



**PREVENTION OF HIV/AIDS INFECTIONS AMONG FEMALE  
COMMERCIAL SEX WORKERS IN KAMPALA, UGANDA**

*Discussion Paper No. 004/2010*

*AMREF Discussion Paper Series*

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Discussion papers are aimed at presenting evidence to inform and solicit discussion on a wide-range of topical issues related to health and development

## **LIST OF ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ARV	Antiretroviral
AVD	Abnormal Vaginal Discharge
CBDA	Community Based Distribution Agent
CCA	Community Counselling Assistant
CHW	Community Health Worker
CSW	Commercial Sex Worker
FGD	Focus Group Discussion
FP	Family Planning
HCW	Home Care Worker
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
KCHDP	Kawempe Community Health Development Project
KI	Key Informant
LAP	Lower Abdominal Pain
LC	Local Council
NGO	Non-governmental Organisation
OI	Opportunistic Infection
PLWA	People Living With AIDS
PMTCT	Prevention of Mother to Child Transmission
RPR	Rapid Plasma Reagin
SRH	Sexual Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TOT	Trainer of Trainers
UDHS	Uganda Demographic and Health Survey
VCT	Voluntary Counselling and Testing

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## **ABSTRACT**

The Kawempe Community Health Development Project (KCHDP) located in a poor informal urban setting of Kampala aimed to improve sexual and reproductive health (SRH) services available to female commercial sex workers and equip them with employable skills for behavioural change. Project strategies included provision of user-friendly services at a community health facility, building critical community capacity for promotion of service utilization and safe sex behaviour change, and providing vocational skills training to CSWs. The review was conducted to assess project impact on increasing SRH services uptake among the CSWs and document changes in their demand for adopting safe sex behavioural change.

This retrospective and cross-sectional study was conducted in July 2009 and reviewed project information from 2001 to 2008. The combined study design was intended to facilitate a more in-depth analysis of issues, taking into consideration the perspective of project key stakeholders. Both quantitative and qualitative data was generated with descriptive analysis methods and thematic analysis being used, respectively.

The study observed a steady increase in service uptake for VCT from a monthly average of 51 in 2001 to 96 in 2009, representing an 88.2% increase, with the proportion of HIV positive CSWs declining from 16% in 2001 to 8% in 2009. Use of family planning methods and treatment of STIs and opportunistic infections accessed through the project facility increased from 26% in 2001 stabilising at 40% in 2009. Qualitative data confirmed improved negotiation for safer sex and use of male condoms (although consistent use was not realised) during the project period 2001 and 2008. Free vocational skill training to CSWs was in great demand and it created opportunities for alternative income. However, lack of start-up capital limited the number of trained CSWs who could quit the sex trade.

The project contributed to increased service uptake for SRH services and demand for safe sex behaviour change among CSWs in an urban poor community. There is need for the programme to strengthen its institutional and financial sustainability to match the increasing demand for SRH services and vocational skills training for CSWs. This may be through formation of partnerships and mainstreaming project activities into ongoing health and development programmes.

## **1.0 INTRODUCTION AND BACKGROUND**

### **1.1 Introduction**

Uganda is often cited as a rare example of success in reducing the prevalence of HIV/AIDS in Africa, a continent facing a severe AIDS crisis, from close to 30% in the 1980s to 6.4% in 2002. The country is still battling with the pandemic and several initiatives are ongoing to educate the public about how to avoid becoming infected. According to the Uganda HIV and AIDS Sero-Behavioural Survey (2006), it is estimated that one million Ugandans live with HIV, of whom 130,000 are children under 14 years. The number of people living with HIV is higher in urban areas (10.1% prevalence) than rural areas (5.7%); it is also higher among women (7.5%) than men (5.0%). Women are particularly affected by the epidemic in Uganda, representing 59% of those infected with HIV/AIDS in the country (UNAIDS, 2008). It is reported that HIV infection among commercial sex workers is 22%; one of the highest risk groups in Uganda.

One of the main strategies adopted by Uganda has been the ABC approach, which promotes abstinence until marriage; being faithful to one partner; and condom use, especially for those who have more than one sexual partner (AIDSmap, 2006). As a means to reinforce the above strategies, the country has promoted HIV testing including voluntary counselling and testing (VCT), early diagnosis and treatment of sexually transmitted diseases (STDs), and prevention of mother-to-child transmission (PMTCT). VCT service coverage stood at 45% of health facilities in the country and PMTCT was offered in 34% of health facilities by 2007 (MOH, 2007). It is reported that 25% of new infections in the country were due to vertical transmission. With regard to promotion of universal access to prevention, behaviour change for safe sex is known to play a central role in prevention of HIV infection. The National Strategic Plan (MOH, 2006a) recommends inclusion of civil society organisations in response to the epidemic and thus AMREF began working on empowering vulnerable groups with skills, health education, free early diagnosis and treatment of sexually transmitted infections (STIs) and opportunistic infections (OIs), and community-based family planning services in Kawempe.

Kawempe Division of Kampala has an estimated population of 304,733, living in 22 parishes. It is one of the most densely populated areas of Kampala; 39% of its population live in slums. Women make up more than half of the population (52%) and 56% of them are between the ages of 13 and 24 years (UBOS, 2002). The socio-economic and health indicators are poor. Poverty rates stand at 54.6% compared to the nationwide figure of 38%, unemployment at 21.4% and domestic violence at 52.3%. This socio-economic situation puts young women at risk of sexual exploitation. HIV/AIDS prevalence is high (9-12%) compared to national levels of 6.4%. Also common are unwanted pregnancies (17.7%) and STD infections (15.1%). However, only 8% of the women in the division have used VCT and PMTCT clinics (KCHDP, 2000).

## **1.2 The Kawempe Community Health and Development Project (KCHDP)**

In June 1999, AMREF in Uganda was drawn to the socio-economic needs of commercial sex workers (aged 14 to 35 years) in the slums of Kawempe in Kampala. Most of them comprised school dropouts, AIDS orphans, and other young girls from poor families lured into prostitution. There was high prevalence of sexually transmitted infections and HIV/AIDS, unplanned pregnancies and increased number of street children. The community in the area requested AMREF for assistance in reducing involvement of young women in the sex trade.

A preliminary survey confirmed that women CSWs had high prevalence of HIV/AIDS; between 24-39% of those tested were HIV positive and majority lacked income generating skills. Hence, AMREF in collaboration with the community initiated an integrated project in 2001, known as the Kawempe Community Health and Development Project (KCHDP). The initiative was designed to focus on women and girls, and its objectives were to empower CSWs with income generating and life skills, improve health knowledge and use of contraceptives among CSWs and the urban poor, and reduce HIV/AIDS morbidity and mortality among vulnerable youth and CSWs. The main project strategies included strengthening SRH service delivery and offering vocational skills to CSWs.

The project offers CSWs courses in hair dressing and tailoring and provides SRH services at a community health facility situated in Makerere III parish, jointly run with the Kampala City Council.

The initiative has reportedly recorded several achievements. Some of these include training of over 600 CSWs, a reduction in the rate of unwanted pregnancies, from 17.7% to 10.1%, and STIs from 15% to 9.0%. The use of contraceptives has doubled among the CSWs, and 73% of trained CSWs got jobs or started their own businesses while 72.5% of those followed up reported quitting the sex trade (KCHDP, 2009).

### **1.3 Objectives of the study**

The main objectives of this study were to:

1. Assess the levels and trends in SRH services (VCT, FP, STI/OI treatment) uptake in Kawempe Community Health Development Project and document changes in level of demand for improved SRH services and information for safe sex and reproduction.
2. Explore and document benefits of vocational skills training to CSWs for creating demand for SRH services and better quality life.
3. Document project outcomes, implementation challenges and suggestions for CSWs to adopt safe sex practices to reduce the prevalence of HIV/AIDS among the urban poor.
4. Draw up recommendations to inform programmes and strategies for promoting safe sex practices among CSWs to reduce the spread of HIV among poor urban communities.

### **1.4 Methodology**

#### ***1.4.1 Study design***

Retrospective and cross-sectional descriptive study designs were used to document evidence of SRH service uptake and vocational skills training, and to gather key stakeholders' assessment of project processes, outcomes and challenges, as well as obtain

their suggestions for project improvement. The combined study design was intended to facilitate more in-depth analysis of issues, taking into consideration the perspective of project key stakeholders.

#### ***1.4.2 Data collection***

KCHDP records were analysed to capture levels and trends in service uptake, with special emphasis on utilisation of VCT, family planning, and diagnosis and treatment of STIs and OIs. Where records permitted, proportions utilising services by month, age, sex, parish and user category were extracted. Project records were also reviewed for community-based services such as distribution of family planning products and types and frequency of other project activities including meetings, health education sessions, home visits and family planning counselling and referrals.

A total of 13 focus group discussions were conducted. Participants comprised trained CSWs, the youth (14-35 years) and untrained CSWs utilising SRH services. Groups were constituted to represent teens (less than 20 years), young adults (20 years and above), the unemployed and employed youth.

Fifteen (15) in-depth interviews were conducted with community leaders in project parishes, service providers at the community health unit, community-based service providers, trainers and project staff, to obtain their views on project implementation processes, outcomes and implementation challenges.

#### ***1.4.3 Data analysis***

On analysis, data from review of project records were tabulated and analysed for levels and trends of service utilisation and prevalence of STIs and OIs among CSWs and other users of services. Qualitative data was coded and clustered along developed themes and sub-themes. Analysis for SRH services and information demand covered stakeholders' assessment of the problem of HIV/AIDS/STIs and unplanned pregnancies in their communities in relation to relevance of services provided at the community health clinic and in communities. Quality of services was analysed with regard to ease or difficulty of

accessibility, quality of information and benefits, the value users attached to services and information and implementation challenges. On vocational skills training, analysis covered training processes and outputs and assessment of the quality of training.

Project outcomes analysis focused on assessment of the value of adopting safe sex practices, examining evidence in communities for adoption of safe sex practices or lack of it, changes in prevalence of HIV/AIDS, STIs and OIs, and evidence of increased demand for improved quality of life among trained CSWs. The implementing challenges of meeting service demand and vocational skills training together with those CSWs faced in quitting the sex trade were also analysed. Sustainability of project outcomes analysed the roles and involvement of the different stakeholders in project implementation, funding history and community ownership.

#### *1.4.3.1 Limitations of the analysis*

Project records analysed were primarily collected for implementation purposes and have inadequacies and gaps for scientific analysis. In some cases, project activities slowed down or stopped between funding cycles. In addition, project reporting did not always indicate the gender variable, rendering gender analysis impossible. Monitoring and follow-up of trained CSWs in their businesses was irregular and many of the trained CSWs had left the project area.

## **2.0 RESULTS AND DISCUSSION**

### **2.1 Levels and trends of health service uptake in KCHDP**

This section presents levels and trends of health service uptake in KCHDP; discussing implications of observed trends and benefits of improving SRH service delivery to CSWs in relationship to prevention of HIV/AIDS and unplanned pregnancies among the urban poor. Health service records reviewed included voluntary counselling and testing, family planning, treatment of sexually transmitted and opportunistic infections, and availability of community-based health services.

### 2.1.1 Service uptake at Kalerwe Clinic (2006-2008)

A total of over 20,000 service users at the community health facility were recorded between 2006 and 2008 (Table 1). One in seven (14%) of all services offered was VCT and almost equal proportions for each of the other services – OI (30%), FP (28%) and STI (28%). More users sought services in 2007 than the other two years due to road repairs undertaken in the area. The significant drop in service utilisation between 2007 and 2008 was mainly due to decline in family planning services owing to shortage in supplies at the time.

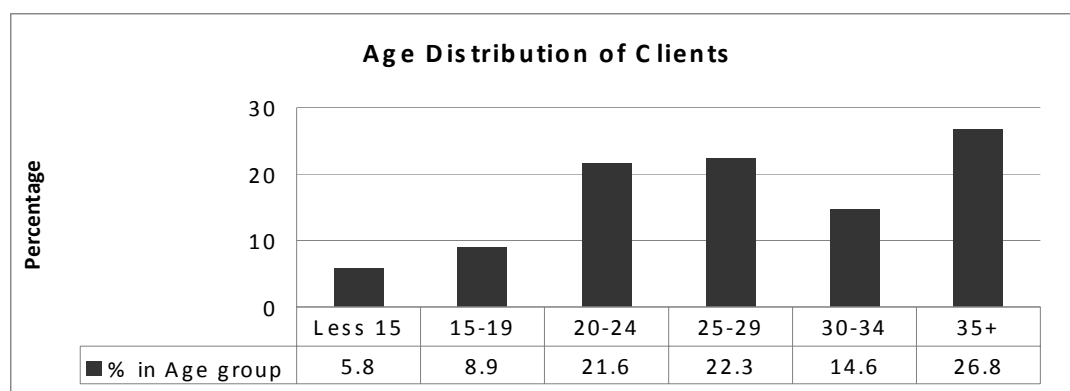
**Table 1: Distribution of service uptake at the health unit (2006-2008)**

Year	VCT	FP	STIs	OI	Total
2006	818	1,977	1,769	1,860	6,424
2007	1,094	2,257	2,032	2,198	7,581
2008	964	1,422	1,744	1,944	6,074
<b>Total</b>	<b>2,876 (14%)</b>	<b>5,656 (28%)</b>	<b>5,545 (28%)</b>	<b>6,002 (30%)</b>	<b>20,079</b>

### 2.1.2 VCT service users and service uptake (2001-2008)

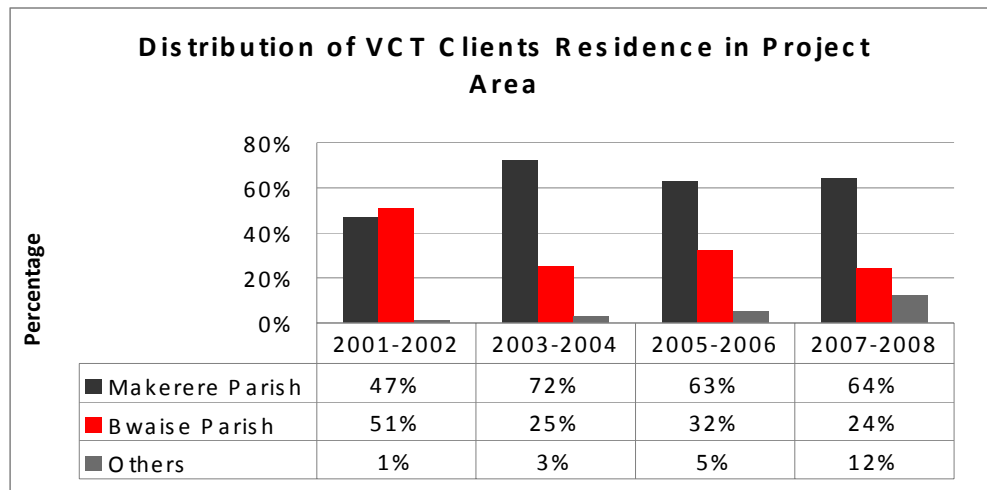
The AMREF-supported community health facility provides VCT services to CSWs and community members. A total of 6,266 HIV tests were recorded from July 2001 to September 2008.

**Fig 1: Age distribution of clients of VCT**



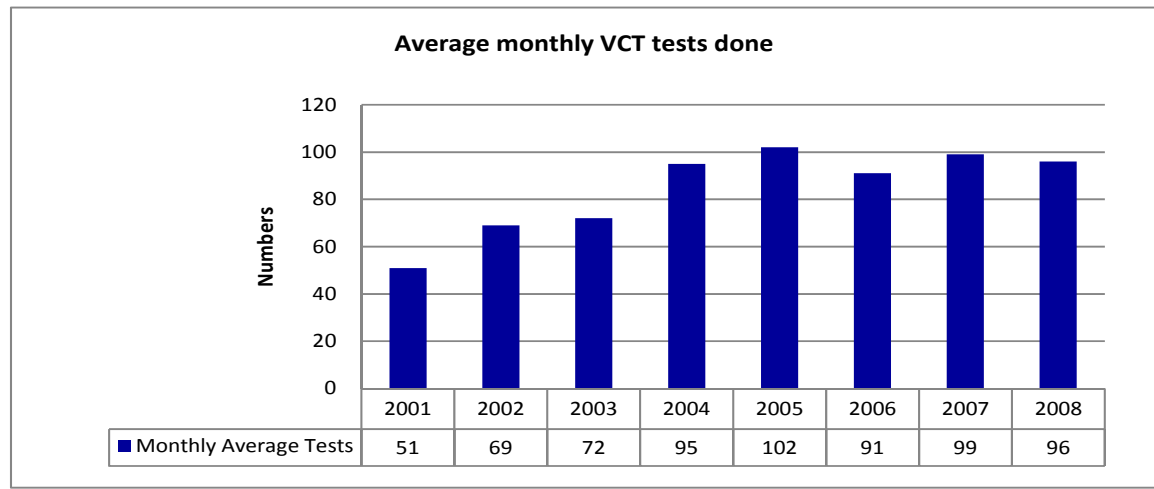
The majority of VCT service users were from the two proximal parishes – Makerere III and Bwaise II (Fig 2) from where residents could easily access services. The number of users from other parishes increased gradually to cover Mulago II and Bwaise I.

**Fig 2: Distribution of VCT clients by parish**



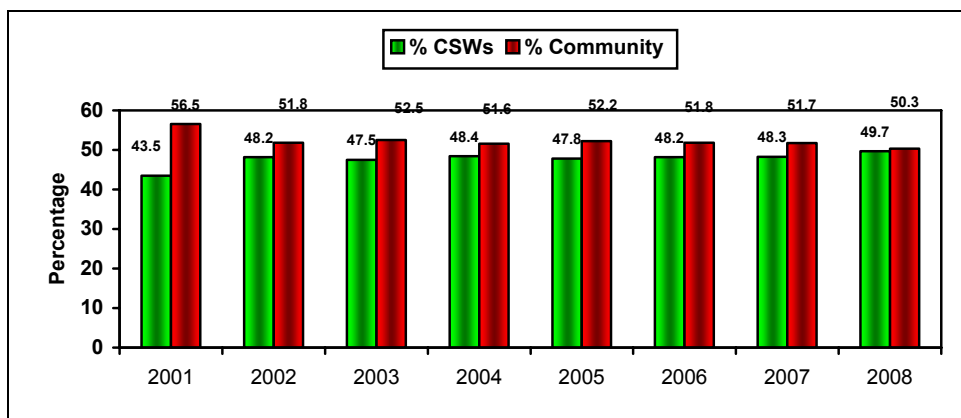
There was a positive trend in VCT service uptake throughout the project period. Monthly mean attendances in each year were computed to obtain trends in cases of missing data. Based on mean monthly tests, the number of VCT clients increased each year, reaching a peak in 2005, and stabilised above 95 tests per month (Fig 3). This could be in part due to general national increasing demand for VCT services and improved access to ART (MOH, 2003). The cost of VCT services has been suggested as a significant barrier to service uptake among service users (Wanyenze *et al*, 2006) and by providing free VCT services, the project must have increased service uptake as studies conducted elsewhere in the country have documented a sizeable proportion of users unwilling to pay for VCT services (Bwambale *et al*, 2008).

**Fig 3: Average monthly VCT tests**



User category of VCT services indicated an overall higher proportion of community members (52.3%) compared to that of CSWs (47.7%), as indicated in Figure 4. However, the proportion of CSWs steadily using services increased to nearly a half of all VCT service users, indicating project success in mobilising the target population for service use. Overall, more women (75% of all VCT users) than men utilised VCT services, the largest proportion comprising CSWs. This was mainly due to the fact that the community clinic was known to be for female CSWs, so male users remained in the minority. Project staff explained that the men were mostly partners brought by CSWs for testing.

**Fig 4: Proportions of VCT user category by year**

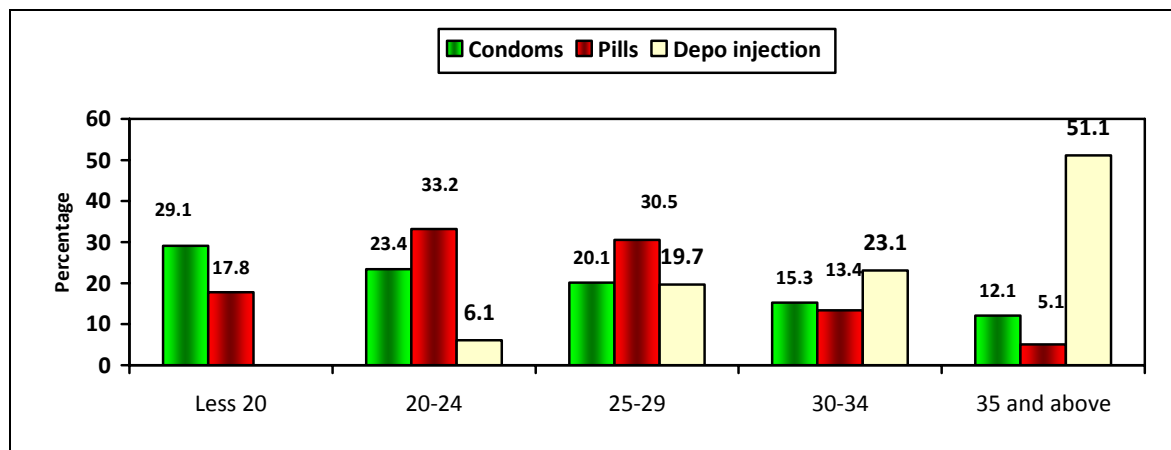


### 2.1.3 Family planning service users and service uptake

Family planning services offered included contraceptives pills, injectables and male condoms. Between 2006 and 2008 more than 5,000 clients were served. An increasing trend was noted with a peak during 2007, when the access road to the facility was improved. There was marked variation in services uptake by month. Service uptake was highest during the period between March and May with a mean attendance of 200/month and was lowest from October to December, when mean attendance was 91/month. This was partly due to floods in the area.

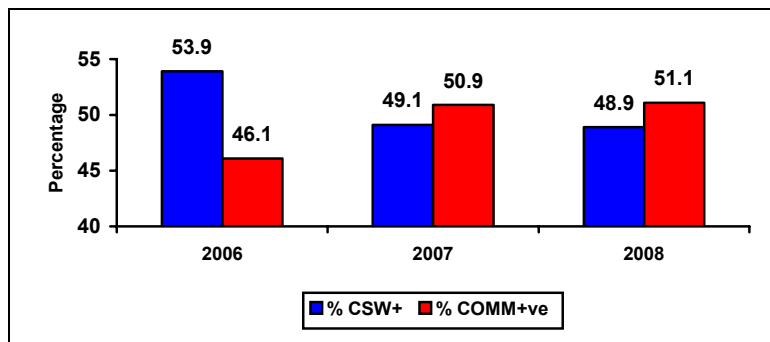
Family planning method utilisation by user age group (Figure 5) indicated that condoms were most popular among the younger age groups; over a half (53%) of condom users were below 25 years, and 30% of users were teenagers. Most young users were CSWs, although clients used more than one method. Data from the Uganda HIV/AIDS Sero-Behavioural Survey (2004/2005) indicated similar findings, an increase in young people using condoms during high-risk sex.

**Fig 5: Proportions of family planning method mix by user age group**



Family planning service uptake by category of users showed an initially higher proportion of CSWs utilising services compared to the community members, but subsequently proportions equalised (Fig 6). This is an indication of increasing demand for services in the whole community following effective community sensitisation.

**Fig 6: Distribution of FP clients by category per year**

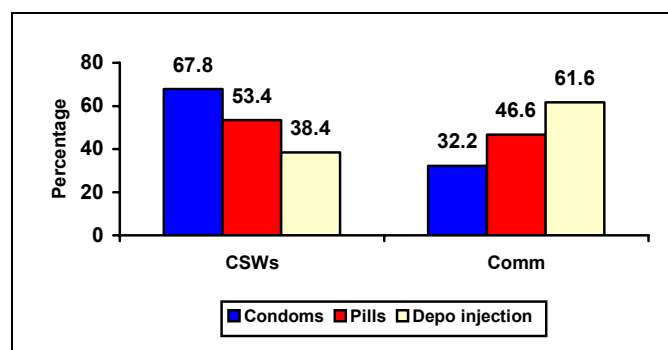


Family planning method mix by user category is shown in Figure 7. The condom was more popular among the CSWs compared to the community members; two-thirds of users of condoms were CSWs as part of the safe sex promotion intervention. However, CSWs in their discussions pointed out that the fear of pregnancy and the social and economic consequences influenced the girls’ decision to use condoms. The CSWs and youth explained that many users had misconceptions about the side effects of the chemicals found in the family planning products, thus the preference for condoms.

*‘I don’t want to use pills. I am not sure what they contain. I always come for condoms, which I use for protection against pregnancies and STDs.*

*Trained CSW under 20*

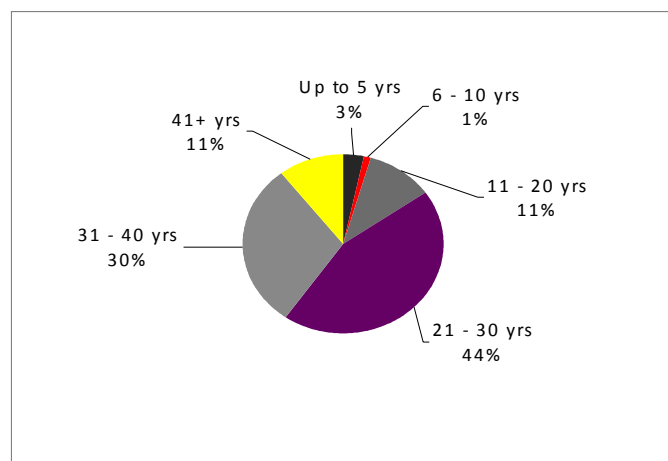
**Fig 7: Proportions of family planning method mix by user category**



There was evidence from focus group discussions with CSWs that while condom use was common, its utilisation was still largely inconsistent, a finding confirmed by previous studies (MOH, 2003). The contraceptive pill was also more popular among CSWs than the rest of the community members, while Depoprovera injections were more popular among community members. Many CSWs were young girls with a desire to have more children and thus avoided more permanent methods of family planning. The UDHS (2006) indicated that the pill was the second most common method used by sexually active unmarried women in their 20s, while older women were more likely to be sterilised.

#### 2.1.4 STI and OI services users and service uptake

**Fig 8: Distribution of STI/OI service utilisation by age group**



##### 2.1.4.1 Services for sexually transmitted infections

The STI service users sought treatment for syphilis, gonorrhoea and candidiasis. Users of services were young adults (44%) aged between 21-30 years; and 11% of all users were aged between 11-20 years (Figure 8). Over 5,500 patients were treated for STI infections between 2006 and 2008. There was a steady increase in service uptake, peaking in 2007. There was monthly variation in service uptake, with peaks during the relatively dry months of May to August, when the health unit was easily accessible.

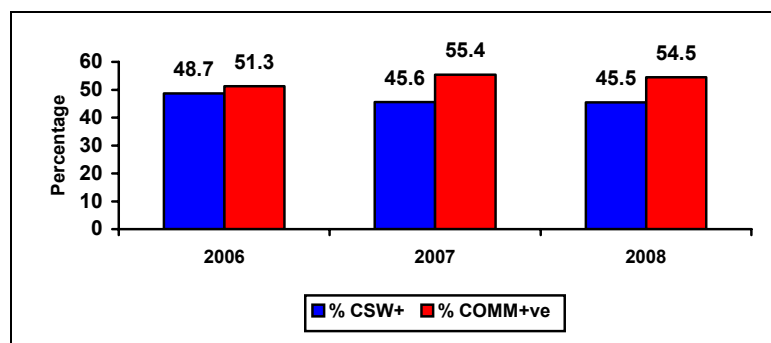
Apart from syphilis, diagnosis of STIs was symptomatic. The main presenting symptoms at the health facility are shown in Table 2. Itching of genital parts and lower abdominal pain were the most common symptoms, followed by vaginal and urethral discharge.

**Table 2: Distribution of main presenting STI symptoms at the health unit**

Diagnosis/Symptoms (n=12,721)	Count	% responses
<b>STI Symptoms</b>		
1. Monilial itching	3381	25
2. Lower abdominal pain (LAP)	3151	24
3. Abnormal vaginal discharge (AVD)	2561	19
4. Penile or urethral discharge	1622	12
5. Dsyuria (pain on passing urine)	1615	12
6. Genital sores	1044	8
<b>Total</b>	<b>13,374</b>	<b>100</b>

Figure 9 shows STI service uptake by category of groups. The proportion of CSWs was lower compared to community members, with a reduction in proportion of CSWs between 2006 and 2008, probably due to effective promotion of safe sex among this group.

**Fig 9: Distribution of STI clients by category by year**



#### 2.1.4.2 Services for treatment of opportunistic infections

A total of about 7,000 patients were treated for opportunistic infections from 2006 to 2008. The conditions treated were mainly malaria, respiratory infections and diarrhoea (Table 3). STI service uptake peaked in 2007 as indicated earlier in Table 1.

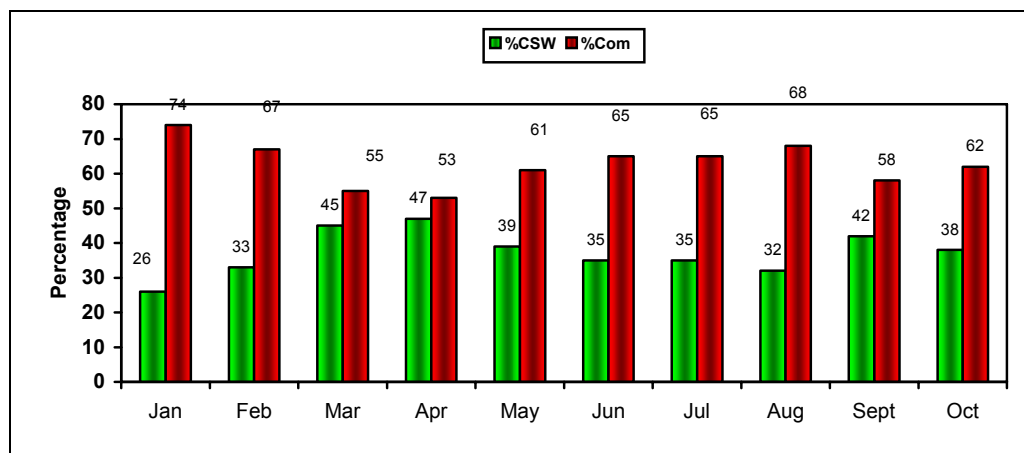
**Table 3: Distribution of main presenting opportunistic infections at the health unit**

Type of infection	No.	%
1. Respiratory infections sore throat, cough, flu, chest pain	3981	57.2
2. Malaria/fever	2341	33.6
3. Diarrhoea	641	9.2
<b>Sub-Total</b>	<b>6,963</b>	<b>100</b>

#### 2.1.4.3 Services for people living with HIV/AIDS

CSWs and other members of the community living with HIV/AIDS were provided with care at the community health unit. People living with HIV/AIDS (PLWAs) received prophylactic cotrimoxazole and were treated for opportunistic infections. Those PLWAs requiring ARVs were referred to other health facilities. Available data on PLWA service in 2007 was analysed for service uptake by category and results are shown in Figure 10. The proportion of CSWs out of the total PLWAs using the services rapidly increased from 26% and stabilised around 40%, indicating an upward trend, though for a limited period of time.

**Fig 10: Distribution of PLWA clients offered care at the health facility in 2007**



### **2.1.5 Training of community-based SRH services providers**

As part of its community-based activities, AMREF trained several categories of providers as indicated in Table 4. These provided a wide range of SRH services within the project. The community counselling assistants (CCAs) help with counselling for VCT while the home care workers follow up PLWAs in the community, especially those that are critically sick. The community-based distribution agents (CBDAs) distribute supplies such as condoms, contraceptive pills and insecticide treated nets. The peer educators help with safe sex promotion and education in the communities. Majority of these were youth who were also provided with training of trainer skills and IEC materials (games such as Ludo and charts on HIV/STIs) to use during their sessions.

The CSWs were mainly trained in vocational skills. They also received life skills training and worked in the communities, advocating for promotion of safe sex among fellow sex workers. In addition, many local council (LC) members were trained in community mobilisation and monitoring of public health issues, especially HIV/AIDS, STIs, FP and mobilising the community for VCT services. Some of them play double roles, as health educators and community leaders.

The trained nurse at the health facility co-ordinated the community-based services, including family planning, counselling for those infected with HIV/AIDS, home care for PLWAs and community meetings. Available records revealed that community workers kept records which were discussed during the monthly meetings with the trained nurse at the community health facility.

**Table 4: Categories of community health volunteers at KCHDP**

<b>Year</b>	<b>CCA</b>	<b>HCWs</b>	<b>CBDAs</b>	<b>Peer educators</b>	<b>CSWs</b>
2004	18	18	78	10	30
2005	18	20	48	10	30
2006	15	15	48	15	35
2007	20	20	20	30	20
2008	20	20	20	50	25
<b>Total</b>	<b>91</b>	<b>93</b>	<b>214</b>	<b>115</b>	<b>140</b>

Community activities included mobilisation and sensitisation of CSWs and the youth through workshops, partnerships and support to youth sports and drama clubs, to enhance communication for behaviour change and reduce high-risk practices related to the spread of HIV/AIDS and STDs. The project also promoted voluntary counselling and testing and family planning services to reduce unplanned pregnancies and provided peer guidance to other slum dwellers through health education for promotion of safe sex behaviour.

Community sessions played an important role in mobilising the population to use services offered at the health clinic and screening users that may need care elsewhere.

*'The number of users had increased because of the peer educators who talk to the people in the community about the health unit close to home where they don't have to queue all day and the provider attends to them courteously and promptly'*

*CSW in employment*

Trained CSWs reported increased condom uptake in communities as a result of free distribution of condoms by peer educators, explaining that the youth were empowered to seek these services at the community health facility.

*'The condom use has increased because in the past it was difficult for a person below 20 years to come to the clinic and ask for condoms. But these days, youth come and get condoms and move with them all the time.'*

*Trained teenage CSW*

#### **2.1.6 Distribution of family planning supplies to CBDAs**

Data on community distribution of family planning products was patchy. However, reasonable data was available for the period between 2004 and 2006. Thus, this was used to illustrate patterns and trends in CBDA distribution of contraceptive products (Table 5). All distributed family planning products show positive uptake trends from 2004 to 2006, evidence of successful implementation of project interventions in the target communities.

**Table 5: Distribution of family planning supplies by CBDAs (2004-2006)**

<b>Year</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Male condoms	11,102	37,252	38,592
Pills	1,827	4,808	4,791
Depo injections	-	1,090	2,300
<b>TOTAL</b>	<b>14,933</b>	<b>45,155</b>	<b>47,689</b>

A total of 86,946 male condoms were distributed by CBDAs to users over the three years. There was evidence that the number of all community-based activities rapidly increased during this time, indicating successful implementation of interventions. The total number of condoms distributed more than tripled from 2004 to 2005 and remained high in 2006 (Table 5). On average, individual CBDAs were given between 100 to 300 condoms at a time, but drug shops were given up to ten times more (3,000 condoms) at a time. Supplies could be collected monthly during monitoring meetings at the health facility. Many drug shops were given penile models to demonstrate the use of condoms. The use of these was reported to be of great value in passing on skills for use of condoms during youth FGDs.

Data available on distribution of contraceptive pills showed that a total of 11,426 cycles were distributed by CBDAs. The highest number was distributed in 2005 (Table 5). Cycles distributed doubled between 2004 and 2006. Depo injection details were available only from 2005 to 2006. A total of 3,390 Depo injections were distributed to clinics and drug shops in the project area. The AMREF family planning clinic received the largest supply.

### **2.1.7 Other community activities**

The CHWs, CBDAs and peer educators undertook additional activities according to the project records. Key among these were organising community meetings for behaviour change communication and education, conducting household visits for those infected with HIV/AIDS, counselling for family planning and VCT, and providing advice on prevention of STDs. Community-based providers met monthly and discussed problems they encountered in their work and possible solutions.

There was a steady increase in the number of community activities between 2004 and 2006, a positive trend for project outputs. Table 6 shows the increasing number of activities reported by CBDAs in the period of three years (2004-2006). A total of over 6,000 community meetings, over 9,000 household visits and nearly 50,000 counselling sessions for service uptake, were conducted in three years. Both community meetings and household visits tripled between 2004 and 2006 while counselling sessions for FP service uptake more than doubled during the same period (Table 6).

**Table 6: Distribution of other CBDA activities by year**

<b>Year</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>Total</b>
Community meetings	881	2,172	3,118	6,171
No. of household visits	1,729	2,343	5,225	9,297
FP counselling sessions	10,292	10,760	24,515	45,567
No. of FP referrals	937	1805	3,409	6,151

The number of referrals for FP services also steadily increased, doubling from one year to the next. There was also an increase in establishment of post-test clubs, sports clubs and competitions, support meetings for trained CSWs and outreach services for PLWAs, confirming sustained high level of project outputs.

## **2.2 Benefits of improved SRH service delivery to CSWs**

### ***2.2.1 SRH service delivery to CSWs in relation to prevention of HIV/AIDS***

This section presents the benefits of improving SRH service delivery and access to information for CSWs to enable them make informed decisions on safe sex practices and reproductive health rights. The analysis attempts to explain how improved SRH services uptake translated into increased demand for services among CSWs.

#### ***2.2.1.1 Relevance of SRH in Kawempe Division***

Participants in FGDs ably articulated major SRH concerns in the project area confirming that they were mostly related to unsafe sex practices and lifestyles. They reported high

prevalence of HIV/AIDS, STDs and unplanned pregnancies, mainly among CSWs and youth in the division. They revealed that a large number of young people and CSWs still practised unsafe sex and many had several partners, despite the fear of death from HIV/AIDS and abortions. Community leaders interviewed concurred. Thus all participants confirmed that the project was extremely relevant since it addressed priority health concerns in the community.

#### *2.2.1.2 Demand for facility-based SRH services*

The community health facility, known as Kalerwe Clinic, was widely known as a clinic supported by AMREF to offer a wide range of SRH services to CSWs in the area, although the facility provided services to everyone in the community. Participants reported that they appreciated services such as treatment of STDs, counselling and testing for HIV, and family planning services, particularly the distribution of free condoms to young people. According to CSWs and youth participants, there was a lot of demand for SRH services in the area. Several reasons were given why CSWs and other young people preferred services at the community health unit although a wider range of services could be obtained from the nearest Kampala City Council health centre. Services at Kalerwe Clinic were reported to be user-friendly, of good quality and were available all the time. They explained that the trained nurse at the community clinic attended to them promptly and there was constant supply of drugs for treatment of STDs. Above all, they were very happy that services offered were free.

*'We thank AMREF for bringing this programme to the area. It makes it easy for CHWs to identify and refer sick people for treatment in the unit. It has helped in treatment and prevention of spread of STIs in the area'*

*CHW KI.*

The clinic also treated CSWs' children, a service they greatly valued. Some CSWs noted that they received support from their partners to participate in project activities due to this service offered by the clinic.

### *2.2.1.3 Demand for community-based SRH*

The community-based service approach directly contributed to increasing demand for SRH services. These services were an important source of information on safe sex practices and on services offered at the community health unit. The trained CSWs were proud to be peer educators and to be the ones giving information to others on safe sex practices and the importance of treatment of STDs. This made them agents of change. Community-based SRH services were not only brought closer to users. User-friendly channels were utilised and this encouraged community members to find out their HIV status.

*‘Through counsellors, peer educators, home visits and drama groups, people get the courage to test for HIV, courage rare to find before counselling’*

*Trained, former CSW*

The home-based care for HIV/AIDS patients was also greatly appreciated as patients were counselled and encouraged to live positively, according to community health workers interviewed. Simple treatments such as pain relievers and transport for bedridden patients to access better care were offered. In addition, home visits were appreciated as advice was given to families on nutrition, sanitation and hygiene.

### **2.2.2 Demand for information on HIV/AIDS and SRH**

Trained CSWs reported that they greatly appreciated information on SRH and prevention of HIV/AIDS/STIs received on enrolment and through vocational skills training. Information was given on promotion of safe sex practices, HIV testing, the importance of reducing partners, seeking treatment for STDs and use of condoms during community workshops and seminars. The same information was given to CSWs as part of the life skills training for peer educators. This helped them to put their knowledge into practice.

Methods that the project used to disseminate information such as drama and youth sports galas, were reportedly popular for passing on SRH messages to the youth. These also included more interactive sessions where they could ask questions and discuss emerging

issues. The use of peer educators was considered an effective method of reaching other CSWs and extra efforts were made to reach places considered to have high-risk populations such as salons, motorcycle stands and pubs.

The best evidence of increased demand for SRH information was the increased uptake of condoms and family planning services. In discussions with trained CSWs, it was evident that information was applied in making decisions for safe sex practices.

*'Earlier, we did not understand the use of a condom and thought that it was a luxury. However, after being counselled, one gets to know how a condom can protect them or decide to abstain altogether.'*

*Trained, teenage CSW*

### **2.3 Vocational skills training for CSWs**

From 2001, the project sensitised and offered vocational skills training to CSWs, enabling sex workers to find gainful employment or start income-generating activities (IGAs). This allowed them to either abandon the sex trade or to reduce risky behaviour. This section presents the vocational skills training outputs and discusses benefits of training and expectations of those trained with regard to reducing the prevalence of HIV/AIDS and unplanned pregnancies among CSWs. Two courses were offered, tailoring and hairdressing.

The training was very popular because it was free and so girls from poor families could enrol. Local councillors were responsible for identifying CSWs for training and gave them letters of support to join courses. There was a lot of demand for this training; many untrained CSWs participants continue to express a desire to enrol. Trainers and project staff reported that only few CSWs could be trained at a time due to limited facilities and resources. Although, the training had been funded from several sources there were times when there was no funding (Table 7 and 8).

### 2.3.1 Training outputs

The project has increased the number of CSWs enrolled in training over the years. Over 600 girls completed their studies and graduated (Tables 7 and 8). More girls were trained in hairdressing than tailoring.

**Table 7: Distribution of CSWs trained in hairdressing (2001-2008)**

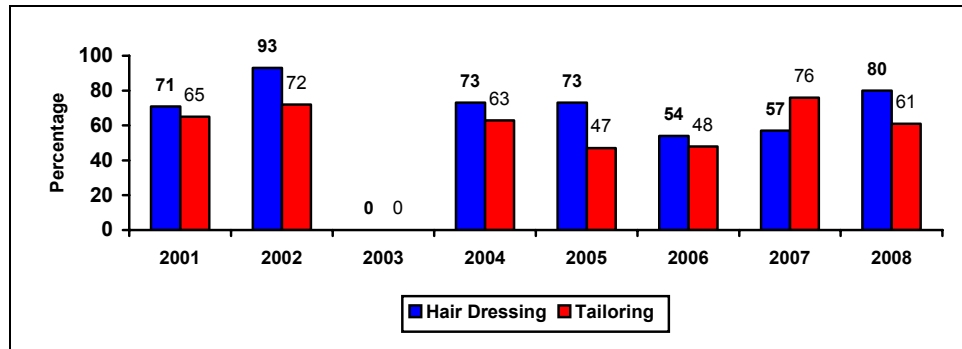
Year	HAIR DRESSING		Funding Source
	Enrolled	Completed	
2001	35	25	ODF
2002	27	25	ODF
2003	0	0	None
2004	45	33	ODF
2005	48	35	AMREF Italy
2006	155	83	McKnight (50) & AMREF Italy (105)
2007	150	85	McKnight (20) & AMREF Italy (130)
2008	102	82	McKnight (20) & AMREF Italy (82)
<b>Total</b>	<b>562</b>	<b>368</b>	

**Table 8: Distribution of CSWs trained in tailoring (2001-2008)**

Year	TAILORING		Funding Source
	Enrolled	Completed	
2001	23	15	ODF
2002	25	18	ODF
2003	0	0	None
2004	27	17	AMREF Italy
2005	85	40	AMREF Italy
2006	111	53	McKnight (30) & AMREF Italy (81)
2007	58	45	McKnight (20) & AMREF Italy (38)
2008	85	52	McKnight (20) & AMREF Italy (65)
<b>Total</b>	<b>414</b>	<b>240</b>	

Overall, nearly two thirds (62.3%) of those enrolled completed their courses. The rate of completion for tailoring course was constantly lower than that of hairdressing (Figure 11).

**Figure 11: Proportion of CSWs who completed training**



### 2.3.2 Benefits of vocational training

Overall, trained CSWs rated the skills acquired as of very good quality, saying it was appropriate for their needs and since many of them had little education, they preferred to work with their hands.

*‘We have learnt a lot because at the beginning, we had no skills. When our teacher is cutting designs, she calls us to learn from her. I didn’t even know how to hold a pair of scissors when I came here. But now if I get capital, I cannot go hungry’*

*Trained CSW*

Many of the trained CSWs were single parents with children to feed, clothe and educate. They felt that the skills acquired would enable them meet these obligations and empower them to change their lifestyle. They also reported that training brought them together; they made friends and formed useful networks for advising and supporting each other during difficult times. The continuous counselling they obtained during and after the training was also considered useful in sustaining changes they had made.

The opportunity of working with the project after training was another benefit, which gave credibility to skills acquired. Those that trained as peer educators mobilised and provided health education on safe sex practices, gaining respect and trust from other people, while others were taken on as trainers in the vocational training programme.

*'I dropped out of school in Senior 2, and became a sex worker in 2003. After I gave birth to my son, I joined the project in 2006 to obtain skills. To my surprise when I finished the course I was called to become an instructor and I am proud to do this work'*

*Trainer*

According to community leaders, the community appreciated the efforts AMREF was making to get the young girls off the streets. They viewed the skills training as an effective means of organising CSWs in the area for affirmative action, explaining that it was effective in ensuring that CSWs practised safe sex, thus reducing the prevalence of STIs and HIV/AIDS among these girls, and subsequently in the community.

## **2.4 Project outcomes**

This section presents KCHDP outcomes with regards to safe sex practices in relation to prevention of HIV/AIDS/STDs and unplanned pregnancies in the area. The increased service uptake and change in attitudes of trained CSWs in relation to creating demand for safe sex practices and quality life were discussed.

### ***2.4.1 Increased demand for safer sex practices***

Reports obtained indicated that the demand for change to safer sex practices had markedly increased among the CSWs and youth, as evidenced by the large number of people testing for HIV/AIDS at the health facility and the increased use of male condoms in the project area. Differences in attitudes and practices were observed between the trained CSWs and the untrained CSWs and other youth not targeted by the project. The

differences in demand for safer sex practices could be attributed to vocational skills training, safe sex promotion and SRH services offered in the community clinic.

Information from the trained CSWs indicated that they understood the importance of consistent condom use. They reported that they had acquired practical negotiation skills for safer sex with their clients and skills for proper use of condoms. They could recognise signs and symptoms of STDs and had adopted appropriate health seeking behaviour for treatment of STIs and use of condoms to avoid re-infections.

*'We are satisfied with the skills we have on how to use a condom. You have to check the expiry date and use it, putting it on the man in case he is being stubborn. Just tell him that you know how to put it on him.'*

*Trained former CSW*

The older trained CSWs had better understanding of the importance of consistent condom use and the dangers of unprotected sex than the younger trained CSWs, a difference attributed to the length of exposure to project interventions on safe sex practices.

It was a requirement for all trainees enrolled in vocational training at KCHDP to be tested for HIV and syphilis. This involved pre-test, post-test and continuous counselling on HIV/AIDS, STDs and unwanted pregnancies.

**Table 9: Distribution of HIV and syphilis infections among the enrolled CSWs**

Year	Test	No. Tested	% Positive
2007	HIV	208	16
	RPR	208	12
2008	HIV	187	7
	RPR	187	10
2009	HIV	93	8
	RPR	93	11

There was evidence that the prevalence of HIV and that of syphilis among CSWs recruited in training was decreasing. One in every six CSWs enrolled in training was HIV positive with a downward trend observed between 2007 and 2009, where one in 12 CSWs recruited for training was HIV positive. Similarly, one in 10 had syphilis with a downward trend, suggesting reduction in prevalence of these infections among CSWs enrolled (Table 9).

#### **2.4.2 Changes in safe sex regarding prevalence of HIV/AIDS/STDs**

##### *2.4.2.1 HIV serostatus of clients at the community health clinic*

Mean monthly tests were calculated for tests/month each year. The number of positive HIV tests over total tests done each year was calculated to obtain the proportion of positive HIV tests per year (Table 10). Overall, one in four VCT clients (23%) was positive during the 8-year period. However, the proportion of positive tests slowly decreased reaching its lowest level in 2007 (Table 10). This pattern in prevalence of HIV infection among clients using VCT services probably was due to project interventions and increased demand for VCT services among participating communities.

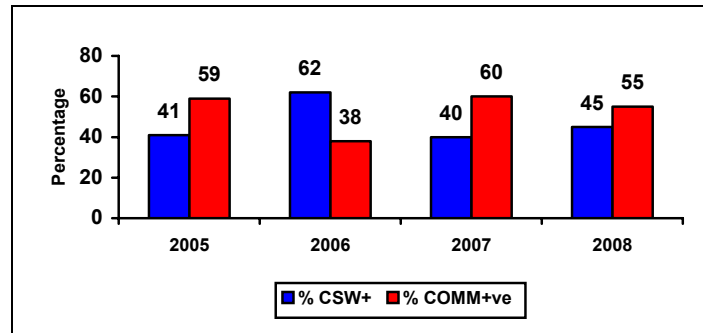
**Table10: Distribution of positive HIV tests**

<b>Year</b>	<b>No. of VCT tests/month</b>	<b>% of positive results</b>
<b>2001</b>	51	25
<b>2002</b>	69	26
<b>2003</b>	72	26
<b>2004</b>	95	20
<b>2005</b>	102	16
<b>2006</b>	91	14
<b>2007</b>	99	12
<b>2008</b>	96	16

Serostatus from 2005 to 2008 was disaggregated between CSWs and other members of the community as shown in Figure 4. The proportion of HIV positive CSWs initially rose but dropped in 2007 and stabilised at a lower level compared to that of the community

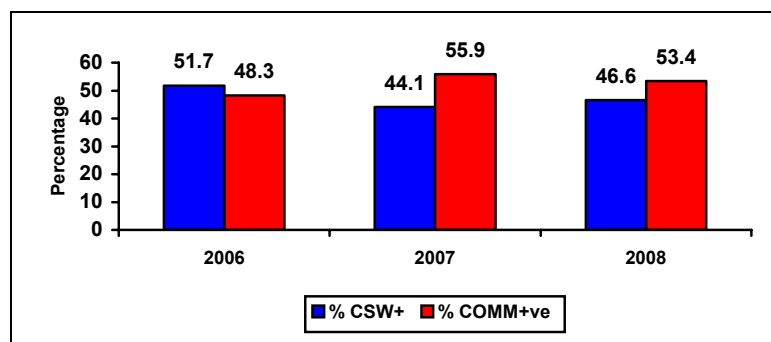
(Figure 12). While elsewhere in the country the prevalence of HIV among CSWs was increasing during this period due to continued high-risk behaviour (MOH 2003), the effective treatment of STIs and promotion of safe sex most likely contributed to the observed downward trend in HIV prevalence.

**Fig 12: Distribution of HIV positive CSWs and community members**



The prevalence of gonorrhoea and candida infections could not be determined since treatment of these conditions was based on presenting symptoms. However, based on distribution of user category of OI treatment (2006-2008), the proportion of CSWs treated decreased from above 50% to stabilise at around 45% of all those treated (Fig 13), indicating a reduction in prevalence of OIs among the CSWs, probably due to successful treatment interventions.

**Fig 13: Distribution OI treatment by category by year (2006-2008)**



The prevalence of syphilis among users of the community clinic based on rapid plasma reagin (RPR) is shown in Table 11. The proportion of positive RPR tests out of the total tests done reduced from a high of 5% to stabilise around 2%, probably due to the effective treatment of syphilis among clients of the community health unit.

**Table 11: Distribution of positive RPR in clients at the health unit**

Year	Total RPR +ve	% RPR +ve
2001	15	4.9
2002	31	3.7
2003	10	1.1
2004	19	2.1
2005	26	2.1
2006	13	1.3
2007	39	2.4
2008	18	2.3

Among the CSWs attending the community clinic, there was evidence of reduction in prevalence of syphilis. According to available data on category of users during 2005-2008, the proportion RPR tests among CSWs steadily decreased while that of community members increased (Table 12), a trend attributable to effective STI treatment in CSWs.

**Table 12: Proportion of RPR positive by user category**

Year	CSWs	Community
2005	58	42
2006	39	61
2007	33	67
2008	34	69
<b>Total</b>	<b>62</b>	<b>101</b>

However, the effect of the KCHDP on prevalence of HIV and STDs in the whole community could not be assessed. Participants in FGDs and KIs were non-committal, although they reported that PLWAs were not dying as much from AIDS due to quality home-based care offered by the project and access to ARVs.

Participants said the evidence for adoption of safe sex practices in the area was the increased number of youth and trained CSWs attending VCT services to determine their HIV status. Trained CSWs reported that there was an increase in condom use by CSWs who operate around the drainage channel, saying many used condoms were found in the morning near this place and on the streets. It was also reported that more youths feared unprotected sex and many men were walking with condoms in their wallets.

Participants in FGDs reported that some trained CSWs had encouraged their friends to quit commercial sex work or discouraged young girls from poor families from becoming CSWs. So they were taking time to teach others what they had learnt, although they mentioned that they did not have solutions to the girls' economic problems. Majority of the untrained CSWs were very negative towards adoption of safe sex practices.

#### ***2.4.3 Change in safe sex regarding unplanned pregnancies***

Data available at the community clinic was insufficient to analyse for prevalence of unplanned pregnancies among CSWs. During the focus group discussions, participants felt that despite adequate knowledge on safe sex practices, there was little evidence of substantive change in the level of unplanned pregnancies among trained CSWs. Abortions were still rampant, evidenced by the many foetuses reportedly thrown in the drainage channels. CSWs allegedly often died in the process of abortion as they use crude mechanical methods or herbal medicines that resulted in excessive bleeding and sepsis. Many CSWs' children did not know their fathers and sometimes babies were abandoned in hospitals because their mothers could not support them. It was reported that men manipulated young CSWs (14-18 years) to engage in unprotected sex.

*'There are very many unwanted pregnancies among young CSWs aged between 14 and 18 years. Men easily manipulate teens to have sex and if they go with four men in a night, it makes it very hard to know the owner of the pregnancy. The girls usually die when they try to procure an abortion.'*

*Trained CSW*

Many girls dropped out of school early since parents were unable to meet their basic needs. Defilement by close family members and sexual exploitation by employers was also common.

#### ***2.4.4 Evidence of CSWs' increased demand for quality life***

There was evidence that among trained CSWs, there was increased demand for better quality of life and willingness to change from the sex trade to a more respectable lifestyle. During the discussions, several CSWs noted the risks they faced in sex work and their desire to quit the trade. Those that quit expressed how they appreciated changes the project made in their lives.

*'Sometimes these men would push us against a wall or make us lie on grass to have sex. But now I have someone who loves me, and I sleep on a bed instead of walls and grass'*

*Trained ex-CSW*

Many ex-CSWs preferred to keep their previous commercial sex work secret from their spouses, and were resentful when reminded of it. They were proud that they were role models to other CSWs and took pride in advising others to quit the trade. They resisted temptations to go back to sex work, despite compelling situations such as loss of income.

*'Having left the sex trade a year ago, I was tempted to go back. I really found it difficult and lasted only two days. I quickly went back to my husband'*

*Trained ex-CSW*

## **2.5 Challenges in project implementation**

This section presents and discusses challenges that CSWs and other stakeholders face in sustaining increased SRH service demands, meeting the demands of vocational skills training and sustaining changes in quality of life.

### ***2.5.1 Challenges in meeting SRH services and information demands***

The main service delivery challenge reported was related to access to VCT services that were provided only once a week. The counsellors available were not able to attend to the large numbers of clients.

On community-based services, participants noted that coverage of project activities in the division was limited, thus excluding many CSWs. Closely related to this was the limited social mobilisation due to inadequate support to LC members and resource persons to reach out to more areas. During the interviews, project staff noted that there was limited funding for programme expansion.

Sensitisation seminar schedules made it difficult for people in self-employment to attend. The frequency of seminars, especially in areas with high emigration, was inadequate to inform new newcomers. There were also other implementation challenges related to religious and political differences among the residents, especially those negatively affecting family planning services and uptake of ARVs. During the discussions, the youth felt that the project did not target schools or parents, and urged that for effective prevention of the sex trade and promotion of safe sex practices these two populations should be targeted.

With regard to home care, there were challenges of ensuring that poor PLWAs had adequate food and other supplies required for proper care. The programme no longer provided this support, thus failed to meet patients' expectations.

### ***2.5.2 Challenges in vocational training***

The limited number of participants who could attend the training courses was a challenge. The trainers concurred, but stated that increasing number of courses offered would require more resources which were not available at the time.

Other training challenges were related to poor socio-economic background of CSWs. Although the project was able to purchase some of the equipment and materials, trainers

reported that the majority of the girls could not afford to buy all the required learning materials. CSWs reported that they did not have money for transport or lunch during training and trainers reported that the 10% attrition rate was due to serious economic constraints CSWs faced.

The CSWs felt that the duration of training, especially for those studying tailoring was too short to ensure acquisition of basic skills. However, the trainers reported that offering longer courses was associated with low attendance and high dropout rates. So to balance course duration and ensure good adherence and completion rates remains a challenge.

There were infrastructural challenges such as limited classroom space that forced trainees to attend classes in shifts especially in the tailoring section. In addition, the number of sewing machines was inadequate to allow hands-on learning for all. Flooding of the training facilities during rainy seasons affected the training sessions and sanitation facilities were inadequate.

### ***2.5.3 Challenges in quitting the sex trade and sustaining change***

Finding a job remained one of the biggest challenges for trained CSWs who wanted to quit the sex trade. The project did not offer start-up capital to trained CSWs, yet jobs were scarce. Many trained CSWs could not raise the capital for sewing machines or hair dryers on completion of the vocational training. Project officers reported that initially the project would grant equipment to trainees who were able to deposit half the payment. They would be required to pay the remaining amount over a period of six months. Only half the number of those who completed in each batch accessed such loans and recovery of the same was a challenge.

*‘Some girls are living positively but when they die, it affects recovery of the loan. Other girls change residence after getting the machines, shifting to far off places, which means that we are unable to recover their loans.’*

*CHW*

The CSWs faced challenges of poor support from their families and communities. Many of them felt they were victims of a society where there was rampant sexual abuse, defilement and rape, with constant exploitation by men who preferred and paid more for unprotected sex. Several ex-CSWs found it difficult to secure employment.

*'The other problem we have is when our bosses discover that we were trained by AMREF, they automatically know that we are prostitutes and think that we are still in that business. This makes it very hard for us to secure employment'.*

*Trained CSWs in employment*

For those ex-CSWs settled in stable relationship, lack of trust by their partners and failure to adjust to living on less income, were key challenges. They mentioned that some of their husbands did not allow them to work, yet gave them little money for household requirements and restricted their movements.

*'When I was in commercial sex, I could buy anything I wanted without asking the man for money. But now when I ask him for money he says if I want I can go back to the streets. And another thing, when I go to visit my friends, he thinks I have been to the streets selling my body'.*

*Trained CSW in a stable relationship*

## **2.6 Suggestions on how to improve project outputs and outcomes**

### ***2.6.1 Meeting the increased demand for information and services***

CSWs suggested that VCT services should be provided more often in the week and the number of counsellors at the community health unit be increased to meet the growing demand. To improve coverage of community education, they suggested that more peer educators and counselling assistants be trained and deployed to cover additional areas. In addition, more skills training in HIV/AIDS home care should be offered to CHWs, to improve on the quality of their work.

There was need to change the timing of community sensitisation to weekends to allow more people to participate. It was also suggested that there was need to increase the number of sessions in densely populated areas with rapidly changing residents to cater for new entrants in the area. The youth and community leaders suggested that safe sex sensitisation should be extended to schools and more youth-friendly channels including film shows, religious gatherings, drama, sports galas and printed material (banners and pamphlets in English and Luganda) be used. The CHWs proposed an increase and prompt payment of their allowances to enable them effectively mobilise and sensitise communities and re-institution of food aid in home care for the very sick and poor HIV/AIDS patients. The participants recommended that the programme deliberately target more parents to sensitise them on the importance of reducing girls' attraction to sex work.

### ***2.6.2 Improving vocational skills training***

Participants made suggestions to review the scope of courses offered, training duration, infrastructure and training facilities, and financial support during and after training.

Community leaders and trained CSWs suggested that AMREF should look for better and more spacious facilities for training to meet the growing demand. Trainers concurred and added that more space and equipment was necessary to provide practical hands-on training. More sewing machines were needed to allow more hands-on learning in class. In the meantime, it was essential to work with the community to construct better drainage to avoid flooding during the rainy season.

Trained CSWs suggested that learning hours in tailoring should be increased to give more confidence to trainees and ensure that they gain adequate skills to secure employment. Additionally, they suggested that the scope of courses offered could be increased to include catering and computer skills. Some felt that trainees should be given certificates on completion of the training.

Many trained CSWs suggested that there was need to support trainees with allowances for transport and meals during training to increase the retention rates.

### ***2.6.3 Adopting safe sex practices***

Trained CSWs suggested that on completion of the training course, girls should either receive loans or initial capital to start their own businesses. Some mentioned that they could be attached to existing projects. This would ensure that they are gainfully employed and would reduce the temptation to go back to the sex trade. Many girls were from poor backgrounds and could not raise even the down payment on loaned equipment. Special considerations need to be made in such cases. It was suggested that post training clubs could be formed for channelling support and marketing goods produced. Some trained CSWs proposed that there was need for AMREF to work with other service providers and connect trainees to micro-finance programmes in the area to help them get money to start income generating activities.

To address the challenges of the loan scheme, project officers suggested that an independent organisation take up the management, supervision and recovery of loans to ease loan recovery.

Trained CSWs brought up the need for continued provision of sensitisation workshops and counselling in post training clubs to reduce the temptation of girls going back to the sex trade. More training in life skills would equip ex-CSWs to persuade their peers to abandon the trade. They suggested intensifying sensitisation for behaviour change in wider communities where they live as this could provide a more supportive environment for reducing the demand for unprotected sex in the communities.

## **2.7 Sustainability, ownership and expansion of project activities**

The main mechanism of establishing institutional sustainability in KCHDP was capacity building in participating communities. The project extensively built the capacity of community members and trained CSWs to effectively participate in implementation of project activities, as indicated in section 2.1.5. Skills were offered in leadership,

mobilisation and monitoring of public health issues skills to community leaders while several community-based SRH providers were trained as indicated in Table 4. This was in line with AMREF’s community partnering with programme beneficiaries to empower them to solve their problems. Former CSWs were given trainers of trainers (TOT) skills as peer educators and two of them were recruited as instructors and mentors in vocational skills training.

With regard to community ownership, the project had a steering committee that dealt with policy and planning matters. The committee comprised church leaders, former CSWs, project staff and city council officials. There was also a technical committee consisting of councillors, community leaders and project staff who periodically reviewed technical issues and provided guidance to the project team. When the issue of sustainability of KCHDP was discussed with trained CSWs, youth and community leaders, many participants felt that the project belonged to CSWs as it was brought to assist them to address rampant prostitution in the division.

Financial sustainability was weak, with very little evidence that it had been addressed in the project design. The project had been almost entirely funded by donors, apart from the training facility that was provided by the community. The project’s annual budget fluctuated from one year to the next, depending on AMREF’s ability to raise the required funding. The financial history in Table 13 indicates funding available between 2001 and 2009. There was a steady increase in funding from year 2001 to 2009, but all this was from external sources. There was significant decline in funding in 2005 that was reportedly due to major project reorganisation, while the drop between 2008 and 2009 was attributed to the ongoing global economic recession.

**Table 13: KCHDP’s financial history (2001-2009)**

Year	Donor	Amounts	Total
2001	ODF	4,204.00	4,204.00
2002	Katalemwa	3,612.00	3,612.00
2003	ODF	19,400.00	24,104.00
	Katalemwa	4,704.00	

<b>2004</b>	Hewlett	47,261.00	81,407.75
	AMREF Italy	34,146.00	
<b>2005</b>	AMREF Italy	35,897.00	35,897.44
<b>2006</b>	AMREF Italy	180,147.06	209,872.06
	McKnight	26,000.00	
	AMREF USA	3,725.00	
<b>2007</b>	AMREF Italy	104,109.59	125,109.59
	McKnight	21,000.00	
<b>2008</b>	AMREF Italy	80,000.00	256,251.00
	McKnight	13,000.00	
	AMREF Spain	163,251.00	
<b>2009</b>	Merck Foundation	50,000.00	215,000.00
	AMREF Spain	165,000.00	

Although project staff reported that the community had been requested to explore ways of making some contributions towards the project costs, there was no evidence that this was likely to happen in the near future. Many participants interviewed were aware that the project was supported by external donors. Asked if they knew of plans for continuation and expansion of the programme, many respondents were not aware of such plans, but stated that they hoped that AMREF's support would continue and expand to cover the whole of Kawempe Division.

### **3.0 CONCLUSIONS AND RECOMMENDATIONS**

This section presents conclusions and recommendations on some of the critical issues emerging from targeting female CSWs with improved SRH service delivery and vocational skills training, as a means of preventing HIV/AIDS among urban poor communities.

### **3.1 Conclusions**

#### ***3.1.1 Increase in SRH service demand for prevention of HIV/AIDS***

There was a sustained high service uptake for all services – VCT, FP, and treatment of STIs and OIs, which was clear evidence that vulnerable groups can demand improved SRH services for HIV/AIDS prevention.

The proportion of service uptake among CSWs was higher compared to the rest of the community members for all services offered, an indication of project success in mobilising CSWs for service uptake. The condom was the most popular method among the young CSWs and two-thirds of all users of condoms were CSWs, a reflection of the success of promotion of safe sex among the target group.

The treatment of STIs and OIs was extremely relevant in addressing CSWs' priority SRH needs; services at the community clinic were valued and in great demand because they were easily accessible, of good quality, free and more user-friendly compared to other local facilities.

The project trained several community resource persons and involved them in implementation of community-based health services. Community leaders were also involved in policy and planning activities. This served as an effective strategy for empowering communities and contributed to community project ownership.

Community seminars were important mobilisation tools for service utilisation and contributed to increasing demand at all levels. The distribution of free condoms increased condom use which was the most effective way to promote safe sex among CSWs.

#### ***3.1.2 Benefits of vocational skills training***

Free vocational skills training which was offered to CSWs in tailoring and hairdressing was extremely popular and equipped them with income generating skills. The training was viewed as an affirmative action for organising CSWs, giving them a chance to quit

the sex trade. This led to increased demand for better quality of life among CSWs and provided them with opportunities to form social support networks.

### ***3.1.3 Adoption of safe sex behaviour and reduction in HIV infection rates***

The project had created demand for CSWs to change to safer sex practices as evidenced by the large number testing for HIV/AIDS and increase use of male condoms. CSWs had gained practical negotiation skills for safer sex with their clients, acquired skills for proper use of condoms and were able to recognise STI symptoms and seek treatment.

The proportion of positive HIV tests had slowly decreased among all VCT clients, but the proportion of HIV positive CSWs that was initially higher, became lower compared to that of community members, a trend suggestive of effective sensitisation and promotion of safe sex among CSWs.

STI treatment was effective in reducing the prevalence of syphilis and symptoms of other STIs among CSWs, as evidenced by decreasing proportion of positive RPR tests among CSWs and decreased proportion of CSWs seeking treatment for STIs at the community health facility.

The project had influenced some trained CSWs to quit the sex trade. This was the best evidence of increased demand among CSWs for better quality of life. These ex-CSWs recognised the risks of the sex trade and were proud of changes they had made.

### ***3.1.4 Implementation challenges and sustainability***

The main project implementation challenges were related to limited human resources to match the increased service demands and the necessary expansion to reach more CSWs. Other challenges included inadequate infrastructure and support to trainees during training and inadequate arrangements for start-up capital following training, which posed the greatest challenge for CSWs to quit the sex trade and sustain the change.

The level of community involvement in project management and implementation was commendable and served as a testimony of community ownership of the project; evidence that AMREF's community partnership strategy delivered as expected. However, financial sustainability was weak.

### **3.2 Recommendations**

1. Programmes for prevention of HIV/AIDS among CSWs in poor urban communities should include strategies for improving SRH service delivery as a way of reducing high-risk behaviour and adopting safe sex practices.
2. Efforts should be made to ensure that there is a well-functioning community clinic providing free, good quality and user-friendly services to CSWs to improve access to HIV testing and treatment of STIs and OIs.
3. The wide distribution of free male condoms to CSWs and communities, accompanied with strengthening skills for their proper use was an effective intervention that should be promoted.
4. For programme success, it is necessary to build an adequate human resource base in participating communities to ensure continuous mobilisation and sensitisation for sustaining safe sex practices among mobile residents in poor urban slums. The training of multi-purpose community health workers, peer educators and local leaders should be promoted.
5. Vocational skills training should offer skills relevant to job markets in poor urban settings and explore innovative strategies for meaningful support to CSWs during training (transport and a day meal). After the training, CSWs should have access to initial capital to enable them start their own businesses.
6. Programmes should continue working with trained CSWs as peer educators to reach more sex workers. The programmes should also continue to offer opportunities for counselling to support trained CSWs in sustaining safe sex practices adopted.
7. For programmes to effectively achieve reduction of HIV/AIDS among CSWs, funding needs should be continuously reviewed and meaningful partnerships formed with other providers, including those involved in poverty alleviation.

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