revealed that they share male partners" (p4). The same study also shows that the majority of people in these fishing communities were single, with percentages ranging from 52.3 percent in one community to 78.8% in another community.

Another recent study in Uganda (Bishop-Sambrook and Tanzarn, 2003), outlines 3 defining characteristics of fishing communities which make them 'cauldrons of HIV infection' (p2): 1) their neglect by government and service sector – this deals with issues of poor infrastructure in the fishing communities and lack of access to health and education services, and in general a policy environment that has done little for the fisheries sector; 2) the high degree of mobility of the fisherfolk – this reflects the daily and seasonal flows of people in and out of fishing communities in search of good catches, often these people coming from areas where their previous livelihoods may have failed; and 3) the lack of social cohesion that is found in these communities – this reflects findings from other studies that social cohesion, social capital, community support and trust are important elements in understanding the rapidity of HIV infection and the existing structures for supporting those affected. In fishing communities in Uganda, this was found to be lacking with the "ethos being very much one of independence, with individuals relying on their ability to raise cash when needed and returning to their home village in the event of a calamity such as AIDS related sickness" (p3).

In addition to the above, there is growing evidence of transactional sex taking place in fishing communities. A study by Mushinge at al. 1990 in Luapula province of Zambia, found that, in order for female fish traders to access fish, they enter into sexual relationships with men in which sex was exchanged for fish. Women who traveled long distances from the cities to the shores of Lake Mweru found themselves under pressure to purchase and bring back sufficient fish for sale. In order for them to be able to accumulate enough fish at as little expense as possible, most of these women exchanged sex for fish. This clearly increases the vulnerability of fishing communities to HIV infection.

Stressful working conditions have also been seen to play a role in heightening vulnerability to HIV/AIDS. Thus Bishop-Sambrook and Tanzarn (2003), show how when fishermen return from hazardous and physically unpleasant fishing trips they want to celebrate "… their safe return and seek creature comforts, including alcohol consumption and sex" (p4). Notions of danger are also linked in with constructions of machismo and a male sub-culture, in which casual sexual encounters may be viewed as expected male behaviour (Allison and Seeley, 2004, Ndubani 2002).

2.2 The HIV situation in Zambia in general and Southern Province in particular

The national zero-surveillance data indicates that the most severely affected geographical areas in Zambia are Lusaka (22 percent), Copperbelt provinces (19.2 percent) and Southern Province (17.6 percent) (ZDHS 2001-2002). Contributing factors to these high rates in Southern province includes the fact that Livingstone, the provincial headquarters is a border town and is both a transit point for truckers and a centre for tourism. Fishing and fish mongering are important income generating activities within southern province. These income generating activities are associated with a style of life which is likely to lead to risky behaviours.

In southern province, as in most parts of Zambia, the HIV/AIDS epidemic poses a major threat to both health and socio-economic development. However, the two decades of HIV/AIDS work has taught Zambia a number of useful lessons. These lessons are crucial in guiding the future national response to HIV/AIDS and are very relevant to this assessment. The following are some of the lessons that could be learnt and fit in well with the fishing occupation and trade:

- The low social and economic status of women contributes to high-risk sexual behaviour and vulnerability to HIV;
- Some men's beliefs and attitudes towards the prevention of HIV/AIDS are still negative. For example, the use of condoms as a protective device is low partly because men doubt their safety and also argue that they reduce sexual pleasure.
- Misconceptions, stigma and discrimination that surround HIV/AIDS still exist suggesting that attitudes are not changing in response to the HIV/AIDS epidemic.

Livingstone district has a population of approximately 118, 659, with 85% concentrated in the urban are and the remaining 15% living in peri-urban areas of the district. The Livingstone General Hospital (LGH) has been providing ART as part of the government programme since October 2003. As of January 2005, there were approximately 700 people on treatment coming through LGH. At that time, the majority of people accessing treatment were coming from Livingstone town (with the majority from Maramba and Dambwa compounds), with some outsiders coming from a range of places including the fishing camps in neighbouring Kazungula district. Although the research team did not return in 2007 to visit LGH and the urban clinics, it is likely that ART is now being provided in Maramba and Dambwa clinics since in 2005 they had already undergone preparations (training of appropriate personnel, construction of buildings) to also start administering ART.

2.3 The socio-economic and health services context in Kabala

2.3.1 Kazungula District

Kazungula district, formed in 1995, is named after a border post on the Zambezi river which serves as an international boundary between Zambia and Botswana located some 60kms from Livingstone town and takes around 40 minutes along a tarred road that leads to the western province of Zambia. The site for the new district offices (under construction), is about 2 km from the border post. Estimates indicate that Kazungula district has a population of 81,381 people. Kazungula does not (yet) have a district hospital and whilst district offices are being built in Kazungula, most of them, including the DHMT are still based in Livingstone. In 2005, the only place to access ART for people in Kazungula was in Livingstone; by 2007, ART had been scaled-up and was being provided at Kazungula clinic.

Situated in Kazungula district, are several fishing communities that include Mambova and Kabala. Kabala fishing camp, where this assessment was carried out, is on the western side of Kazungula and has a population of about 300 people and a total of 91 households[1]

[1] A census of the population was carried out in 2005, this was not repeated in 2007.

2.3.2 Kabala

Kabala fishing camp is located in Kazunglula district under the chiefdom of Sikute of the Toka-Leya people. The camp is situated about 17 kms to the west of Mambova sub-centre and takes about 30 minutes by vehicle and two hours to walk from Mambova. The camp is situated on the banks of the Zambezi river. During the rainy season, the road leading to Kabala becomes impassable so that the vehicles that go everyday to collect fish stop at Lupani and Luzila settlements, which are upland from Kabala. Also during this period, Kabala itself floods so that many of it inhabitants move to the villages of Lihuka in the drier Lupani, Ngwezi and Luzila where some of the residents have second homes. A 15 minutes canoe trip away from Kabala is Kalikalika fishing camp which is considered to be part of Kabala and under the same Lihuka village.

Traditionally, due to flooding of the Barotse plains during the rainy season, most Lozi people have two villages; one on the bank of the Zambezi river and another one upland. In Kabala, the Lupani area provides the drier upland settlements where people usually have permanent structures. During the heavy rainy season, around February and March, the people of Kabala vacate the camp to settle in the drier land around Lupani. There are many villages located in the Lupani area but most people from Kabala and Kalikalika shift to Lihuka, Luzila and Ngwezi villages. A few people migrate to Livingstone town where they either own or rent houses. People return to Kabala and Kalikalika towards the end of the month of May when the water subsides and low lying lands become drier. In 2005, due to the low rainfall in the whole of Zambia, Kabala did not flood and the road was dry during the fieldwork period in April. In 2007, however, Kabala did flood so the research team followed the residents to the upland in *Lupani* (Mopane woodland).

There are three shops, one bottle store and five shabeens in Kabala; whilst there is no school in Kabala, in Lupani there is a community school with one volunteer teacher. The main occupation in the area is fishing and fish mongering; some farming of maize, sorghum, millet and beans is taking place, though it is mostly subsistence farming. Some of the inhabitants own cattle. During the assessment, six people reported owning cattle, with numbers ranging from one to 14 herd of cattle. One person who owns 14 cattle stays permanently in Lupani area. People in Kabala also raise chickens mainly for food but at times sell them when they have financial needs.

Every day a truck comes to Kabala from Livingstone - there are two trucks which take turns to visit the fishing camp; the transport system is organized by the fishmongers association in Livingstone. The truck starts off from Maramba market in Livingstone and then goes to Dambwa market before heading for Mambova and Kabala. At each of the markets in Livingstone, it collects empty crates, goods, letters, etc. that are sent by people from town. The truck drivers and conductors also collect note books in which is written details of what is being sent and what is expected, the name of the person sending and the one receiving is on the book. After collecting the empty crates, goods and money the truck starts off for the fishing camps first stopping at Mambova where it drops off empty crates, goods and the note-books and then proceeding to Kabala where it does the same. It then loads up with the fresh fish from both locations and heads back to Livingstone markets, dropping off the fish at Dambwa and then Maramba markets where the people receiving take it immediately for sale. Whilst loading the fresh fish at Kabala, a council fish levy is collected for all fish that is taken out of the camp. If there is space, the trucks also transport people backwards and forwards.

2.3.3 Health Care Services

The nearest health facility to Kabala is located at Mambova. Located around 7kms from Kazungula border post, Mambova is the largest settlement around the fishing camps, it has a primary school, a number of taverns and shops, a market and a rural health centre which has been in existence since 1968. A mini bus comes from Livingstone every day dropping people off and collecting others to take to town. Mambova is also the transit place for the fishing trucks on their way to Kabala and Ngwezi.

Mambova health centre is manned by 5 members of staff: a nurse/midwife, a male Zambia Enrolled Nurse (ZEN), Environmental Health Technician (EHT), a maid and a watchman. The nurse/midwife is the health centre in-charge. Since February 2006 a doctor has been visiting once a week (see below). A few years ago, with support from local investors (owners of Mambova Safari Lodge), two new wings were added to the health centre. It has a ward with four beds that are often occupied by severe cases of malaria. The health centre catchment area covers the fishing camps of Kabala, Ngwezi and Simalaha and has a population of approximately 3,134 people.

When the team visited the rural health centre in 2005, the in-charge said that since January 2005, VCT was being done at the health centre, prior to that blood was taken and sent to Livingstone. In 2005, the rate of VCT uptake according to the staff was increasing steadily, with as many as five new people per day presenting for testing. By January 2005, the team was told that a total of 58 people had been tested – 30 women and 28 men; in 2006 a total of 187 people were tested – 136 women and 51 men; by May 2007 a total of 73 people had tested – 48 women and 25 men. Mobile VCT had been undertaken by Mambova health centre staff. The major reasons for testing were antenatal for women and generally self referral for most men. Of those tested during the year, 51 were from Kabala and out of these, 40 were women and 11 were men. Of the 73 tested in 2007, 9 are from Kabala: 4 women and 5 men. On average, for every 10 people testing 3 are positive.

For women that test positive, the clinic has provided PMTCT services; in 2005, nine women received Niverapine after testing HIV positive; three out of nine notified their partners and only two turned up for review after 18 months. In 2006, nine women received Niverapine after testing HIV positive; none notified their partners and none as yet has come for review. As of May 2007, three women received Niverapine after testing HIV positive; one had notified their partner. The records show that none of these women are on ARVs because their CD4 counts are still above the threshold of 250.

A major change from the baseline is the scaling up of ART: Since October 2005, Kazungula health centre started having ARVs; at that time FAPCAS (see below) were organizing transport to take people from Kabala to Kazungula, though this was not free from problems, as, it was reported, often transport was not available and people were transported when they were very sick. ARVs, however, were still being kept at Kazungula so patients had to travel there. As of February 2007, the ARVs were brought to Mambova clinic and are now being stocked there. To date, the health centre has never run out of drugs, they are sent stocks regularly from town. The centre stocks first line drugs and only effivirenz as a second line drug. The centre has not yet faced the situation where they need second line drug, but assumes if and when the case arises they will be supplied from Livingstone. Finally, a week before the assessment in 2007, all the patient registers were finally brought to Mambova , meaning that ART is now fully managed out of Mambova rural health centre. Since February 2006 a medical doctor has been coming to Mambova health centre once a week (Tuesdays) from Livingstone; he attends to both ART and general cases and sees about 25 patients per visit.

In October 2006, the nurse-in-charge received training in ART management; the training lasted for 12 days and was organized by the Ministry of Health and it oriented the nurse on how to manage patients on ART and management of opportunistic infections (OIs).

Mambova health centre currently has 73 people on ART. According to the in-charge, in addition to the 73, 16 people have died, out of which 3 were from Kabala and about five people have been transferred out. A further approximately 50 people are HIV positive but are not yet on ART. The majority of the people on ART are from the fishing camps of Kabala, Ngwezi and Simalaha. The register showed that there were more women than men on ART and most of them in the age group 24-35. The table below shows the annual numbers of people on ART at Mambova health centre.

Table 1: Annual numbers of people on ART in Mambova and Kabala

Year/Month	Total Number for Mambova		Kabala	
2005	**Men**	**Women**	**Men**	**Women**
October	4	7	3	3
November	2	4	1	0
December	1	1	0	0
2006*				
January	0	7	0	2
February	1	1	1	1
March	1	2	1	0
April	3	2	0	0
May	2	3	0	2
June	0	1	0	1
2007				
January	1	2	0	0
February	2	3	1	1
March	2	6	0	0
April	2	3	1	3
May	0	3	0	0
Total	**21**	**45**	**8**	**13**
Total	**66**		**21**	

*No records were available for June to December 2006.

In addition to the above HIV related services, the health centre provides the standard health services that include general OPD and inpatients care and antenatal and post natal services. From October 2005, staff have been conducting mobile clinic and they have been traveling by bicycle to Kabala once per month. They do everything during the mobile clinic: MCH, antenatal, health education and attend to patients with various illnesses. Both in 2005 and in 2007 the clinic continues to have no electricity or piped water. They have a paraffin fridge to store vaccines.

2.4 HIV/AIDS Interventions in Kabala

HIV/AIDS interventions in Kabala were implemented by Fishmongers HIV/AIDS Prevention Care and Support (FAPCAS). FAPCAS project targets fishermen and fishmongers based in Kabala and Kalikalika fishing communities and the surrounding villages. The project was initiated in 2001 as an Anti-AIDS club for fishermen and fishmongers. The organization has membership in Livingstone town and the fishing camps of Mambova, Kabala, Ngwezi and Simalaha.

A number of activities had been started among the fishermen and fishmongers of Kabala fishing camp. These included sensitization on prevention of HIV, peer education and home based care support for the chronically ill. Several community members had been encouraged to go for VCT, but there had been little in terms of caring for those that are found to be HIV positive and there were no links with the ARV treatment programme based in Livingstone. In 2005, supported by the International HIV/AIDS Alliance, FAPCAS initiated a project which aimed to address the above gaps by educating the community of Kabala on ARV treatment and its benefits and mobilizing people for treatment. In addition, the already existing structures were to be strengthened to support those on treatment to adhere and to actively link in prevention messages into treatment services and structures. This was to become the third and rural site of ACER, the operations research project, whose overall aim was to improve health-seeking behaviour, equity of access, adherence to ART, and prevention for people with HIV through a community engagement strategy. Given the specific profile of the community in Kabala, activities were somewhat different from those undertaken under ACER in Lusaka and Ndola.

Generally, the objectives and related activities undertaken by the project in Kabala included the following:

1. To educate and mobilize the community of Kabala fishing camp for ARV treatment:
    - Drama performances;
    - Run *tuntemba* (information stall) at the station in Kabala;
    - Recreation activities such as football, netball, draughts;
    - Traditional folk music and story telling – insaka;
    - Education during initiation ceremonies;
    - Education on ART during monthly village meetings;
    - Sensitization meeting with village headmen.

2. To support adherence for PLHA on ARV treatment in Kabala fishing camp:
    - Consultation with Livingstone General Hospital, NZP+ and other key stakeholders to - recruit the people on ARV treatment in Kabala;
    - Form and sustain support groups for people on ARV treatment in Kabala;
    - Form and sustain support groups for families of those on ARV treatment;
    - Conduct home visits for those on ARV treatment;
    - Start and maintain vegetable gardens for those on ARV treatment.

3. To enhance prevention for people living with HIV in Kabala:
    - Promote and distribute condoms for those on ARV treatment;
    - Conduct referral for STIs and opportunistic infections;
    - Provide information on prevention for people living with HIV to couples.

4. To develop and strengthen the two-way referral system between the health service and the community:
    - Develop referral system;
    - Hold review meetings.

At the time of the follow-up assessment, FAPCAS did not have an executive committee although there was a caretaker committee that was organizing the election of a new executive committee. It was reported that two members of the previous executive embezzled project funds and disappeared leading to the dissolution of the executive committee. In January 2007, the members met and elected a caretaker committee with one member standing in as the Acting Coordinator. There are currently 12 members in the new committee. Each sub-committee from the fishing camps has a representative on the main executive committee which is based in Livingstone. The funds that were stolen were meant to support people on ART with IGAs and it was reported that the local headman had already allocated a plot for growing vegetables.

In carrying out the activities, FAPCAS has worked with other implementers in Livingstone, within Kazungula and the fishing camps. FAPCAS has worked with NZP+ who have a support group with 10 trained members. Mambova health centre has a home based care (HBC) group some of whom operate in Kabala. The HBC group is supported by CARE International. The Corridors of Hope project, targeting sex workers and truck drivers at the border post collaborated with FAPCAS during their mobile activities in Kabala and other fishing camps. The other collaborating partners included World Vision, Planned Parenthood Association of Zambia (PPAZ), CARE International, Catholic Relief Services (CRS), Development AID from People to People (DAPP). FAPCAS has also liaised with local headmen and church leaders in most of their programmes.

3.0 METHODOLOGY

3.1 Study design

This was a post-intervention assessment following the baseline assessment conducted in 2005, carried out to measure change amongst beneficiaries of FAPCAS interventions. The post-intervention assessment was conducted in Lupani (drier Mopane woodland) where most of the inhabitants of Kabala were residing following evacuation after flooding on the banks of the Zambezi river.

In both the baseline and post-intervention assessment people were asked about their knowledge, attitudes and behaviour around HIV/AIDS and ART; at baseline an analysis of their livelihood patterns was also undertaken in order to contextualise this location and gain insights into the link between livelihoods and attitudes and practices in relation to sexual behaviour. The data collection tools consisted of semi-structured interview schedule and documentation of case studies; at baseline focus group discussions were also held. The semi-structured interview schedule was developed based on the tools and experiences of the broader ACER study in Lusaka and Ndola. The data from these tools were supplemented by a review of secondary data and materials.

3.2 Study population

The study population consisted mainly of community members selected with the help of FAPCAS. At baseline a total of 37 people from both Kabala and Kalikalika communities were interviewed, 21 men and 16 women. Three members of FAPCAS were also interviewed as key informants and as respondents who had been trained in HIV/AIDS-related issues by other organisations and, at the time of the baseline assessment, had taken part in some initial training through the ACER project. Two focus group discussions (FGDs) (one with men and another with women) were also held with selected members of the community. An additional 3 fishmongers from Livingstone were also interviewed. An all inclusive selection criteria was devised in conjunction with members of the community to enable the different categories of the community members to participate in the interviews. The selection criteria include people with cattle; a shop; big nets; small nets plus boat; nets but no boat; and no nets and no boat (see below and baseline report).

At post-intervention assessment, a total of 21 people were interviewed, 12 males and 9 females: 14 were members of the community, 4 FAPCAS members, one health worker, one NHC member and one community leader.

3.3 Data collection and analysis

As in the baseline assessment, the researchers, who authored this report, conducted the interviews. Each interview lasted about one hour. The interviews were either conducted in the respondents' homes or in the FAPCAS meeting area. Whilst at baseline some of the interviews were tape recorded, at post-intervention the tape recorder was not used and extensive field notes were taken for all the interviews. At baseline a facilitator from the area worked along side the main researchers, identifying and listing the respondents, collecting basic information, acting as a key informant and also as an interpreter when necessary (though many of the respondents spoke good English); at post-intervention assessment, the same interpreter was used. The Zambian researcher conducted all the interviews in Silozi.

Data was analysed using qualitative methods. Content analysis was used to give a clear picture of the data. All the interviews were thoroughly read and reviewed to identify the most common responses to the main questions. Common themes cutting across all the responses were identified and compared and/or contrasted among the interviews in order to establish patterns of ideas. Identifying patterns facilitate interpretation of the data (Morse and Field 1996). The final analysis consisted of the amalgamation of the major ideas and themes supported by verbatim extracts, some of which are included in the text as part of the narrative.

3.4 Ethical approval

Ethical approval from the University of Zambia Research and Ethics Committee was obtained before the commencement of the study. Informed consent was obtained from the respondent before the start of every interview.

4.0 KEY FINDINGS FROM THE INTERVIEWS

4.1 Introduction

This section is divided into three main parts: the first reviews contextual issues of migration, residence patterns and livelihoods; data for this section comes essentially from the baseline assessment. The second and third parts deal with issues around health seeking behaviour, KAPB around HIV/AIDS treatment and stigma and discrimination. In terms of the participants, the first and second parts present findings from members of the community whilst the third part presents findings from members of the community who are also members of FAPCAS and have taken part in the initial trainings provided by the ACER project. The rationale for presenting findings separately is that the second group of people have received some training and have already been involved more intensively with the programme. They represent a Trainer of Trainer (ToTs) category, as they are the people who carried out the sensitisation activities within the community. In addition to asking questions around KAPB, they were also asked about their views of the training they attended and the activities they conducted.

4.2 Context and livelihoods

4.2.1 Socio-demographic characteristics

Ethnically, Kabala area belongs to the Toka people of Chief Sikute. However, the majority of the people speak silozi of western province because of historical reasons and Kazungula's close proximity to western province and Namibia where Silozi is predominant. In Kabala, there are also people from other tribal groups, notably the Bemba who are also skilled fishermen from their native Northern and Luapula provinces.

Most of the people interviewed were not born in Kabala; many were born in the Western province of Zambia, e.g. Mongu, Sesheke, Senanga and Kalabo districts. Many of them said they came to the area because they were following their parents or other relatives such as grandfather, brother, sister and aunt who had come to Kabala. Some of the younger respondents were born in Livingstone and have been orphaned, coming to Kabala perhaps with other brothers to 'look for a better livelihood', as one 27 year old orphaned man reported. Others still, may have moved to Livingstone from other rural areas, gone to school there and then moved recently to Kabala in order to make an income. There is the general sense that making money in Kabala is easier than in town and that life in town was harder. Young people can go to 'test' life in Livingstone and return when things do not seem to work.

There is a sense when visiting the camps, that there are many more men than women residing there, both old and young; this is also a common feeling expressed by residents. Out of 80 households identified in the baseline listing (see Annex 1), 63 or 80% were headed by men; the age range of household heads was 23-59 in Kabala and 19-48 in Kalikalika.

Approximately 50% in Kabala are married and around 36% are married in Kalikalika. Whilst there is a lot of movement between Livingstone and the fishing camps, the majority of those married both in Kabala and Kalikalika have wives living with them in the camps.

4.2.2 Residence patterns, movement and livelihoods

The average length of time people have stayed in Kabala is 11.8 years, whilst in Kalikalika is 13 years; the range for Kabala is from 1-40 years and for Kalikalika it is from 1-28 years. Whilst the major livelihood earner is fishing, some people are also engaged in small-scale cultivation, an activity that can support livelihoods when the rains are good.

All people in Kabala live in houses made from reeds with roofs made of thatched grass. All have bathing shelters, but none have pit latrines, using the bush behind for the toilet. There are no wells or boreholes and people drink the water from the river.

Household composition patterns are varied in Kabala, ranging from households full of men whose wives are living in Livingstone, to a few households consisting of single elderly people living on their own, with perhaps relatives visiting every so often. Thirteen people at baseline reported having houses both in Livingstone and in the fishing camp. Usually their wives are staying in the town houses with the children in order for the children to go to school and to sell fish which their husbands send to them. This results in households in Kabala which consist of only males who take turns to cook for each other, travelling to Livingstone regularly to see their wives and their wives sometimes joining them during school holidays or when they can help out during the busy fishing season. Also found in Kabala are households consisting of young men, related in some way, with other members of their family possibly residing elsewhere in the village. Women-only households are also found in Kabala. Often these women are single or widowed. Also fairly widespread are women whose husbands or boyfriends are Namibians and who live in neighbouring Namibia. This arrangement facilitates the fishing business, as the husband will come to sell fish in Kabala and having a contact or 'wife' in Kabala assists this process.

There is considerable movement between the camps and Livingstone town; this is facilitated by the fact that the fish truck comes everyday to Kabala and if people have the money the truck can take passengers as well as fish. As seen above, there is also backwards and forwards movements because of wives living in town. Both married men with wives in Kabala and those unmarried also move frequently between town and the fishing camps, usually for the purpose of selling fish. There are also movements within rural areas: often during the flooding season, people will build or move to their second residences a few kilometres away from the river. Others still move further upland, such as Sikaunzwe area, to farm during the farming season, staying as long as 6 months, coming back to the fishing camps for the fishing high season. Women are also relatively mobile: they can be sent by husbands to sell fish in town and if unmarried they go on their own to sell fish, staying with relatives in town. Despite the extent of movement, there are also some people who rarely go to town, especially the elderly who just remain in the camps.

Fishing and fish mongering are the main occupations for inhabitants of Kabala and Kalikalika. All the people who live in these communities are involved with fish in one way or the other. Although most of them recognised the physical dangers associated with fishing occupation, they saw it as the only means through which they could survive, as one man during an FGD put it: *"People become fishermen because if you have no means, instead of just loitering in towns or stealing you come here and fish.."*. Similarly, for many young men, fishing was seen as transitory, a means to an end, according to one young man: *"you come here and start piecework until you learn the trade and finally become self-sufficient with a hope that you raise enough money to go and start something else"*.

Before the start of the baseline assessment, in order to develop a categorisation of different kinds of people within the fishing community, an economic mapping was done with a group of key informants from the community; they easily identified the following categories: i) Big boat owners; ii) Shop owners; iii) Small boat owners; iv) Small net owners; v) Fishermen who own neither nets nor boats and vi) Fishmongers (mostly women). Within these categories there are variations and sub-categories dependent on factors such as age, wealth and sex. Whilst people in these categories have specific

characteristics, there is also overlap in the sense that, for instance, some boat owners can also be fishmongers and some big boat owners may also own small boats.

A detailed description of the different categories can be found in Annex 2 of the baseline report, to summarise a few key points; all the big boat owners in Kabala are men and represent the upper end of the wealth continuum in Kabala, many also have other assets including houses in towns, oxen and shops/bars and they are also likely to engage in fish trading. This is also the category of person that hires in mostly young men to help with the fishing. Interestingly, many are from the Bemba ethnic group. As for the big boat owners, those who own small boats are all men, the key difference being that they are younger and engage in multiple income generating activities; the aim for many in this group is to build enough capital from fishing in order to buy a bigger boat or built a house in town. Men who own small nets and no boat are very common in the fishing camps; this represents the first step on the ladder to being a 'proper' fisherman with a boat; they often borrow someone's boat (at a cost) in order to fish. Perhaps the most destitute category are those with no nets and no boat; usually they are the elderly, the youth and the women. They hire themselves out to the boat owners and engage in other 'piece work' such as joining and mending nets. As well as engaging in fishing-related piece-work and other income generating activities such as local wine brewing and making mats, many women are involved in buying and selling of fish; single woman buy fish from other men including 'boyfriends' and married women often buy fish from their husbands or from other fishermen. Female fish traders both from within and outside the fishing camps engage in transactional sex in order to ensure a constant supply of fish.

These categories are also likely to determine and influence the relative risk at which people place themselves with respect to HIV/AIDS transmission. Thus, for instance, it could be argued that big boat owners because of their relative wealth, available income and mobility, often with wives living elsewhere, may be more likely to engage in risky behaviour and/or transactional sex. On the other hand, there is also a sense that the youth who mostly do piece work are somewhat carefree and irresponsible and what little money they manage to raise goes on alcohol and then women. Clearly, women are also vulnerable in this situation which often, for survival purposes they engage in transactional sex.

4.2.3 Membership to groups (social capital)

At baseline a set of questions around social capital was asked, with the objective of obtaining and understanding the extent to which support structures exist in the fishing camp and whether there is a sense of community belonging and trust within this community. The discussion on social capital was seen as pertinent because of the inherent mobility of this population and their diverse areas of origin and understanding how this is played out with respect to social relations. Furthermore, these questions were necessary for a project intending to enhance the understanding of and support for ART which will always have strong implications for social or community support.

At baseline it appeared that there were few organized groups in Kabala, the FAPCAS group being one of the few that also embraced some members of the HBC. Membership to other groups and clubs included: the local football club, a foundling church group and the NHC. At post-intervention there are appears to have been little change in the existence of organized groups.

When asked who they turn to for support or when in need, many spoke about getting help and support from relatives in the area. Support consisted usually of borrowing money (getting credit), obtaining food during times of illness or getting advice regarding a problem. The headman's name came up a number of times as a source of assistance, probably because he is one of the wealthiest people in the area and also, being a local, has many relatives in the area. In a rural setting like Kabala, the headman is a key leader and the custodian of the people as he plays a major role in resolving their personal and social concerns. Other sources of financial assistance were the shopkeepers who also lent money to people in need.

During a FGD, when probing for the difference between here and home villages the following responses emerged:
"Have relatives here but also people from different tribes, someone who has been working in town and comes here, someone who retires, mixed people".
"It is a good thing to have people from different tribes, there's cooperation and understanding; people advise each other when doing fishing or other things"
"Also have that in home area".

There is a sense, therefore, that perhaps life might be easier when there are fewer relatives and people from the same tribe around, that there is more cooperation and assistance; when amongst ones own there is more jealousy and rivalry coming into play. The same FGD also pointed out that if someone is sick they will visit them, and if they have money will take them to town, and this was the case whether the person was a relative or not. However, there are those that found life hard among people that were not relatives. This was more so with those who were chronically ill and the aged who often did not have enough support. One elderly man in his 60's had no help from anybody other than the daughter who lived in Sikaunzwe area, some 20 km away. He wished he had money to enable him return to his home. One elderly woman, probably in her 60s had very little help from the community members. She came in Kabala to live with her elder sister who was married but later died. After the death of her elder sister, she married the sister's husband who also died after a short while. Even though her late husband had relatives in the area, none of them gave her adequate support.

4.3 Interviews with community members

4.3.1 Demographic information of the respondents

During the follow-up assessment, a total of 14 community members were interviewed and one community leader, 8 women and 6 men. The age range for the community members was 21 – 51 years with a mean age of 33 years. The majority of them (12) were currently married.

4.3.2 Common Illness and treatment seeking behaviour

The community members felt that Malaria, STI, TB, diarrhea, HIV/AIDS were the most common illnesses in the area. These are the same illnesses that were reported during the baseline assessment. Indeed, some of the respondent said they had not seen any change with regards to common illnesses. They said that malaria, TB and diarrhea were still affecting the people of Kabala and Kalikalika at the same rate as they have always affected them. A difference between baseline and post-intervention assessments was that the during the second round of data collection, most people mentioned HIV/AIDS as affecting people in the area. At baseline, although it was mentioned, awareness of it did not appear to be as widespread as after the interventions. Despite this, there are still people who do not refer to it in an upfront manner, i.e. there is a sense that it is sometimes viewed as taboo to speak about HIV/AIDS, that HIV/AIDS is still not seen as simply any other chronic disease and similarly, that stigma is still very much around (see below).

It was reported that Mambova health centre was the only health facility in the area and, as in the baseline assessment, most people during the follow-up data collection mentioned that it was to this clinic they went to if they had a health related problem. A few people both at baseline and follow up did mention the existence of community health workers (CHWs) as people to turn to if they have a problem; people often went to them first, if perhaps the problem was not so severe, in the hope that they could solve the problem without needing to refer to the clinic. Similarly, as in the baseline study, in the follow-up some people mentioned at first trying African herbs, with some getting the herbs from the traditional doctors and others getting the leaves from the bush themselves. Interestingly, it was noted at follow-up that these traditional doctors can only really help with diarrhea "nothing else", as one women says. To sum up the above, according to this woman says: "*Most people go to the clinic when they have health problems, also there's the CHW whom people go to, no one else"*

In addition to the CHWs, the clinic and African herbs, a number of people during the follow-up data collection mentioned treatment supporters as being people who were turned to when health related problems were being faced. This cadre of health care providers did not exist during the baseline, were instigated by the intervention and the fact that people are becoming aware of them and their role is an indication of the positive effects of the intervention.

As at baseline, people in Kabala continue to complain about the long distance to Mambova; they believe this limits their access to health care especially by the very ill and the elderly members of their community. Despite this distance, there is a sense that the relationship with the clinic has become stronger in the last 2 years, mostly as a result of the intervention. The following narrative from the headman brings out a number of the issues raised above:

> *"Common illnesses are malaria and diarrhea, have not seen any change over last 2 years. The clinic at Mambova has not gotten closer, people are walking a long distance to the clinic. The treatment supporters are attending to people here, the relationship between them and Mambova has become stronger. Each month clinic personnel come - environmental health technician and others come to give health talks. The relationship has changed since the project was launched. Mambova staff has seen that they need to attend to people here as well"*

4.3.3 Current health problems

The respondents were asked whether they had a current health problem. A number (approximately 4) of respondents had current health problems and included toothache, body rashes, scabies etc. Some of the respondents (see below) were living with HIV and were on ART. The symptoms mentioned were similar to those observed during the baseline assessment two years ago the only difference being that at that time none of the respondents were on ART. As a result of a combination of increasing awareness and HIV testing becoming more accessible since the start of the interventions (Mambova organized some mobile VCT clinics, see above and below?), there are more people both who know their status and are living with HIV.

4.3.4 Sources of information about HIV/AIDS

In terms of where people get HIV/AIDS related information, a number of people mentioned receiving it from Mambova clinic, with some mentioning specifically the sister-in-charge; they also spoke about the mobile VCT clinics that had taken place as a location in which they received HIV/AIDS related information. The more or less regular visits made by the Mambova clinic staff to carry out a range of activities, were also a source of HIV/AIDS related information. Some respondents reported that, in the past, staff from Corridors of Hope project in Kazungula used to come for sensitization but they had since stopped coming.

What stood out at the follow-up data collection was that fact that FAPCAS members, often mentioned by name, had become a key source of information about HIV/AIDS. FAPCAS members were a source of information both in terms of them being available to respond to questions as well as through the community sensitization activities they carried out. Despite this, there was some concern regarding the frequency of the sensitization events, with some respondents saying that, in the last one year, FAPCAS had reduced on these kinds of activities. Similarly, one respondent indicated that the last time they spoke to a FAPCAS member about HIV/AIDS was last year, where they taught him how HIV was transmitted. This assessment showed, therefore, that as a result of increased access to information through sensitization activities, respondents' knowledge on HIV/AIDS was extremely high (see next section).

There were, however, still respondents who said they never received information on HIV/AIDS. When asked how they knew about HIV/AIDS they responded by saying they had heard their neighbours or friends talking about it. Some were aware of the sensitization activities taking place, but most reported being too busy to attend; some admitted never seeing anyone from FAPCAS conducting sensitization

activities. Thus whilst the community sensitization activities carried out by FAPCAS have no doubt had impact, it seems the impact may have been limited to relatively few members of the community.

4.3.5 Knowledge about HIV/AIDS/TB

During the baseline assessment, whilst knowledge about HIV/AIDS was already relatively high, the FGDs in particular revealed some misconceptions. During the follow-up interviews, however, it became apparent that most people had extremely good knowledge about HIV/AIDS and similarly, there appeared to be fewer misconceptions than at baseline. Most people clearly knew how HIV was transmitted and were able to state all the ways of preventing the spread of HIV including the use of condoms, according to this woman:

"HIV is transmitted through sexual intercourse, using the same razor blade you can get HIV through blood contact; when give birth nurses put on gloves to protect themselves"

The increased knowledge was reflected in the clearer understanding of HIV/AIDS risky situations. The majority of the respondents perceived that all the people were at risk of HIV/AIDS. They noted that, even married people were at risk of getting HIV especially those who had a tendency of having extramarital relationships. A few, however, said that women were at more risk because they had multiple partners as they were more interested in monetary gains. Others felt that women were at greater risk because they were perceived to be drinking a lot of beer.

"Those at high risk- especially us women who drink, become loose and agree on any person and get HIV, that's all; younger ones are more at risk; because of poverty. Men also at risk" (woman)

With regards to prevention, some of the respondents mentioned that the most effective prevention of HIV was the use of condoms: *"Prevention: using condoms – nothing else". (man)*

4.3.6 Views about condom use

Most respondents believed that, if used correctly, condoms provide protection against HIV. They also noted that these days there were more people using condoms than a few years ago. However, some commented that, although knowledge about condom use was wide spread, it was difficult to tell whether people were actually using them. It was evident that FAPCAS had been doing a great job of distributing and sensitizing people on the use of condoms. It was observed that Kabala people were now more open and positive towards condoms than they were a few years ago. Although people claimed that condoms were widely available, at the time of the assessment, the FAPCAS members did not have any condoms for distribution neither did the local shops and *tuntemba* have any condoms for sale.

4.3.7 Views about VCT and ART

Most people in Kabala now know about VCT and the need for people to know their status. The main reason given for people to undergo VCT was the availability of ARVs. They noted that since the coming of ARVs, it was important that people know their status so that they can access treatment. However, it was noted that the issue of VCT was still very sensitive among community members. Some felt that not as many people as expected were going for VCT mainly because of perceived lack of confidentiality and stigma. Asked whether there were people going for VCT in Kabala, one man said: *"Many people go for VCT but never go back to collect the results. The main reason being that health workers reveal to community members the HIV status of people who go for VCT"*

Asked specifically which health workers he further indicated that:
"The HBC and FAPCAS groups. This is what people fear. Once these peoples' statuses are revealed they feel stigmatized. The community starts laughing at them. We hear gossips about people on ART. They definitely feel sad, they are never free. Here in Kabala the people who reveal are FAPCAS and NHC. I confronted Chairperson to tell his workers to stop and I reported to the headman"

4.3.8 Knowledge about ART

At baseline, most of the respondents knew that AIDS had no cure but that people could prolong their lives by more education on positive living including treatment. They said that people could go for an HIV test and if found positive they could be given treatment in the form of "pills". Most of them had heard about ARVs, though most had never seen ARVs, nor had they seen any one taking them. With the little they had heard about ARVs, they were positive that ARVs could help in prolonging life and most of them said that they could encourage other people to go for treatment when necessary.

During the post-intervention assessment, all the respondents were aware that ARVs were being provided at Mambova health centre and that within Kabala there were treatment supporters who were assisting those taking medication. Some respondents reported knowing some of the people living with HIV/AIDS in the area. None was aware of any support group of people living with HIV/AIDS. They attributed their knowledge of ARV to the interventions by FAPCAS.

"Everyone now knows about ARVs, because of the project. The information is correct but people are still reluctant, because of stigma, if information goes around that they are positive many do not feel good"

"People suspected to have AIDS should go to the hospital to be tested. Last year there was a mobile testing unit by Corridors of Hope that came and conducted VCT here in Kabala but now people have to go to Mambova health centre. People are no longer scared because during the last mobile VCT many people turned up"

Knowledge about how ARVs work was relatively high, as this man explains:
"There is treatment for AIDS. ARVs are now available. These are pills that increase energy in a person's body and are available at Mambova health centre. Here in Kabala there are not many people on ART. You can here and see, through ones health, he was down and suddenly he improves then you can speculate that may be they are on ART"

In terms of what was needed for a person to be put on ART, the respondents said that when ill a person needed to go to the clinic for VCT. They said they knew people that had gone for testing over the years but could not tell their statuses as it was confidential. Whilst the respondents knew those that had taken an HIV test because they saw them do so during mobile VCT, they gave accounts of how they could tell when a person had AIDS and was on ART. Some respondents seemed to know people on ART by their looks. They said that the pattern for most people who have AIDS and are now on treatment seems to be the same. They get too sick and lose a lot of weight and blossom as soon as they start taking ART. In the community anyone who was too sick and had lost weight and suddenly regained it was suspected to be taking ARVs.

Some respondents said:
"At times they are secretive and at times they are open. They fall ill and lose weight. When beginning treatment they develop side effects, and then they change and adapt; they take the medicine on their own. Eventually they look better"

"Most of these people, before they commence taking the medicine, they are rough and they shout but as they take the medicine they become cool and easier to live with"

Case Study

One of the respondents who is living with HIV/AIDS gave an account of his illness experience as detailed below:

The respondent has been on ART for 6 months now. He went for testing in October 2006 because of ill-health; had chest pains and so he decided to go. After testing he went for CD4 count after which he

waited for one month before he could start taking medicines. He goes once per month to collect his medicines and he said has not had any problems with the medicines. He takes lamivudin - 2 tablets at 8:00 and at 20:00 hrs. His wife reminds him to take the medicines and he claims he has never missed. His wife is also positive, she was tested last year but she is not yet on ART because she has not gone for CD4 count. He emphasized that he feels a bit ok now as he has no health problems. He gets information from the clinic

4.3.9 ART, pregnancy and sex

At baseline, most of the respondents felt that people on ARVs must avoid sex, live in a clean environment and eat good food. There were mixed feelings about whether women on ARVs should become pregnant. The women who had heard about PMTCT said that HIV positive women could become pregnant as long as they were given ARVs. Some said that they had heard from those attending antenatal services at the health center that there were ARVs (Niverapine) given to HIV positive mothers before delivery to protect the infant.

At post-intervention, although there some who remained unclear, most respondents felt that pregnant women could take ARV if they were found to be HIV positive. In addition to knowing about PMTCT, respondents pointed out that babies born from mothers who are HIV should be breastfed for only 6 months and then weaned off. *"Pregnant women and can take ARVs. There is a drug that they take just before they give birth" (man)*

Regarding sexual intercourse and ART, almost all the respondents pointed out that someone on ART should not engage in indiscriminate sexual activities because of the risk of high multiplication of the virus. Others specified that if they have sex whilst on ART, they must use a condom, as this man says: *"Sex whilst on ART. Yes they can have sex but they must use condoms every time"*

It was pointed out that people on ART still face a lot of challenges, including the need for support in terms of food, transport and money. They observed, for instance, that the distance to Mambova health centre was too long for people on ART, taking 3 hours to walk. They did all believe, however, that the availability of drugs at Mambova clinic was not a problem.

4.3.10 Stigma

There were mixed views about stigma. Some of the respondents felt that stigma was still prevalent whilst others observed that it had greatly reduced. However, there seems to be a big change from the 2005 findings as it is evident that some reduction in stigma and discrimination has been recorded mainly due to the interventions by FAPCAS.

Owing to the availability of ART, many respondents were aware of people who were living with HIV/AIDS and were on ART. They said that they knew some of the people because of the illness episodes these people went through.

One respondent narrated that she knew two people in Kabala who were on ART. They said that these two people looked quite well now that they were on ART.
"They look fit now. They have been on ARVs for one year now and are not having any problems. But they are not free, they hide, the only reason I know is because they are my relatives, they have told me. When one of them had a rash, I advised him to go for test and they found they were HIV+ and then started taking ARVs"

"People on ARVS are now different, before were sick, they could not work but now they are better, have started working"

Despite changes and reductions, stigma and discrimination persist often resulting in people not wishing to come out in the open about their HIV status.

"He's not free to tell people he's on ART, can start shouting at him, he's experienced that before"

"Stigma is changing, but just a bit, if someone looses weight others still say he is HIV+, even drinkers don't want to associate with that person; but before was worse, even if had headache they would say he is HIV+"

4.3.11 *Views about interventions*

Many people felt that FAPCAS had done a great job of sensitising people about HIV/AIDS in general and ART in particular. They noted that FAPCAS conducted sensitizations through drama and other ways of educating the people. They also noted that sometimes people were too busy to attend FAPCAS functions and when that was the case the FAPCAS members followed those community members to their homes. Some said that every month FAPCAS conducted drama and they held at least two meetings per month. Many said that the messages disseminated by FAPCAS were very effective as most community members had become more open about HIV, many are coming to buy condoms and these were mostly young men. Due to the sensitization by FAPCAS one respondent said: *"Also people used to drink beer, especially women but now most of the women have reduced, even stopped completely".* This particular respondent sells beer so he sees that less women are coming to buy beer now.

There were those respondents who felt that FAPCAS had not done much. Whilst some acknowledged that FAPCAS had started well, the last one year they had lost the momentum.

"FAPCAS are working but not to the expectations of the people. They seem to work because when I have a headache they will give me some panadol but what they do not do is to consistently visit patients. They take too long before they visit a patient"

"FAPCAS started well, maybe the executive misfired, things not moving smoothly between FAPCAS and the people here so led to a lot of talking."

"People stigmatise others because they are not completely aware of how this disease comes about. The information is still irregular- maybe there should be another group coming to teach people. The current group (FAPCAS) is no longer as effective as it used to be because they have no money"

4.4 Interviews with FAPCAS members and key informants

4.4.1 ART training and related activities

The assessment found that five FAPCAS members were trained as ART treatment supporters in 2005 by the International HIV/AIDS Alliance; they reported never having been trained in anything since then. The training they attended lasted for three days and the trained members subsequently went on to train 17 other people at Mambova including three from Kabala. They reported that the sensitization activities had been going on since 2005. As a result, the people of Kabala were now able to access ART from Mambova. Whilst at the beginning people on ART were accompanied by treatment supporters, they were now able to go on their own to the health centre.

FAPCAS members interviewed confirmed that since 2005, Mambova health centre had been administering ART and that a medical doctor comes from Livingstone once a week. They further reported that, in February 2006, FAPCAS conducted VCT training for fishmongers and gatekeepers in Livingstone where three people from Kabala attended. In March and April 2006, FAPCAS facilitated a training of 23 indunas (Village headman) in VCT at Mambova. Among some of the activities carried out by FAPCAS was the construction of project structures within Kabala. FAPCAS members built an information centre with funds from the Alliance. They also erected a shelter in which they hold their meetings. It was reported that, when the fish truck comes to Kabala, FAPCAS members meet people

in the shelter to answer HIV/AIDS related questions and also refer some people to the information centre where condoms are distributed. However, the research team was not able to observe these activities take place as people were in Lupani.

As treatment supporters, clients come to them to seek assistance but they also reported that they visit either once per week or as often as once per day in case of the seriously ill clients to ensure that they take the drugs and are feeding. They said they usually involve the family when counseling the client so that they can help. They indicated that, as treatment supporters, they got no incentives as their work was voluntary.

The reported that there were more people now than in the past who were going for testing. They recalled that in 2005 during a mobile VCT clinic about 72 people came for the tested whilst in 2006, 90 people tested. They also noted that the first people in Kabala commenced treatment around August 2005 and observed that these people were doing well although they had lost three.

4.4.2 Condom availability and use

FAPCAS members conducted sensitization activities during meetings organized by the village headmen and also improved the availability of condoms. They obtain condoms for distribution to the fishermen once a month from Mambova health centre. They have also noticed a reduction in STI compared to the past when condoms were unpopular. According to them, use of condoms had increased.

"In terms of changes, before people were not used to condoms, now they are and ARVS, now people are coming out , they are opening up, stigma is being removed, can now even mingle with positive people, people able to disclose"

They noted that through their teaching and supply of condoms people were using condoms more that they did before the interventions. They noted that, according to the statistics at mambova health centre, the rate of STIs had decreased.

4.4.3 Perceptions about illness and health related problems

Tuberculosis malaria and diarrhea were indicated as the most common illnesses in Kabala. These illnesses occur throughout the year in Kabala. Mambova is the only nearby health facility although Kabala has a community health worker who administers panadols when people have minor ailments. These illnesses were also said to be the most common ones during the baseline assessment.

4.4.4 Stigma

FAPCAS members pointed out that they sensitize the community on stigma and discrimination against people on ART. They however, observed that stigma was still common although was reducing. They admitted that no one in the area had come out in the open to live positively, mainly due to stigma.

"Stigma is there but it is reducing. Some people refuse to obtain treatment from Mambova and prefer Livingstone due to stigma"

"Stigma is still there, but slowly being removed, still there, if see someone sick prefer to sit alone, they isolate them"

4.4.5 Perceptions about community knowledge and awareness

FAPCAS members felt that peoples' knowledge levels had increased due to the interventions. They noted that people have been changing their sexual behaviour and they have over the past one year seen an increase in condom demand due to positive behavioural change.

4.4.6 Challenges of carrying out the interventions

FAPCAS members mentioned that conducting the interventions among the fishermen who live in fishing camps had several challenges. To access people for senstisation activities was not always easy as many people had no time to attend meetings, since when they were not fishing, they would spend their time mending fishing nets, repairing their boats or engaged in other economic activities such as brewing beer for women.

They also mentioned difficulties of looking after people on ART in an environment like Kabala which was a long way from the nearest health facility, where food was scarce and where people's livelihoods were dependent on the physical fitness of the individual.

"The problem that ART patients have now is food and distance to the clinic – CARE International gives food but it is not enough; we collect food for everyone - TB and ART patients - but transport is a major problem".

They noted that many new patients usually developed side effects and are often too sick to do anything. Additionally, some of the clients on ART are old, with no dependants, are unable to go fishing, which, compounded often by severe side-effects, results in their ability to get food and in general, their survival, extremely problematic.

"Many new clients have side effects and are very sick so difficult for them to go the clinic, bikes are not convenient if someone is sick"

They said that, since 2005, three people in kabala died whilst on ART -a man and woman in their 60s and a man in his 30s.

The most common side effects that the people on ART experience are severe headache, sight, rash, loss of appetite, nausea. However, they stated that, with time and continuous counseling, the clients adapt to the drug. They also pointed out that the levels of adherence to ART were quite high. They reported that only one person in Kabala had stopped taking the drugs after he felt better. Despite counseling he resisted resuming treatment and later he died. Despite good levels of adherence, they observed that some men on ART tend to have a poor record of adherence due to drinking and engaging in sexual relationships.

"Generally people are adhering well, if there's a new client the treatment supporters follow them closely for first two weeks, before they go for review"

5.0 DISCUSSION

The post-intervention assessment shows that there has been a significant amount of sensitization in Kabala and Kalikalika and some positive behavioural changes have taken place among the community. The assessment also shows that the relationship between the local health centre has improved and the community appears to be accessing some HIV/AIDS related services. The treatment supporters have played a significant role in sensitizing the community about the need for utilizing the HIV/AIDS services available at Mambova health centre. Furthermore, there are now more women in their reproductive health age group getting information when they attend antenatal and children's clinics including information on PMTCT despite the long distances between Kabala and Mambova.

Most of the interventions seem to have yielded benefits as the overall knowledge has increased- more people now know about HIV/AIDS transmission and prevention, they know about ART and how to take them; they know where to access them and that they are provided free of charge. In terms of VCT, it appears that, in the last two years, the numbers of people testing has increased although the figures show that still many more women than men are testing. Some women get tested during antenatal clinic and during VCT drives. The national data shows that more women are more likely to be tested.

The sources of information from varies, ranging from FAPCAS, the health centre, CHW and the NHC. The media was also mentioned as the source of information. The interviews revealed that the social behaviour of the people following sensitization had changed positively and one of the indicators of this positive change was less alcohol consumption as opposed to the past; similarly, the ways alcohol is being consumed, as pointed out by one respondent, is changing, where men are seen to buy beer and drink at home with their wives, thus possibly stemming getting themselves into situations where risky behaviour could ensues. During the baseline assessment, excessive alcohol consumption was blamed for fueling risky sexual behaviour.

The data also indicates that condom use has increased following more sensitization by both the health centre and FAPCAS. During the baseline assessment the use of condoms was perceived to be low due to a number of factors including the negative attitudes towards their use. The situation has changed with the health centre stocking adequate supplies of condoms and reporting that more are now being distributed. The health centre also supplies Kabala and other fishing communities, often through FAPCAS, with free condoms. The shop keepers also reported that people were now buying more condoms from their shops. However, the observations also seemed to suggest that constant availability of condoms was not guaranteed, especially through FAPCAS, as there was no sign of them during the assessment.

As expected, not every one had changed their behaviour and there are still members of the community who were perceived to be at risk of STIs including HIV/AIDS. The interviews show that there was still widespread perception that women are more at risk than men due to the need to make more money through transactional sex. Reasons stated why people, especially men, are not changing their behaviour is that, according to one respondent, when a new person/woman comes to the area everyone has to “sample her”. Regarding why people, and again especially men, do not want to go for testing is because, according to one respondent “they will not be free once they know their status”.

VCT services are now available at Mambova health centre and it is clear that most people can access the services when they need them. For those who opt to go for testing, the ARVs are also available. However, it seems that issues related to lack of confidentiality are still a hindrance to people going for testing. Many people complain that the treatment supporters (and other health workers) do not maintain confidentiality by revealing and exposing the names when they bring ART drugs for specific people and when they transport them to the clinic. Whilst FAPCAS members may be blamed for their lack of sensitivity, confidentiality is hard to deal within a rural setting where everyone knows everyone and also knows what every neighbour is doing, i.e. generally where secrets are difficult to keep. FAPCAS are keen to raise awareness, encourage positive living and reduce stigma and the question is how do they do that without compromising confidentiality? Clearly, people have a right to decide whether they want to disclose their status and outsiders can only provide encouragement and advise, nevertheless, it remains is an individual right.

The above are highly complex and sensitive issues and highlight further the need for careful training, community mobilization and preparedness. Often stopping at merely training may be not enough; those trained, for instance, need to be followed-up to assess the kinds of information they are in passing on and the ways in which they are doing this. Similarly, people at the other end, or the receivers, need to be followed up to assess the affect of, in this case, the treatment support workers on their self-esteem, feelings of stigma, and so on. Generally, as also discussed below, some simple forms of monitoring and evaluation need to be established to assess the real effects and ultimately impact of the project on the community.

This leads on also to the wider issue of HIV-only programming, which in themselves are often likely to create stigma amongst community members. One of the options of dealing with this issue is to develop broad and horizontal programmes with HIV being just one component of many, and,

therefore, implementers are not associated with HIV/AIDS alone. This is more of an issue in rural than urban areas as in urban areas there is still the possibility to maintain certain levels of confidentiality and secrecy, since, for instance, there is much social mixing and people can keep a distance from their neighbours and relatives if they so choose.

In terms of age composition, the fishing community has more younger to middle aged members than the very old; this is so partly because of the nature of fishing which requires energy and strength. Thus this age-group tend to be targeted with awareness campaigns, with little targeting of elderly members of the community on account of numbers but also due to the perception that they were beyond the age for sexual activity although they may certainly still be sexually active. To demonstrate the fact that these elderly people could be sexually active, two 60 year-olds who reported to be on TB treatment during the baseline assessment were subsequently put on ARVs although they later died. These people are likely to have acquired HIV in their 50s so there is need to target this age group as well with awareness campaigns. Older people are also those who will instill the importance of tradition and culture in the young, so if they are giving wrong or risky messages, e.g. the importance of sexual cleansing upon the death of a spouse, there is need to make sure they are being given the correct messages with respect to HIV/AIDS.

The Kabala experience and research from the other urban ACER sites, shows that there appears to be large difference between urban and rural areas in terms of HIV and age. In urban areas more elderly people, especially the women, are involved with HIV/AIDS - are being tested, are accessing ART, belong to HBC. In Kabala the younger people, and especially women, are the people most easily accessing HIV/AIDS messages, the women mostly getting the information when they go for antenatal or under 5 clinic. These are also women in the most productive age-groups, 20-30. It can be argued, therefore, that women in their 40s and 50s are usually missing out on this source of information. Similarly, one also gets sense when talking to women who are married and in their mid 40s, for instance, that these message around HIV are not for them, that there is nothing they can do now as they are married. As a result, they are not so keen to know or feel it is not so important for them to know. The issue becomes how to target both by sex and age group.

Generally, with regards to FAPCAS, it remains somewhat unclear exactly how they are viewed in the community, since, as described above, conflicting views were received. It is also somewhat unclear the extent to which they were doing activities beyond 2005; in 2005, they were writing reports, (also encouraged by the headman) but after that it stopped. FAPCAS members did say they continued doing activities, visiting people, bringing drugs, even when the ACER project stopped; if this is the case it shows commitment from members of the community continuing despite lack of resources and support from a larger body.

Related to the above is also the issue of incentives, it was unclear what FAPCAS members were getting, they said were doing the work voluntarily. This represents an imbalance between the urban ACER sites where both the community mobilisers and the treatment support workers were getting paid; clearly this is also budget- dependant, as in Kabala the budget was very small. Nevertheless, the extent to which people can carry out effective, continuous and sustainable interventions when they are not receiving any incentives, whether they are urban or rural based, remains an issue and needs to be taken in consideration when developing such kinds of projects in the future.

To reiterate what was already alluded to above, the reporting ended in 2005; even when FAPCAS was providing reports, they were not comprehensive enough, leaving many questions unanswered. As will be picked up again in the recommendations, reporting is crucial, both financial and programmatic. If capacity is lacking on this, support needs to be provided to carry out basic reporting of activities.

Although the life styles of most people in Kabala are risky, the assessment suggests that many fishermen and fishmongers are capable of changing their sexual behaviours. Many studies have

observed that most fishing communities are rarely targeted by HIV/AIDS interventions and they suggest a need for scaling-up interventions. A positive aspect about the Kabala interventions is that they are conducted by the fishermen themselves and thus the concept of peer education is being applied in reality and essence.

6.0 RECOMMENDATIONS

Following the baseline assessment, a set of recommendations were made. Some of the recommendations have already been taken on board, relating mostly to wider issues and aspects related to national policy. Thus, for instance, a mobile VCT has started and ART has been brought down to the community. Whilst this is related to national policy and commitment from government to scale-up ART, the work that FAPCAS and ACER have done around raising awareness about bringing ART to rural communities, and beyond urban centres, has played a role, as was pointed out by the health centre staff and FAPCAS themselves. So change had already started early on in the intervention process. Other recommendations made at baseline remain largely valid and can, therefore, be reiterated:

6.1 Sensitization and awareness raising strengthened and continued; the following is a list of topics which emerged as being important from the baseline assessment which could be included in sensitization and awareness raising sessions; they are in no order of importance and clearly this is a long list and would have to be prioritized and perhaps topics combined in the same session:

- HIV/AIDS transmission and prevention
- Testing and counselling
- Treatment and adherence
- Alcohol and recreational drug use and links to risky behaviour, prevention, transmission and treatment
- Positive living
- STIs and their relationship to HIV/AIDS and treatment issues
- Links between TB and HIV/AIDS
- Links between TB and HIV treatment
- Links between TB, HIV, Malaria
- Nutrition and HIV/AIDs and treatment

6.2 Masculinity and fishing; linked to the above, some awareness raising and further exploration of the concept of 'Water, Wine and Women'; this may include discussions on:

- gender and sexuality;
- what in means to be a man and a woman in contemporary Zambia
- how masculinity is expressed through the fishing
- implications this has on sexual behaviour

6.3 Careful targeting of messages in terms of content and form; often message reach only reach one category of people (e.g. youth), therefore there is need to take into account the following criteria when developing and carrying out sensitization activities:

- Age and gender of people; carry out separate activities for different age and gender groups, including children and the elderly, facilitated by the appropriate gender/age in order that people are more at ease to ask questions and raise issues
- The livelihood activities and when different categories of people are available to take part in sensitization activities
- Place of residence of people, or where they are in the chain in relation to fishing, i.e. fishing camps, Livingstone, Namibia; ideally sensitization activities need to happen in the fishing camps (to include fishermen from Namibia who play a key role in fishing and transaction sex) but also in Livingstone when many fishmongers and families are based.

- Literacy levels; those who can read and speak English have different requirements than those who cannot; need to consider more visual approaches and methods

6.4 Locally and culturally specific approaches to delivering messages; linked to the above, there is need to ensure that messages have been translated into locally and culturally specific notions and terms. The means of expressing these concepts also need to be acceptable locally and might, therefore, include:

- drama activities,
- story telling events,
- family centred or intergenerational transfer of knowledge, i.e. instead of children being exposed to risky behaviour have this explained to them by their elders,
- other community events organised by the chief or headmen

6.5 Broadening the ToTs base; currently a few people in Kabala have been trained as ToTs; there is a sense that they are the selected few who will benefit; it is important to widen the base, invite others if possible to go through some training, to ensure that there is an equitable selection of people involving FAPCAS but also the headman who is very active and enlightened. There is also the issued raised by those already trained of additional or refresher training.

6.6. Other stakeholder involvement;

- the community school in Kabala could be explored as a possible base for undertaking awareness raising activities amongst school children.
- A number of CBOs and NGOs are working in Mambova and Kabala areas; there is potential overlap in many activities so it is important to ensure there is communication and building on each others work rather than duplicating.

6.7. Rural Health Centres and capacity

- Given the shortages of medical staff in Zambia as a whole, and in particular in rural areas, a wider spectrum of people should be trained to be able to administer treatment and should not just be left to medical doctors as in many RHC these do not exist and therefore there non-existence is one of the reasons for stalling rolling out of treatment to these areas.
- In order to encourage medical staff to go and remain in rural areas an appropriate incentive structure needs to be in place.

In addition to the above, a few additionally recommendations from the post-intervention assessment can be made:

6.8. ***Reporting, monitoring and evaluation*** **–** in order to measure the effects of the intervention, financial and programmatic reporting, monitoring and, eventually, evaluation are crucial. Support needs to be provided from the onset on these issues. Ongoing support and oversight also needs to be provided to ensure that these activities are taking place.

6.9 Horizontal HIV programming –integrating HIV programming into broader programmes at village level should be considered; this could either be done through one organization carrying out integrated, multi-sectoral programmes or collaborating with other organizations, both NGO and government, to develop these integrated programmes. The benefits of these kinds of programmes may result in reduced stigma and, therefore, generally improved affect of the programmes.

6.10 ***Appropriate incentive structures*** – when implementing programmes, in order to ensure sustainability and continuity, appropriate incentive structures need to be instituted, whether they are in rural and urban areas; one cannot expect an individual to carry out unpaid work at the expense of making their own livelihood.

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