



Graduate School of Development Studies

COMBATING HIV/AIDS THROUGH NGOs IN POST-  
CONFLICT AREAS:  
Analysis of Major Strategies for two Local NGOs in Gulu District.

A Research Paper presented by:

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In partial fulfilment of the requirements for obtaining the degree of  
MASTERS OF ARTS IN DEVELOPMENT STUDIES

Specialisation:  
**Local and Regional Development  
(LRD)**

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The Hague, the Netherlands  
December 2008

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## **Dedication**

This paper is dedicated to my parents whose investment in my education is graciously appreciated beyond what words can express, and to the love of my heart, my best friend Assumpta, for her emotional and spiritual care and support that has enabled me persevere through this trying moment.

## Acknowledgement

Fifteen months down the road to achieving a MA award in development studies in the Diaspora thousands of miles away from home and from loved ones has been very trying. Nevertheless I am grateful for being where I am now and thanks to the many people and organisations that have been by me in one way or another.

First I would like to express my sincere gratitude to Nsamizi Training Institute of Social Development for the opportunity it accorded me to advance my career. Special thanks go to the Principal Mr. Kanyesigye Charles and his deputy Mr. Kalule Duncan who supported and defended my application for the scholarship with the NPT project. The mentoring I have been receiving from them in the last ten (10) years has also been very instrumental in making me what I am today.

This remarkable piece of work would not be possible without the support and encouragement of my supervisors Dr. Nicholas Awortwi and Dr. Auma Okwany to whom I am deeply indebted. Their intellectual and emotional insight shared with me in a parental way greatly motivated me to push on, even when everything seemed difficult.

I am also grateful to my lecturers in the LRD specialisation, Prof Bert Helmsing, Dr. Peter Knoringa, Dr. Joao Guimaraes, Dr. Erhard Berner and my colleagues in the struggle for their intelligent information sharing and exchange of ideas from across continents and from a wide pool of knowledge backgrounds during all our class sessions and discussions plus the numerous social events shared. Cisca, the course administrator for LRD will sincerely be remembered for her motherly care and support during my time at ISS.

While I reflect on this paper I can't stop thinking of the innumerable and unconditional support extended to me by the various organisations and individuals during my research. I would especially like to Thank Mr. Ochwo Michael, the Counselling coordinator for TASO and his entire team for their kind support in providing information much needed. Mr. Obutu Francis, the Director of HAU and his entire team will always be remembered too. The different officials at the district and individual clients who were my respondents are greatly appreciated.

Last but not least I extend my sincere gratitude to the new friends I acquired at ISS. These include all Ugandan colleagues, none of whom I knew at the start of the course and others from countries like Ethiopia, Indonesia, India Tanzania, Kenya, Zambia, Rwanda, Colombia, Holland, and the Philippines among others. My interaction with them during the entire study period has been so inspirational and has made my study and life in the Netherlands quite comfortable.

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## List of Acronyms

ACCORD		African Center for the Constructive Resolution of Disputes
ACP	-	AIDS Control Project
AIDS	-	Acquired Immune Deficiency Syndrome
ARV	-	Anti Retro Viral
CASA	-	Community AIDS Support Agencies
CBO	-	Community Based Organisations
CDD	-	Community Driven Development
CDDP	-	Community Drug Distribution Points
CDO	-	Community Development Officer
CSIS	-	Center for Strategic and International Studies
CSO	-	Civil Society Organisation
CVC	-	Community Volunteer Counsellors
DDHS	-	District Director of Health Services
DDMC	-	District Disaster Management Committee
FBO	-	Faith Based Organisations
FGD	-	Focused Group Discussion
HAU	-	Health Alert Uganda
HIV	-	Human Immunodeficiency Virus
IDP	-	Internally Displaced People
INGO	-	International Non Government Organisations
IOM	-	International Organisation of Migration
LG	-	Local Government
LRA	-	Lords Resistance Army
LWHA	-	Living With HIV AIDS
MOH	-	Ministry of Health
MOU	-	Memorandum of Understanding
MSG	-	Male Support Group
MTCT	-	Mother To Child Transmission
NGO	-	Non Government Organisation
PLWHA	-	People Living With HIV AIDS
PMTCT	-	Prevention of Mother To Child Transmission
POMO	-	Prevention of Male Organisation
SSA	-	Sub Saharan Africa
STI	-	Sexually Transmitted Infections
TASO	-	The Aids Support Organisation
UAC	-	Uganda Aids Commission.
UN	-	United Nations
UNAIDS	-	United Nations Program on AIDS.

UNASO	-	Uganda National Aids Services Organisation
UNDP	-	United Nations Development Programme
UNHCR	-	United Nations High Commission Refugees.
UNICEF	-	United Nations Children's Fund
VCT	-	Voluntary Counselling and Testing
WFP	-	World Food Programme
WHO	-	World Health Organisation.
WV	-	World Vision



## Abstract

In recent years, NGOs have experienced a dramatic growth in numbers and funding, making them the most important factor in building a strong civil society as the state continues to lose grip in terms of providing social services. This has been mainly due to their rigid and hierarchical structures, yet NGOs are distinguished by their flexibility, willingness to innovate, a capacity to operate at low costs, a capacity to promote local participation and implement projects in direct collaboration with target beneficiary groups. (Marcussen 1996, Edward and Hulme 1992). Because of this the government of Uganda and Gulu local government in particular have embraced the role NGOs can play in Combating HIV/AIDS. This can be seen from the over 500 organisations all poured in one single region partly for relief aid and most recently in 2005 for HIV/AIDS interventions.

The research paper in answering one of its key questions comes to the conclusion that indeed armed conflict in Gulu district between 1987 till recently in 2005 was a major factor that contributed to the reportedly higher prevalence rate of HIV/AIDS. The destruction of the Acholi customs and cultural beliefs, inevitable prevalence of lawless and high levels of vulnerability that saw many women and girls being raped/defiled, while many still got engaged in risky sexual behaviours just for survival and desperation do justify the conclusion.

The local NGO strategies in combating HIV/AIDS in Gulu district were to a great extent successful. The use of especially participatory approaches and direct involvement of PLWHA in the interventions brought confidence among PLWHA but were still suffering from self stigma and denial. They could see the human face of HIV/AIDS in those who had disclosed their status, who also bought the idea for the want of a longer and healthy life. Equally, the scaling up of outreach activity in the far to reach communities and forging of partnerships with the state and other key actors led to increased VCT services especially the men, increased adherence to drugs, reduced couple conflicts related to HIV/AIDS and record numbers of people coming out to disclose their status.

State- civil society theories and Community Driven Development were used to argue the case for NGO interventions in development work in general and HIV/AIDS in particular. Also reviewed and discussed were the theories on conflict and post conflict reconstruction in relation to the situation in the north during war and now in post conflict situation.

The research methodology used helped a lot in realising the required information need for this paper. The research was based on both primary and secondary data collection. Thirty seven respondents were interviewed using both FGD and semi- structured interviews with staff of the two local NGOs purposively selected and their beneficiaries plus some local government staff and other institutions. Most if not all of the analysis has been qualitative.

## **Relevance to Development Studies.**

HIV/AIDS has become one of the deadliest global development challenges of the 21<sup>st</sup> century. For over three decades, the pandemic continues to have great social, economic and psychological impact as the number of people getting infected and those affected continue rising, especially in Sub-Saharan Africa. Civil society organisations and governments have taken a lead in prevention, care and support efforts. This study will bring to light the need for local and regional development actors to re-draw their strategies on how they would combat HIV/AIDS in regions that are either at war or in a post- conflict situation.

### **Key Words**

HIV/AIDS, Non Government Organisations, Internally Displaced People, state, civil society, Armed Conflict, Post- conflict.

# Chapter 1 Introduction

## 1.1 Background

As HIV/AIDS continues to become a deadly global development challenge, the role of NGO's in combating the scourge both at local and international level has also increased. NGOs have and continue to rapidly replace state role in health related areas. The AIDS pandemic and prevalence rate of HIV has had and continue to have great social, economic and psychological impact on the people. According to UNAIDS (2007) epidemiological up dates, the virus has in the last 25 years virtually spread to every country, infecting 33.2 children and adults killing 2.1 million, with 2.5 new infections. SSA, where Uganda lies bears the heaviest burden of the epidemic accounting for 68% of those living with HIV/AIDS globally while about 76% of the Aids related deaths in 2007 alone occurred in the region.

For the last two decades now, "Uganda, one of the first countries in sub-Saharan Africa to experience the devastating impact of HIV/AIDS and to take action to control the epidemic, is one of the rare success stories in a region that has been ravaged by the HIV/AIDS epidemic" (WHO 2006) Its further observed that since 1993, the infection rates among pregnant women, a key indicator of the progress of the epidemic, have been more than halved in many parts of the country.

The role of the current government in the fight against HIV/AIDS cannot be underestimated. Shortly after capturing power, it recognised the presence of HIV, and set up the ACP to establish the extent of the disease's spread, transmission mode and strengthen the safety of the national blood bank. Later in 1992 the UAC was established by statute of Parliament and mandated to coordinate the development of policies and implementation of guidelines, forge the integration and harmonisation of efforts to combat HIV/AIDS and to monitor activities in the country. (Tumushabe 2005)

Uganda's success in tackling the pandemic is as a result of the state's leading role in formulation and implementation of appropriate policies backed up by shrewd and high level political commitment to HIV prevention and care where all sectors have almost been involved. Its argued that though the role of the state as agents of development continues to diminish, paving way for markets and in many cases NGOs, its argued that no matter how strong and popular the NGOs can become, the state will and still remains a regulator and ultimate arbiter of NGO activities. (Edwards and Hulme 1992). The state role has thus led to the active participation of religious and traditional leaders, community groups, NGOs, and all sectors of society, forging a consensus around the need to contain the escalating spread of HIV and provide care and support for those affected. Same day results and social marketing of condoms and self treatment kits, anti retroviral treatment, backed up by sex education programmes have had great impact on the reduction of the high infection rates. Not only have Local NGOs increased HIV/AIDS awareness, they have also provided assistance in form of counselling to PLWHA, food, shelter,

clothing, school fees, basic training and income generating schemes. (Tumushabe 2005)

Today the key justification for the increased reliance of governments, multilateral organisations and donor communities in using NGOs as agents of development, include among other things the belief that NGOs efficiently and cost effectively are able to implement projects in a sustainable manner, particularly close to the grassroots. (Marcussen 1996a). Literature further indicates that many donor communities prefer to channel their funding through NGOs more than the state. This is because NGOs are looked at as a means of getting benefits directly and cheaply to the poor than governments have been able to accomplish on their own. (Edwards and Hulme 1992). Local NGOs more than the state are considered to be very important in development work and especially in combating HIV/AIDS because of their capacity to reach the poor and out reaches to remote areas, a capacity to promote local participation and to implement projects in direct collaboration with target beneficiary groups besides being seen as innovative, hard working and good at targeting. (Marcussen 1996a).

Thus the combined efforts of the state and NGOs in Uganda has brought down the infection rates from 15% in the early 1990's to around 5% in 2001. At the end of 2005, 6.7% of adults (15-49) were living with the virus and 58% of HIV cases occurred among women (15-49) by the end of 2005 while about 91,000 people's lives have been claimed by the pandemic and an estimated 1,000,000 children have lost their mother, father or both parents to AIDS and who were alive and under the age of 17. (UNAIDS, 2006)

However, despite Uganda's success story in tackling the pandemic, prevalence rates in northern Uganda still remains high and considered the second highest, Kampala being one with the highest. According to statistics from UAC (2007), the Northern region including Gulu is put at 8.2% while Kampala with the highest at 8.5%. The prevalence rate in the rest of the country remains relatively lower.

The higher prevalence rate of HIV in northern Uganda has been argued to be as a result of a deadly cycle of violence and suffering of the Acholi people since the Lords Resistance Army leader Joseph Kony waged war on the government in 1986. Over 90% of the population in northern Uganda out of a total of over 300,000 people has been confined in over 200 IDP camps in Acholi sub region with a staggering 60,000 people occupying a single camp in some places. The global IDP project (2006) further estimates that two million IDPs are currently in Uganda; 16,000 children in 20 night commuter centres in Gulu and approximately 18,000 children abducted throughout the conflict.

Gulu has been referred to as home to the world's largest forgotten emergency and sub Saharan African longest running war, a region that has failed to taste the benefits of Uganda's development miracle. (Civil society organisation for peace in northern Uganda, 2006) "Where else in the world have there been 20, 000 kidnapped children, 90 percent of the population in large districts been displaced, children making up 80% of the terrorist insurgency movement" (Jan Egeland, UN secretary for humanitarian affair

This paper focuses on the argued case for local NGO strategies for combating HIV/AIDS in Gulu district. The success of the key strategies like community outreaches, partnerships and collaboration with other actors and involvement of PLWHA in combating the scourge that have been widely but also successfully used by two local NGOs studied in Gulu district. The situation of HIV/AIDS in the district and war as a main casual factor is argued out in the paper.

## **1.2 Justification for the Study.**

Local NGOs have been widely documented on their success in steering development work and especially HIV/AIDS in both urban and rural settings but very little on their role in management of HIV/AIDS in post conflict situations. The findings from this study will therefore attempt to provide appropriate practices for development actors intending or already dealing with HIV/AIDS in similar situations around the world.

Though literature has already suggested that HIV/AIDS is affected negatively by wars around the world by breaking all the social net works there are still gaps in information dissemination to development partners the vital role indigenous NGOs can and should play in tackling the scourge in especially post conflict situations. The findings attempt to stimulate thinking about the potential for timely and appropriate policies and intervention measures that are specific to people in post conflict situations.

There is no doubt that HIV/AIDS is a development issues that need not to be ignored any longer. This being so, Insight on the experience of Gulu district in tackling the pandemic will add knowledge to the still scanty literature in the Local and Regional Development Specialisation about the role of local NGOs in tackling HIV/AIDS and most specifically in post conflict situations.

Despite the size of the health consequences, military conflict has not received the same attention from public health research and policy as many other causes of illness and death. In contrast, political scientists have long studied the causes of war but have primarily been interested in the decision of elite groups to go to war, not in human death and misery. (Murray et al. 2002), this research attempts to bring the issue of HIV/AIDS out clearly and the role Local actors have played in such complex situation.

## **1.3 Aim of Study**

The study describes and analyses the key strategies employed by local NGOs in combating HIV/AIDS in Gulu district, a region that has since 1987 up till recently in 2005 been torn apart by war. The paper thus limits its study to the period after 2005.

Secondly it's an attempt to comprehensively document the situation of HIV/AIDS in northern Uganda and how the war has been a factor in keeping the prevalence rates high. The role and contribution of Local NGOs and other actors in combating HIV/AIDS in the district has also been well documented.

## **1.4 Research questions**

1. To what extent did armed conflict in northern Uganda contribute to current HIV/AIDS prevalence rates in Gulu District?
2. What key strategies have Local NGO's employed in tackling HIV/AIDS in Gulu district?
3. How successful are the strategies employed by local NGOs in combating HIV/AIDS in Gulu district?

## **1.5 Organisation of the Paper.**

This paper contains six chapters in total. Chapter two is a brief discussion of theories and literature that builds the theoretical atmosphere within which local NGO strategies for combating HIV/AIDS and the very situation of HIV/AIDS in the district are discussed; the next chapter locates the setting of the study area, further describing the genesis of HIV work and role of actors, whereas chapter four argues the case for the extent to which armed conflict has been key in HIV/AIDS prevalence rates. Chapter five describes and analyses the key strategies employed by two local NGOs, successes and limitations of the strategies in combating HIV/AIDS. The last chapter provides a brief conclusion to the study.

## **1.6 Research Methods.**

The researcher based the study on findings from both field and desk research. The study was conducted in Gulu district in the period July - August 2008. Gulu district was purposively selected because of its central location to the Northern districts and the fact that it had the highest number of IDP populations with a high HIV/AIDS prevalence rate. Primary data was gathered through face to face interviews from a total of thirty seven (37) respondents among whom included staff and clients of the target NGO's, Local Government staff and others from sister organisations and institutions like NGO's, Police and Hospitals. HAU and TASO were the two key organisations purposively selected for interviewing. This is because they had gained a lot of prominence and respect in the district for their long work on HIV/AIDS and secondly because they presented themselves as more formal organisations compared to other local NGOs combating HIV/AIDS in the district.

Focused group discussions were used to obtain vital information from Male support groups of People living with HIV/AIDS, women enrolled on the PMTCT program and members of the drama group at TASO. This especially helped very much in getting in-depth information about their involvement with the organisations under study and the impact of the organisations' interventions to their health, which would otherwise be limited if only one – on- one interviews were held.

Semi- structured interviews were conducted with individuals purposively selected from the target communities, the two local organisations under study,

the district officials and a few staff from sister organisations with similar/related interventions. The rationale behind this was to get first hand information directly from clients of the organisations under study, staff of the organisations and other key actors from the district and support agencies. Questions asked aimed at finding out key strategies of local organisations in combating HIV/AIDS and how successful these have been in not only bringing down the prevalence rate, but also managing HIV/AIDS cases, but also on the how the war has affected the population and led to HIV/AIDS.

Secondary information collected was mostly based on institution literature from organisations under study and international institutions like UNAIDS, UNICEF and World Vision, especially quarterly/annual reports/policy documents and internet based data and books.

Data analysis was mostly based on qualitative methods. The qualitative analysis is a comprehensive description of the situation of HIV/AIDS and war in Gulu district and the strategies employed by Local NGOs in combating the scourge. Analysis is guided by the key research questions for the study.

## **1.7 Research limitations.**

Some information especially on prevalence rate of HIV/AIDS over a period of 3-8 years and other vital information related to HIV/AIDS couldn't be obtained from the Gulu HIV/AIDS Focal Person. He claimed it got lost from the computer due to virus attack. The researcher did however manage to get a presentation by the Focal Person on the situation of HIV/AIDS and some more information from the office of the DDHS. Related to this is the lack of vital information especially from HAU. They have only so far one known documented annual report; that of 2004, thus much of what is documented in the findings is based on Interviews with the staff and beneficiaries of the organisations.

The thesis is limited to mostly description of efforts taken by two local NGOs in combating HIV/AIDS. This is because of lack of vital backup statistical information that would enable for deeper analysis, from HIV/AIDS related organisations and the state due to simply the fact that they didn't have any organised data base and also the little time used considering financial constraints on accommodation and other logistical requirements for fieldwork.

## **Chapter 2            Theoretical Framework**

### **2.1 Introduction**

Now that HIV/AIDS has been long proven as one of the major development challenges, Interventions by Local Organisations in HIV/AIDS work is a very much needed ingredient in steering development especially in conflict as well as post conflict situations. This chapter attempts to unearth theories and literature relevant to justifying the role of local NGO's and State in HIV/AIDS work. This research study premised its findings and discussions on state civil-society theoretical frame work and Community Driven Development Approaches (CDD). Also reviewed are theories on conflict and post - conflict reconstruction.

### **2.2 Community Driven Development approaches**

This is an approach that supports and empowers participatory decision making, local capacity building and community control of resources through its five pillars of community empowerment, local government empowerment, decentralisation, accountability and transparency (World Bank, 2004), literature indicates that many of the development efforts are initiated, promoted and implemented by various actors in development such as the state, donor agencies, NGO's and CBO's.

The CDD implementer and operational partners agree to the following principles that must be followed for effective delivery of services; Employ a well-thought through community planning process that considers the underlying causes of HIV/AIDS within the community; Maximize participation among community members in all decisions related to development intervention projects; Maximize voluntary community participation in and ownership over the project implementation process; Include capacity building within the community membership to implement and oversee the projects and ensure all permanent community resources like community centers, land have management structures in place; coordinate closely among other operational partners; Develop links to line ministry and local decentralized government as soon as feasible to ensure sustainability of interventions; Build in sustainability by promoting quality methodology through monitoring and evaluation processes (Corps 2004)

Some of the selection considerations for CDD should be based on areas of significant need for example many parts in Gulu that are already torn apart by war; areas with limited aid in recent years either from government international donor community or non state actors; and those that are less likely to have major interventions by agencies using supply driven approaches. (ibid)



## **STEPS, the community evolution model.**

Malawi has successfully used one of the CDD model referred to as Scaling-up HIV/AIDS Interventions through Expanded Partnerships (STEPS). The STEPs initiative assists local HIV/AIDS committees' with community mobilization and capacity building so that communities become empowered to act collectively to address their own problems. (World Bank, 2004)

Scaling up is a multi-dimensional process through which the impact of a community-driven programs is broadened and deepened. Dimensions of scaling up that have been identified include quantitative (physical replication); programmatic (new activities and programs); social (increasing the capacity of the community to engage in development activities, and mobilization of increasing numbers of local residents, including the vulnerable and marginalized); organizational (increasingly effective internal management and financial viability); and political (incorporation of the CDD approach by higher levels of government, and the direct entry of grassroots organizations into politics) (ibid)

### **2.3 State- Civil Society Theory**

A state embodies a system of law and government; a structure of offices with jurisdiction over a definite territory in which its citizens are located; and a centre of bureaucratic skills focused on information, calculation and implementation' (Tilly, 1986).

CSOs emerged in the 1990s as increasingly influential actors in national development. They became especially very prominent in one particular area, and that is the provision of basic services. (Clayton et al. 2000). It's further argued that a key influence on CSO involvement in service provision is the relationship with government, and this is critically reviewed in the context of the notion of partnership.

UNAIDS defines civil society broadly to include AIDS service organizations, groups of people living with HIV and AIDS, youth organizations, women's organization, business, trade unions, professional and scientific organizations, sports organizations, international development NGOs, and a wide spectrum of religions and faith-based organizations, both globally and at country level.

Civil society is also considered to play a key role in the consolidation of democracy, in checking abuses of state power, preventing the resumption of power by authoritarian governments and encouraging wider citizen participation and public scrutiny of the state. (Mercer 2002)

Since 1960, a dramatic shift in policy focus has taken place in which the role of the state has been drastically reduced. Previously, the state sought to control all levels of society, neglecting the development of civil society and its institutions. According to Secher (1996) decentralisation, democratisation and empowerment of the local population have gained ground. He further contends that the political vacuum left by a diminishing state has allowed advocates of the market and the private sector to claim them as the prime

agents of development. In many situations however, this has been left to NGOs rather than the market to fill the vacuum left by the state. “NGOs have experienced a dramatic growth in numbers and funding making them the most important factor in building civil society; supplementing, but more often replacing the state, opposing, or disengaged from state policies and strategies” (Marcussen 1996b)

In the past twenty years, there has been a growing importance of NGOs in steering development work. This can be seen from the increase in the aid channelled through NGOs, from \$2.7bn in 1970 to \$7.2bn in 1990 (Fowler, 1992), its estimated that NGOs today account for about 13% of the total Official Development Assistance (ODA), while also a steady rise in the confidence and reliance of multilateral organisations on NGOs for implementation of projects. According to Landell-mills (1992), forty four World Bank (WB) assisted projects in Africa were implemented by associated local NGO's, equalling 55% of all loans and credits accorded Africa in that year.

According to Korten (1987) “in an area of declining financial resources and deepening poverty both donors and national governments are looking to NGOs as a means of getting benefits more directly and cheaply to the poor than governments have been able to accomplish on their own. Many NGOs are becoming increasingly aware of their potential to command national attention and international funding, and of the need and opportunity to exert badly needed leadership in addressing people centred development issues within a broad policy and institutional context that donors and governments have too long neglected.” In fact as rightly put by Edward and Hulme (1992), there seems to be a mismatch between NGOs and the state. This according to them arises from the fact that government structures are rigid, hierarchical and autocratic. Power and control rest at the topmost level where programmes are designed and resources allocated. While NGOs are distinguished by their flexibility, willingness to innovate and emphasis on the non hierarchical values and relationships required to promote true partnership and participation. (Edwards and Hulme 1992) However they conclude that no matter how strong and popular the NGOs can become the state will and still remains a regulator and ultimate arbiter and determinant of the wider political changes on which sustainable development depends. (Ibid: 17)

Conventional wisdom contends that the comparative advantages of NGOs include; a capacity to reach the poorest, and outreach to remote areas; a capacity to promote local participation and to implement projects in direct collaboration with target beneficiary groups; a capacity to operate at low costs; a capacity to be innovative, experimental, adaptive and flexible and a capacity to strengthen local institutions/organisations to empower marginal groups. (Marcussen 1996b) in addition, Tender (1982) in Edwards (1995) to have stated there can be a comparative advantage if NGOs develop a much closer relationship with the population of a given area, which enables NGOs to strengthen popular organisations, respond to peoples needs, facilitate meaningful participation by beneficiaries and target their assistance at the poorest sections of the population. “Sensitisation is looked at as a key strategy for strengthening people’s involvement in their own development by raising

understanding and awareness of the causes of their problems and by increasing their self- confidence, ability to assert their own point of view and pride in their cultural identity.”(Edwards and D.Hulme 1995)

The key justifications for the increased reliance of governments, multilateral organisations and donor communities in using NGO’s as agents of development include among others the belief that NGO’s efficiently and cost effectively are able to implement projects in a sustainable manner, particularly those close to the grassroots, and that, consequently, donors increasingly look to them for implementing projects, making still larger amounts available. (Marcussen 1996b).`a similar view as in (Thomas 1992). More so, when also allowed to operate freely and independently from state interference, it increases the freedom of NGO as actors in civil society for development of localities. (Ndegwa 1996). He does however add that much as this is so, there is need for local NGOs to liase with Local governments and also ensure there is active coordination. Lack of coordination it’s argued can lead to “NGOs duplication of work, reinvention of solutions, and general lack of information exchange which according to Ndegwa showed a more important indication of their disorganisation” (Ibid)

## **2.4 Conflict and Post Conflict reconstruction**

Political instability and war affect people and their vulnerability to HIV/AIDS in many ways. First of all it disrupts society and erodes its social institutions. It also splits families up, destroys the social status of people and causes them to be uprooted and displaced. These are outcomes that destroy self-esteem and the morale of the people caught up by them, placing people in social and psychological situations where they are easily at risk of HIV and other “social diseases” associated with the loss of place, status and tradition. “War and upheaval destroys self esteem of uprooted people and clamp for coping mechanisms that are sometimes risky..” (Carballo and Solby 2001)

Armed conflict between warring states and groups within states have been major causes of ill health and mortality for most of human history. Health consequences like HIV/AIDS from the displacements of populations are mostly as a result of the breakdown of health and social services, and the heightened risk of disease transmission. More reason to worry is the rate at which Gulu region has opened up to trade with neighbouring Sudan , where as argued, health workers are worried that unless information about HIV reaches these already vulnerable populations early enough, they will be ( health workers) unprepared for the possibility of a rapid spread of HIV. (Murray et al. 2002).

Literature further indicates that populations destabilised by armed conflict in Internally Displaced People’s (IDP) camps especially women and children are at increased risk of exposure to HIV infections (Spiegel, 2004). The break down in social structure, lack of income and basic needs, sexual violence and abuse, lack of health infrastructure and education are identified as factors that increase the vulnerability to HIV infection in conflict areas, Gulu being no exception to this situation.( Spiegel et al., 2002 in Spiegel 2004). Because of armed conflict, IDP’s are highly vulnerable to sexual predation by those with

food or money and to rape by those with weapons. In such complex emergencies like the northern war, women and girls have used survival sex with men who have food or money to avoid starvation for themselves and their children (Hankins, Friedman e'tal, 2002)

According to a document by the CSIS and the Association of the United States Army (AUSA) on post conflict reconstruction (2002), Countries emerge from conflict under differing and unique conditions. Thus as argued by the publication, the priority, precedence, timing, appropriateness, and execution of tasks will vary from case to case by different actors in development of the affected locality.

CSIS contends that while reconstruction must lie with indigenous actors in this case Local NGOs and Local Governments, international intervention is often critical during the early stages of post-conflict transition. Not surprisingly, initial response is often characterized by military intervention for basic security, stability, and emergency services. The second phase, transformation, focuses on developing legitimate and sustainable indigenous capacity, often with special attention to restarting the economy, establishing mechanisms for governance and participation, and securing a foundation of justice and reconciliation. The final phase, fostering sustainability, consolidates long-term recovery efforts, often leading to the withdrawal of all or most of the international military involvement. It is this phase that also lays the foundation for the prevention of conflict and the re-emergence of violence. These phases occur over a time span that varies according to local conditions and by each individual task. As such, this framework should be read horizontally as transitions are task specific. Comparing different tasks vertically is misleading because not all of the tasks that appear in a given phase will occur at the same time. The framework also assumes that some phases, such as the initial response, which entails humanitarian aid, may well overlap into the period of transformation. Likewise, fostering sustainability, the path toward normalization, may also emerge during the transformation time frame.

The CSIS provides comprehensive four key pillars for post conflict reconstruction to be successful. These are security; justice/reconciliation; social/economic well-being; and governance/participation.

**Security.** Addresses all aspects of public safety, in particular establishment of a safe and secure environment and development of legitimate and stable security institutions. Security encompasses the provision of collective and individual security, and is the precondition for achieving successful outcomes in the other pillars. In the most pressing sense, it concerns securing the lives of civilians from immediate and large-scale violence and the restoration of territorial integrity.

**Justice and Reconciliation** addresses the need for an impartial and accountable legal system and for dealing with past abuses; in particular, creation of effective law enforcement, an open judicial system, fair laws, humane correction systems, and formal and informal mechanisms for resolving grievances arising from conflict. These tasks encompass the provision of mechanisms to redress grievances, exact appropriate penalties for previous acts, and build capacity to promulgate and enforce the rule of law.

Incorporating the concept of restorative justice, they include extraordinary and traditional efforts to reconcile ex-combatants, victims, and perpetrators.

**Social and Economic Well-Being** addresses fundamental social and economic needs; in particular provision of emergency relief, restoration of essential services to the population, laying the foundation for a viable economy, and initiation of an inclusive, sustainable development program. Often accompanying the establishment of security, well-being entails protecting the population from starvation, disease, and the elements. As the situation stabilizes, attention shifts from humanitarian relief to long-term social and economic development.

**Governance and Participation** addresses the need for legitimate, effective political and administrative institutions and participatory processes; in particular, establishing a representative constitutional structure, strengthening public sector management and administration, and ensuring active and open participation of civil society in the formulation of government and its policies. Governance involves setting rules and procedures for political decision-making, and delivering public services in an efficient and transparent manner. Participation encompasses the process for giving voice to the population through the development of civil society that includes the generation and exchange of ideas through advocacy groups, civic associations, and the media.

## **Chapter 3      The Setting**

### **3.1 Introduction**

This chapter presents key issues on the social-economic characteristics of Gulu district and other demographic information about the district in general and on HIV/AIDS specifically. The chapter also goes as far as narrating the genesis of HIV/AIDS interventions. The chapter concludes with a brief profile of the two local NGOs studied.

### **3.2 Gulu District at a Glance.**

Gulu is one of the major districts that form the greater Acholi sub-region in northern Uganda. It has a total land area of 3,449.08 sq.km, making 1.44% of the national land area. The district is bordered by Kitgum District in the North East, Amuru District in the West, Oyam District in the South, Lira District in the South East and Pader District in the East. The district headquarter is 332 km by road from Kampala. The district is made up of eleven (11) sub- counties and four divisions premised within the municipality. The district has a projected population of 343,651, whereas it had a total population of 298,527 in 2002. (Uganda National Census, 2002) the annual population growth rate is 3% with an average household size of 5.1persons. (Luwa 2007)

The last two decades in Northern Uganda and Gulu in particular have been marked by untold suffering, loss of lives and property due to a deadly rebel armed conflict led by Joseph Kony of LRA. The war heightened in 2004 and led to mass displacement of the Acholi people into IDP camps. These camps are characterised by appalling living conditions, hunger, disease, lack of education, poor sanitation and lack of water, medication services, and other social amenities and house hold and community poverty. This situation has increased the vulnerability of the Acholi people to HIV and AIDS particularly girls and women.(International Agency for Migration 2006). Their condition as observed was made even very unbearable by their inability to walk even a kilometre outside the camp due to fear of rebel attacks. (Irinnews Sept 2008). No wonder that the UN under secretary General for Humanitarian affairs Jan Egeland has regarded the situation in the Sub region as being “among the worst and most forgotten humanitarian disasters in the world.” (Icg 2004)

Peaking the gruesome character of the conflict is the abduction of people who are then used as porters, combatants and sex slaves. The social-cultural norms and values were broken down, mutilations and serious psychological/traumatic acts were the order of the day. Schools had to close or be relocated in safer places, health centres, roads and other social amenities were not functional at the time.

Despite all this, the district and the greater northern region received some relative peace at the signing of the cease fire agreement in 2005. This saw the renewal of the peace negotiations under the chairmanship of Riek Machar, the Southern Sudanese Vice President.

However, it's still too early to say whether peace will finally come to the people of northern Uganda. This is because the rebel side of the peace negotiation team till now has not signed the final peace agreement that will climax the issues on agenda and the ushering in of peace to the people of Gulu and also enabling them to return home from the IDPs without fear of further conflict.

At the moment the district has already started encouraging and facilitating people to return to their original homes. This started initially with decongestion of the camps into small satellite camps to allow for better living conditions and preparation to returning home. As of 2006, only 10% of the IDP population had resettled back to their original homes while about 30% percent were in the process of resettlement, leaving the huge percentage (60%) still settled in the camps. (Luwa 2007)

### **3.3 HIV/AIDS interventions.**

#### ***3.3.1 Genesis of HIV work in Gulu***

Despite the fact that in many parts of the country, interventions in HIV/AIDS in the area of prevention, care and support had taken shape, Gulu District was still lagging behind due to the ongoing war at the time. The first counselling unit in the whole of Gulu district was established in 1991 by Mrs. Florence Opoka, a trained counsellor and a nurse by profession with a few other medical personnel. Though Lacor hospital had already started some interventions in HIV/AIDS like treatment of Tuberculosis and other opportunistic infections, it hadn't started delving into a vital component of HIV/AIDS intervention- counselling and even then, its services had not been widely popularised.

According to Mrs. Florence Opoka, a key respondent, due to the high level of stigma, people feared to come out openly due to fear of suffering from an incurable and very shameful disease. So, convincing clients to test became virtually difficult for the Opoka team in the hospital. People whose illnesses failed to cure were brought to the counselling room where they were convinced to have an HIV test. "That is how we started registering HIV positive people" reveals Opoka. In her narration she admits that she could do the work better with an HIV positive person if well trained. That is how she and the hospital administration contacted ACCORD, the only NGO in the district at the time for support.

The initiative to train the three men and twenty two women who had accepted to disclose their viral status took off with full support from ACCORD and trainers from the Philly Lutaaya initiative- an HIV positive living group led by Philly Lutaaya, the first prominent Ugandan to give HIV/AIDS a human face in 1989. After the training, the group was later to become the ambassadors of hope in the various communities within the district, talking about prevention and the need to come out to voluntarily test for HIV.

“One of the trainers, a young beautiful lady disclosed her status at the end of the training before a shocked and surprised team of participants” Mrs. Opoka.

As a strategy the HIV unit schemed public functions and radio programs to disseminate information, not only about available services but also on the dangers of the scourge and the advantages of VCT and disclosure. This didn't however do much in breaking the ice of stigma and detest towards the counsellors, but the food aid got from INTERAID, an organisation based in Kampala at the time, financial and logistical support from UNDP attracted record numbers of PLWHA.

The above strategies saw record numbers of people from all corners of the district; both men and women (but mostly women) turn up for the services at the hospital. The need to train another 35 clients who accepted to disclose arose, making the total of all those trained in basic counselling skills rise to 60 counsellors. Outreaches were established in the communities where once a month staff from the center would go with drugs, and food accompanied by two or three counsellors and a medical personnel. Sensitisation about HIV/AIDS would be on the agenda for the day, besides food and drug distribution to clients.

When the number of disclosed clients cloaked over 1000 in 1992, it became visibly difficult to contain them in the small room that the hospital was operating from. On the visiting day for clients, everything else at the hospital would come to a stand still, and because of this the hospital administration suggested that the counselling team led by Mrs. Opoka registers as an independent organisation.

### ***3.3.2 Situation of HIV/AIDS in Gulu.***

Although Uganda had received international acclaim for national HIV/AIDS prevalence rate, the country was slowly loosing out on these gains as the war continued raging on, making people very vulnerable thus highly susceptible to HIV infection. (Anderson et al. 2005)

Records from the district HIV/AIDS focal person show that about 11.9% of the general adult population in the district is living with the virus that causes HIV/AIDS. This thus translates to about 42,086 persons living with HIV/AIDS in the district. The remaining 88.1% of the 311, 577 people presumed to be HIV negative logically need preventive services to avert further spread of the virus, while treatment, care and support for those with the virus already takes shape. (Luwa 2007)

The main sources of new infections are coming from marital sex rated at 42%, followed by mother to child infections at 21%. Casual sex and commercial sex according to the report seen by the researcher, is put at 14% and 22% respectively. Prevalence rates are high among women and girls as compared to men and boys, but also high among young people between 08 years to 35 years old. The large incidence of vulnerability among IDP communities who were reduced to dependants on food, enslaved and confined to IDP life has brought out hunger as the single largest risk factor to HIV/AIDS in the district. (Ibid)



Other potential risk factors included, but were not limited to inadequate prevention programs targeting men, lack of focus on programs for married and cohabiting couples, very few and moreover urban centred programs emphasising positive prevention and positive living. As Spiegel rightly states in his article (Spiegel 2004) “conflict, displacement, food insecurity and poverty have the potential to make affected populations more vulnerable to HIV transmission. ...”

### ***3.3.3 Key Actors in the fight against HIV/AIDS.***

The role of both the government and Civil Society organisations at local, national and international level is seen as very vital in combating the scourge in the district. this is strongly supported by already existing literature suggesting that partnerships between governments and CSO is key influence in bringing change especially in the area of social services provision (Clayton et al. 2000). The district has seen the largest humanitarian interventions and NGO presence ever in the last fifteen years compared to any region in the country, but with nothing much done in the area of HIV/AIDS, partly due to ongoing war and emergency relief operations taken as priority at the moment. NGOs in Gulu are far stronger than Local government As in (Marcussen 1996a), the political vacuum left by a diminishing state has allowed advocates of the market and the private sector to claim them as the prime agents of development. Thus increasing efforts have been made to build grass root organisations in form of CBOs and Local NGOs. Marcussen (1996) further argues that due to increased numbers and funding for NGOs, they have become the most important factor in building civil society, supplementing but most often replacing the state, opposing, or disengaged from state policies and strategies.

In the post conflict situation however more interventions are now being redirected towards among other things HIV/AIDS since the cessation of hostility agreement in 2005 between government and the rebel forces. The question of the day thus is whether their strategies have been successful in combating the scourge since there are no very many organisations claiming to combat HIV/AIDS in the district.

Key actors supporting the provision of HIV/AIDS services in Gulu include; Government departments/institutions such as DDHS, hospitals/health centres at the counties and sub counties (centre 4 and 3 respectively). There are three major hospitals in the district. That is; Gulu regional referral hospital, Gulu Independent, the Army 4<sup>th</sup> division hospital and Lacor hospital. (The last three are private); UN Agencies mostly take up the supportive role to government and local NGOs/Institutions These include WHO, WFP, UNICEF and IOM among others; International NGO's such as Save the children alliance, WV, AVSI- an Italian agency, Christian Relief Services; National NGO's include Joint Clinical Research Council, TASO, Family Planning Association of Uganda, Northern Uganda Malaria Aids Treatment, Vision in Action; Local NGOs/CBO's include HAU, Gulu Youth Center, Walokokwo, Dyeretek among others and other actors include private for profit partners and traditional practitioners.

The organisations mentioned engage in the numerous HIV/AIDS activities much needed by the people in the district either directly or through partners and individual community groups. The activities include among others VCT, STI prevention and management, Adolescent Sexual and Reproductive Health services, Youth friendly services, Infection control, PMTCT, ARV management, Community Based Health Care services, Psychosocial support, Nutrition support, Palliative care, Orphans and Vulnerable Children services and treatment of opportunistic infections. (Luwa 2007) As of march 2007, the district had sixteen testing centres, eleven (11) PMTCT sites and seven (7) Anti retroviral centres, all of which are either owned/run by government or NGOs. (Ibid)

### ***3.3.4 Existing Policy Guidelines and Structures of operation***

Gulu district follows the same guidelines in HIV/AIDS prevention, treatment, care and support as stipulated by the WHO and adopted by relevant national organs like the MOH and UAC among others. Some of the policies in Uganda include the drug regiment policy, the PMTCT policy guidelines and HIV/AIDS workplace policy.

HIV/AIDS activities within the district are monitored and coordinated through well laid structures at the district. The district has a functional district Aids committee supposed to meet quarterly and bi- annually respectively; the HIV sector working group, a sub committee of the DDMC which meets monthly. UNASO is an umbrella for all organisations with interventions in HIV/AIDS. It's mandated to regulate and monitor operations to ensure that NGO activities are not exploitative and that they yield results.

The NGO forum in Gulu is a membership institution formed in 2001 as a voluntary, non partisan umbrella network organisation to enhance lobbying and policy dialogue with local governments; promote networking and information sharing among CSO's, including carrying out capacity building in terms of trainings. The forum draws its membership from NGO's, CBOs and FBO's operating in Gulu district. The 1995 constitution of Uganda guarantees the right of every Ugandan to engage in peaceful activities to influence the policies of Government through civic organisations. Similarly, the Local Government Act 1997 specifically provides CSO with an important role in service delivery at community level. (UgandaGovernment June 2008)

The district also has an HIV/AIDS Focal Person who is responsible for the supervision and follows up on HIV/AIDS activities in the district, collecting of and profiling all data related to HIV/AIDS, including updating and dissemination of the most current data.

### **3.4 Brief Profile of the Two NGO's Under Study.**

#### **3.4.1 TASO**

TASO is the single largest indigenous NGO providing HIV/AIDS services in Uganda. The organisation has eleven (11) service centres spread in various regions of the country, with fifteen (15) mini TASO's within the country in parts that are out side the catchments areas of 75km from the nearest service center.

The organisation was founded in 1987 by Noerine Kaleeba and fifteen (15) other colleagues, some of whom have now been claimed by AIDS. The founding of TASO was based on people unified by common experiences faced while encountering HIV/AIDS at a time of high stigma, ignorance and discrimination. Being either directly infected or affected by the scourge, they took time and their own resources at the time to visit the sick, carrying them to hospital and some times providing basic material and counselling support. (Taso 2008b)

TASO Gulu is one of the major centres established in 2004 following a baseline survey in 2003 whose results indicated the region as viable for TASO's intervention. It was started by twenty seven (27) pioneers among who were counsellors, medical team and other officers. In 2004 its projected number of 500 clients by the end of the year met a shocking and overwhelming turn up of clients that saw the figure shooting to 3000 clients at the end of the year. *"When people heard that TASO is coming to Gulu they sprung up in record numbers..."* notes the manager. The manager further reveals that the organisation has a total of over 10,000 clients and 75% of whom are women.

Since its inception in Gulu, TASO has been engaged in treatment, basic prevention, care and support services to HIV clients at the center and their outreaches spread throughout the district. Counselling to TASO is very important and the magic bullet that catapults clients to positive living, drug adherence and disclosure of own status.

#### **How does one become a client?**

Before one becomes a TASO client, he/she has to undergo a confirmatory test from the center that proceeds his/her earlier testing from VCT centres which initially declared him/her HIV+. Once confirmed positive by TASO, a file is opened and the client is given a registration number which is used to identify him/her. After which a CD4 test is taken to see if the client is eligible for ant- retroviral or not. Septrine prophylaxis is started on the client immediately she/he registers with the organisation to guard against opportunistic infections and other complications. There is no client ceiling at TASO, and because of this a first in- first out approach was taken to manage the ever increasing number of clients.

### ***3.4.2 HAU***

HAU is a child focused local NGO established on 15<sup>th</sup> July 2004. The organisation since inception has championed the lead in promoting the right of HIV positive children by enabling them access to adequate treatment, care and support. Health Alert came in at a time when most agencies were looking at emergency relief and others already active with HIV were focusing on adult populations and very little to children with HIV/AIDS.

In the same year of 2004 the agency was already active with mothers living with HIV/AIDS, providing PMTCT services. The organisation currently has 1273 child clients compared to the initial 67 in 2005. The organisation works in collaboration with treatment centres earlier mentioned and links the children with the health facilities. HAU is also engaged in advocacy for early access to treatment and care for HIV positive children and a champion now in the involvement of male clients in the fight against HIV/AIDS within the district.

HAU operations are in the districts of Amuru (a recent break away from mainstream Gulu) and Gulu district. And are in close working relationship with existing local government structures in the sub counties, parishes and villages. They cover all the divisions within Gulu municipality and work with Gulu referral hospital, fourth division hospital, Gulu Independent hospital, Lacor hospital and other private entities like TASO.

## **Chapter 4 The case for armed conflict and HIV/AIDS rates in Gulu district.**

### **4.1 Introduction.**

Chapter four presents description of the various factors behind prevalence rate of HIV/AIDS in regions during war. Though at the time of this study the region was enjoying relative peace after a long war that lasted almost two decades, the impact of the unrest cannot be undermined when it comes to talking about the high prevalence rates of HIV/AIDS. Gulu ranks second to Kampala in prevalence rates of HIV/AIDS compared to all other districts that have lower rates as will be explained. This chapter argues that the presence of war that just ended in 2005 explains the higher prevalence of HIV/AIDS in the district and the task NGOs have in combating it.

### **4.2 Armed conflict as Casual Factor to HIV/AIDS.**

Armed conflict has been pointed out as a major lead to higher rates of HIV/AIDS in Gulu. The HIV/AIDS focal person in the district intimated that though there is a slight decrease in the rates of HIV/AIDS among adults, the prevalence rate is still high among children. Though however he couldn't still deny the fact that Gulu district still holds the second position. Different sources have justified the same contention so far. According to (Luwa 2007), Gulu is at 11.9% compared to the 12% in Kampala, while according to Uganda Aids Commission (April 2007), the HIV/AIDS prevalence rates in Gulu remain higher (8.2%) only second to Kampala (8.5%) compared to the averagely lower (6.9% in the south, 3.5% in the east and 2.3% in westnile) prevalence rates in other parts of the country. (Kindyomunda et al. April 2007)The contrast in figures though does lead to the same contention that HIV/Aids rates are higher in the north.

Literature shows that between 8% and 10% of those living with HIV/AIDS globally are also affected by armed conflict (Unicef and Unhcr 2006: 3).Can it be thus concluded that armed conflict has been a factor? According to a paper compiled by Kindyomunda for UAC (2007), "conflicts and civil strife usually lead to displacements that hinder delivery of HIV/AIDS services to displaced communities" the same paper further argues that sexual violence that mainly affects women and young girls through rape/defilement is the making of armed conflicts that creates a lawless environment for the civilians at the expense of both rebels and government soldiers in the case of Gulu. According to a conference report by UNICEF and UNHCR (2006) though there is no evidence of rape affecting HIV prevalence in camps, at individual level, many social, behavioural and biological factors increase the risk of transmission of HIV to girls and women who are raped. Field based findings have suggested that the military and rebels who are mostly the rapists/defilers have a higher HIV/AIDS prevalence.

#### ***4.2.1 IDP situation and HIV/AIDS.***

Respondents the researcher spoke to concurred that forcing people to leave their homes and go into the camps was the beginning of their suffering and start of destitution and frustration. The community development officer of Bobbi told the researcher that for any one who refused to leave their homes would be considered a rebel collaborator, and that the soldiers would later come and harm or even kill them in the night. With this the over 90% of the entire population in the entire Acholi land had no option but to go to the camps. In fact most of the respondents interviewed from the two organisations seemed to suggest that many times their outreaches have had to be cancelled or even delayed due to security tensions. Worst of all, HIV/AIDS services in communities like Bobbi and Pabbo, the largest camp before de-encampment had to be withdrawn!

According to the Civil Society Organisation for Peace in Northern Uganda (2006). The camps situation has been considered the worst habitable place for humanity and home to the world's largest forgotten emergency and SSA longest running war, a region that has failed to taste the benefits of development in Uganda. As observed during the fieldwork and previous interventions in the IDPs, the houses are constructed very close to each other so much so that one can barely walk between two huts. No mention of a compound! In the past the Acholi had pride in their culture, in their wealth and in their land. Interestingly, according to Mr. Obutu, the director of HAU, every evening they would sit around a fire place as they chat events of the day, play musical instruments. Elderly Acholi people, mostly male would use this opportunity to pass on to their younger generation the customs, norms of the clan through story telling. "People used to be free to move, to attend functions in distant places, look after gardens and rear livestock. Now this is history!" Reveals Mr Obutu. Jan Egeland, the UN secretary General for Humanitarian affairs wonders.

"Where else in the world have there been 20,000 kidnapped children, 90% of the population in large district been displaced, children making up 80% of the terrorist insurgency movement"

Once in encampment, IDPs are barred from going out of the camp, even for a kilometre, cannot have gardens of their own as there is no space except that which is limited to renting land from local owner which is practically impossible given the poverty situation. So some struggle to have small vegetable gardens on the peripheries of the camps. The IDPs are solely dependent on relief aid in terms of food and other materials like blankets, household utensils and tarpaulins used to cover their leaking hut roofs. Given the situation above as literature suggests, the people in the camps become very vulnerable and are at an increased risk of exposure to HIV infections (Spiegel, 2004). This is so, because the war broke up the once cherished social structures (Ibid)

With no schooling and no income-generating activities to occupy them, youths in the camps have become idle, left to self-destructive practices like drinking, unprotected sex, and early marriages. Their continued stay in the camps is slowly destroying what little is left of their dignity. (IRIN news

August 2008), due to this level of social breakdown, girls as young as 10-12 according to respondents have traded their bodies for sex at a cost more or less than 5 euro cents as also supported in Hankins, Friedman e 'tal (2002)

Respect for elders among the young generation is no more. Findings showed that it's very hard to instil discipline as they interact with people from different communities all squeezed together. They see bad habits done by other families. Worst of all they are confined to sharing one single hut together with their parents, which is what, is allowed for in the camp. Girls and boys, mother and father in one small round grass thatched hut. Cases of sexual abuse among the children and between parents are not uncommon. Men and women spend a lot of time idling, with nothing to do, they resort to drinking local beers and gins, and wait to return home and terrorise the family while some are enticed to engage in risky sexual behaviours that have led to HIV/AIDS incidence. Rampant hunger and low or even total lack of income in the households among the camp population means that young girls will accept sex for small amounts of money or favours. Surely in such a situation where social structures have been broken to great length HIV/AIDS infections can be prevalent. According to Alfred a CDO, people have information about HIV/AIDS, but knowingly go in for people living with the virus, just if they can give them food for the next day.

#### ***4.2.2 Armed Conflict, Lawlessness and HIV/AIDS***

Lawlessness in the district during armed conflict has seen record numbers of rape and defilement cases many of which pass on unreported for fear of reprisal from the attackers who are mostly government soldiers. These stories the respondents say only come out when victims are taken for medical check up.

The researcher interviewed three clients raped by both government soldiers and rebels. One such case that was most saddening is of Georgette (not real name) now 15 who was raped at age 12 by a government soldier in the presence of her mother.

“On that fateful night I slept with my mother in the house as our dad did not return that night. The soldier came and demanded my mother to hand me over so I can direct him to where the other girls are living. When my mother refused he beat her severely with the brut of the gun he was holding and threatened to shoot her. He forcefully pulled me out of the bed and walked with me through out the night, warning my mother not to follow. We reached an empty hut where he threw me down and raped me and afterwards dumped me for dead. Later on I tested positive for HIV from Gulu regional hospital. I am the only child in a family of two sisters all married and five brothers with HIV/AIDS, not even my parents have it. Coming to this organisation has helped me a lot on stigma and isolation since I play and interact with other positive children every Sunday when we meet here.”

December, a staff of HAU Uganda, told the researcher that many of those hard hit by HIV/AIDS communities are those within or near army detaches. He revealed that there is a higher prevalence of HIV in Bobbi (a camp 12 kilometres from Gulu town) because their used to be a big army detach and

that the biggest number of children and women with HIV/AIDS come from Bar-dege division, being that its the home to the fourth division army command post where mostly the population is of soldiers who are feared to be living with HIV/AIDS. Thus according to the online South African News web site, it quoted the Uganda Aids Commission director as saying “the mobility of servicemen and the stress of their jobs were seen as factors to the high rate of HIV/AIDS among soldiers” From the findings, this seems to be true especially where its argued that soldiers in Gulu are rotated within camps across the whole region.

“A group is in Pabbo today, tomorrow you find it in Unyama and the next day it’s somewhere else. In each of the camps they get wives or even rape girls and women, so at the end of the cycle if the soldier is infected, what happens?” wondered December. He added that soldiers always boast of risking with the bullets, what about the HIV which is even not going to kill them in one day!

As can be already seen in the descriptions above, armed conflict has to a larger extent contributed to the spread of HIV/AIDS in the IDPs. If social structures that bound the Acholi people together are broken, if there is lawlessness permitting rape/defilement, if there are high levels of vulnerability and desperation among IDPs due to confinement and no productive work, drinking themselves mad, engaging in very risky sexual behaviours and if local organisations due to insecurity couldn’t reach their targets with information and support during conflict, what then can better explain the rise in HIV/AIDS prevalence rate in post-conflict Gulu district? Of course other causes factor in, but all in all the war of almost two decades is surely to blame.



## **Chapter 5 Local NGO Strategies for Combating HIV/AIDS.**

### **5.1 Introduction**

In chapter five, the researcher endeavours to describe and analyse three main strategies the two local NGOs in Gulu have employed in combating HIV/AIDS. The chapter also attempts to discuss whether or not the strategies have been successful in first of all reducing infection rates and secondly helping those already living with the HIV/AIDS cope and live long healthy lives. The strategies are a representation of the two local NGOs – HAU and TASO. These include; involvement of people living with the virus as models in combating the scourge; community based outreach programs and; partnerships/collaborations with state and other non state actors.

### **5.2 Involvement and participation of PLWHA**

Literature has shown that active involvement of and participation of key beneficiaries has a comparative advantage of NGOs working with local communities. This as stated “enables NGOs to strengthen popular organisations, respond to people’s needs more efficiently and more effectively. (Marcussen 1996a). While HAU has specialised in involving mostly children living with HIV/AIDS, they also consider and actively involve their caretakers (mothers formerly on PMTCT program) and men (notably fathers to the children supported by the organisation). TASO from the start has considered dealing with all categories of clients with special attention to children as well. The target population is of PLWHA who are encouraged to act as models in their communities and take up the work of sensitisations, mobilisation, basic counselling and treatment and reporting emergency cases among others.

While the involvement of PLWHA is considered of worth generally, Male involvement in combating HI/AIDS in the district has been greeted with excitement and success. This has been the one unique strategy that has seen tremendous improvements in welfare of households, and increase in disclosures, adherence to drugs and record numbers in VCT. Men not only get involved in preventive measures in the community, but also care and support their wives and family already living with the virus. HAU refers to them as MSGs, though women are equally involved. While to TASO they are POMO.

#### ***5.2.1 How it is done.***

The PLWHA, both men and women who are already in one way or other beneficiaries in the organisations are identified and encouraged to undergo training. They get skills and knowledge on adherence, PMTCT, Tuberculosis, basic counselling and mobilisation skills and prevention messages against HIV/AIDS. TASO started by training the first 20 people in those skills and the numbers have since gone up. HAU has so far now trained over 40 male clients in similar skills and empowered women on PMTCT with ways in which

to guard against MTCT before birth, during birth and after birth and they are asked to pass on the same information to other women in the community. The national ART policy states that all pregnant HIV+ women are eligible for free ARVs during pregnancy to avoid MTCT.

The groups are further supported with material support in terms of ox ploughs, crop seeds and capital for revolving funds among them. The ox ploughs are rotated among the members with larger gardens. This has quite eased their work and lessened the stress to the already weak bodies. So far in health alert five out of the seven MSG have been supported with seeds and use two ox ploughs in turns among the PLWHA families and within the target sub counties. This support is meant to encourage self support for the already weak and vulnerable community members besides the vast support they get from the organisation in terms of treatment, replacement feeds and milk support for women on PMTCT and provision of counselling and guidance.

TASO recruits male directly as they register to become clients. They are counselled and asked if they would be willing to disclose their statuses to their fellow clients and if possible to become members of POMO. On acceptance they are led to the head of the group who gives them orientation. In HAU Uganda they mostly target husbands to mothers on the PMTCT program. Just like in TASO, they are encouraged to disclose their status as this would help them live a happier and longer life.

In 2006 the initial meeting for men started with 37 men and their wives on milk support and PMTCT being invited at HAU to convince and encourage them become ambassadors in combating HIV/AIDS in their communities, but also to support their wives. From 37 men in 2006 to over 600 in seven (7) support groups across the district is evidence of the efforts put in by HAU. In each of the sub- counties that they operate in, there is are MSG's. TASO boasts of over 170 under POMO by the end of 2007. (Taso 2008a)

“We men realised that many of our colleagues were suffering and dying in record numbers largely due to self denial/stigma in the face of their wives who had long declared their status and were already receiving medication and other forms of support.” Mr. Oloyo, Member of POMO.

According to December, Jackie and Jennifer, all staff of HAU during a FGD, MSG were asked to be models in their communities and become ambassadors on prevention against new infections. They were also tasked with roles of mobilisation of community members for sessions on HIV/AIDS, VCT, PMTCT program, visiting homes of PLWHA to ensure adherence to drugs and refilling for them, but also encouraging those that had not yet disclosed their status how important it is to do so.

The director HAU Mr. Obutu explains that the MSG and CVC in order to win the acceptance of members to support their wives and to encourage disclosure as a best way to prevention, they first create rapport in the families after the woman has reported the case of refusal to go for VCT or support from a man on PMTCT. They would visit the home and talk generally about issue of HIV/AIDS and the need for families to know their viral status. At the end of about three or two visits they would encourage their fellow man to go for a test. In case he refuses, they request if his wife (who already tested

positive) can go and test. The husband in this case will be very interested in knowing the results of the wife to which now the MSG will sit them down and prepare the man to not only receive but also accept the results. Then the new converts are taken through a process of orientation into how to survive and be happy with the infection. Mr. Obutu does however agree that some times it gets mad, to the extent of family separation or involving local leaders to arbitrate in issues between the man and his wife.

Disclosure is no easy thing for many of the clients talked to and counsellors who facilitate the process. As many of the community members especially men struggle to cope with the HIV/AIDS pandemic, they are stressed up with stigmatisation and discrimination from fellow community members. Members of the male support group during FGD concurred that the men and other community members who point fingers at them are the prime spreaders of the dreaded HIV/AIDS. Their argument is based on the fact that if they cannot not still be strong enough to disclose their status while all signs show they might have the virus, but continue secretly encroaching on young girls and women in the community, there is no doubt that they are spreading it. They agree with the contention that if somebody discloses his or her status, then whoever wishes to engage in an unprotected relationship with him/her does so at their own risk.

Clients as well as counsellors truly agreed that it takes time for a client to appreciate the need to disclose his/her status. Men are mostly afraid of stigma, and disrespect from the extended family. For women the greatest deterrent is their husbands, especially if they are married. Their husbands threaten to divorce, abandonment and some times beating them. What the researcher was also told, is that many people in the camps who depend of relief aid, would disclose their status as a requirement for being enrolled in the special food program for PLWHA.

So, as models and ambassadors, PLWHA in the described groups walk through their respective villages/camp monitoring drug adherence, drug refills, counselling couples and their families, handling petty family conflicts related to HIV/AIDS in the home among others.

### ***5.2.2 Success and Limitations of the strategy.***

Involvement of PLWHA in combating the scourge has to a great extent been rewarding in terms of getting the people more aware of their status and how to live positively, high rate of drug adherence and reduction in new infections through VCT, PMTCT and aggressive sensitisation campaigns and testimonies by PLWHAs themselves. PLWHA with HIV/AIDS have been actively and directly involvement to participate in helping out their fellows.

According to the 2004 TASO annual report, out of the 3000 registered clients in that year, 2374 were able to reveal their status, 76% of them Female and the rest( 24% male), while in 2005 and 2007 the rate of disclosure has been at 3.5% of the total number of clients who received services at the TASO center. Further statistics indicated that the rate of clients who succeeded in adhering to drugs over a period of one year has been improving. For instance 22 clients missed taking ARVs at least once in the whole year of 2004, while

only 18 clients had been registered to have missed taking their drugs by the end of 2007. Credit has to a large extent been extended to the shrewdness in involving PLWHA in combating the scourge which has been seen as a key to success. Respondents and staff of the NGOs argued that PLWHA are received with a spirit of solidarity bearing in mind that they are communicating one language to the clients.

From interviews conducted with clients of the organisations especially the men themselves and staff, they revealed that initially men were not turning up for VCT. Those who would actually turn up were denying result of their wives, abandoning them and or even beating them with accusations of promiscuity that has led to their infection. Currently with a huge force of male involvement in combating the scourge, women who test positive and are mistreated by their husbands have where to run to. Though respondents couldn't indicate figures for such level of success and with lack of statistical backup, they generally see how visible the involvement of especially men helped enlist the support of fellow men that were previously aggressive to their wives.

“Today a man goes with his wife both living positively with HIV to a home where there are still difficulties in disclosure and acceptance to provide support and encouragement. They share their experience to the host family and the problems they have undergone and tell them how they managed together as a couple to overcome the difficulties, how they have benefited from living positively...” Narrates Mr. Obutu, Director HAU.

According to respondents, such a scenario would be an impossibility before then, and that the war did a great lot of havoc by blocking free movement of people and provision of services to those who need them. As noted, today many husbands with the support and guidance received from their colleagues with HIV/AIDS they find no difficulty in accompanying their women for VCT and them themselves testing. The rate of separations/divorces was previously higher than it is today. The findings reveal that for every 10 couples living with HIV/AIDS, 5 of them would immediately divorce, fight or mistreat their wives.

“those days you would hear that a husband drove the wife out of home, the man has run away leaving me with nine or seven children... now the men are vital role models who openly testify and disclose their status” Noted Mr. Jackie, staff HAU.

As opposed to earlier situations, today the men can afford to swallow their pride and carry their wives on the bicycles to the hospital, help them in home chores and support adherence and positive leaving at home. The men especially are helping so much in convincing more positive men still out there to disclose their status.

### ***5.2.3 Limitations.***

Some staff have confidentially revealed that many of the PLWHA more so from the camps have no choice but to come out in the open for purposes of getting the special support given to PLWHA. The record numbers of disclosures are therefore dependent on how long the food aid project lasts. Thus the issue of self stigma has been recorded and reported by the counsellors for attention. Respondents who are clients with the NGOs were concerned that while also the long distances they have to move within their communities home to home usually on foot are so straining given their already weak bodies. Routine sicknesses and untimely death of the strong pillars of combating the scourge was reported as an inevitable and grisly situation. These have to some extent affected the success.

The issue of facilitating especially the CVC's and CASA's in terms of money, transport and some times the badly needed food is in question. Given their high expectancy level from organisations that use them, they get frustrated and de-motivated on many occasions. For instance HAU doesn't have a clear way of rewarding the volunteer clients. As revealed by one of the MSG members, they are given some money only once in a while and when it comes it's a meagre 30,000/= (nearly 13 euros) only. As reported by the staff the NGOs, especially HAU is cash strapped, the fact that at the time of study it had only one single donor- Save the children. With the massive force of volunteers HAU uses, given their sickly and vulnerable situation, impact of the strategy could easily be seen to be slim. TASO, though struggles to get membership fee annually from subscribed members, it still has to battle with the increasing number of clients.

Much as the PMTCT program has been a great success in reducing new infections of babies it has put a lot of constraint on HAU due to the high number of mothers they have to support, yet they do have very limited and targeted resources. It was reported that these are mostly women who lost their husbands earlier and are cohabiting in the camp settings with other men sometimes without even revealing their status. These are women who don't have children and would vow to make sure they get one at least before they meet their death. Secondly HAU reported that numbers of PMTCT mothers who are continuing to have more children after their first one with support from the organisation are increasing. Thus putting additional constraint on the organisations.

“these mothers have the right to have children as they wish, but the organisation takes the initiative to educate them about family planning and the danger in having many children when HIV+.” Observes Mr. Obutu.

Achayo 19, a registered client with HAU has successfully had two children free from HIV, and both children have separately been enrolled in the nutrition feed program. She got infected with the virus from a rape encounter with a rebel one morning in 2003 while she was rushing to pick food from the neighbouring village. She was a virgin at the time.

### **5.3 Outreaches and Community Based services.**

Virtually HAU and TASO have since their inception scaled out their services into the community, though however the outreaches have previously been met with the bigger challenge of insecurity. Five years ago the NGOs had to withdraw from far away communities and concentrate on those communities within the range of 5kms. The state would provide security to the NGOs with outreaches but this also had its constraints as they had to await security briefing, after which they would be escorted in a convoy from 9am. By the time they reach the targeted communities they are very late, meeting a very large number of people waiting, yet they have only up to 3:00pm to wind up their services due to insecurity. But now since the war came to an end and relative peace seems to be assured, the local NGOs have resumed their outreaches and are doing quite well.

#### ***5.3.1 How it's done.***

The NGOs through their regular coordination meetings at the district and with the NGO forum, agree on priority areas. Organisations with competencies in particular areas like HIV/AIDS known to be for HAU and TASO mainly are asked to operate in areas where no other NGO exists and where nothing has so far been done. This is done to avoid duplication and to distribute health services in the district proportionately. This though is not the case in many instances. The respondents especially from the district said that NGOs are sometimes too powerful and influential that they convince the district to work in areas of interest to them, neither is the district nor the local leadership know exactly how much they spend on human resource as compared to the widely popularised services presented during the meetings for scrutiny. Korten (1987) argues that

“in an areas of declining financial resources and deepening poverty, both national governments look to NGOs as a means of getting benefits more directly and cheaply to the poor that governments have been able to accomplish on their own.”

NGOs liaise with local leaders in the area and plan together on key priority areas of interventions. They also enlist the local leaders support in especially mobilisation of the masses for the NGO campaigns, though as intimated by one of researchers key respondent's, lip service without pay can never yield the desired turn up that NGOs always look forward to when they go into the communities.

Both HAU and TASO have teams of volunteers down in the communities who are themselves mostly PLWHA that help the organisations in mobilising clients to turn up for services at a given location with the community whenever a team comes from the head offices. The team from the head offices usually involve nurses, counsellors and the field coordinators who are facilitated with motorcycles and are put in charge of particular areas. While TASO is much more able to reach out further and deeper due to availability of vehicles, HAU has only one field vehicle and rely on hiring vehicles for most of their outreaches. The volunteers who help the organisations in the communities are

beneficiaries in terms of getting treatment, care and support. These are the CASAs, CVCs, and POMO/MSGs.

For TASO, to become a CASA one has to be HIV + and a registered beneficiary with TASO, one who is exemplary in the community in terms of drug adherence and living positive lives in their communities. At the time of the study TASO had over 80 CASA's trained and spread through out the district, where at least five in each sub county while HAU Uganda had 60 registered CVC's within the municipality, Pabbo sub county and Bobbi Sub county.

TASO unlike HAU prides in CDDP's and Mini TASO canterers which are attached to the community health centres that are trained and empowered to do work similar to that of TASO. With this they have trained nurses and CASA's at the drug distribution points who collect drugs for the clients in their communities every month from the center. The nurses are responsible for handling client emergencies before they are referred to the center for further treatment and or to a major health unit. The CASA's also reach out the center on a hotline number set by TASO using the village phones in case there is an emergency. One only has to flash/beep the number and the center calls them back.

The initiative to roll out the services is based on two factors. One is distances beneficiaries have to travel to come to the center for treatment. Care and support coupled with their level of vulnerability in terms of income and secondly the large number of clients, like for the case of TASO who have a massive number of clients who come to the center for treatment, care and support. Key activities carried out during the field visits in the community are briefly explained below.

#### **Sensitisation in the outreaches.**

The organisations under study have both continued to use drama, posters and fliers, seminars and radio talk shows to reach a wider community. As argued, NGOs have a comparative advantage of being able to reach out to most remote areas and in being cost effective and innovative as seen in the use of volunteer beneficiaries. (Marcussen 1996a) The key messages are on condom use, drug adherence, disclosure, importance of PMTCT to expectant mothers, positive prevention and positive living in general, abstaining from sex, faithfulness and encouraging VCT and early treatment care and support for those already sick. Scholars have argued that "sensitisation is looked at as a key strategy for strengthening people's involvement in their own development by raising understanding and awareness of the causes of their problems and by increasing their self- confidence..." (Edwards and D.Hulme 1995)

HAU alert is working hard to promote positive living and positive prevention during the Anti- stigma campaigns, where positive living is seen as a way of life that PLWHA choose to take to prolong and live healthy lives, while positive prevention encourages people to stay negative in an environment with HIV/AIDS. For instance the case of discordant couples and index families. (Families where a couple or one of the members is HIV+) Health talks are conducted as a follow up on the topical issues discussed in earlier sensitisation drives say using drama or seminars.

In drama as an approach to disseminate information, HAU uses what it calls the Stop- Start method. This means that questions and discussions are invited from the target communities watching the play at the end of every short skit that usually last about five minutes. In the play the researcher watched in one of the communities, they portrayed widow inheritance, showing the traditional process of handing over the wife while on the other hand have no idea what killed the husband. As the play goes on they later realise she is positive after one of the HIV focal person intervenes and objects to their inheritance by first taking the woman for a test. But for every act/scene questions 10minutes are used to pause questions to the audience.

Such messages sink deep into the minds of the target group and indeed reflect exactly what happens in the communities. On question time the momentum is built and all are eager to ask question relating to what they have seen in the drama and also based on what actually happens in their community. At the end of the day many people contact the facilitators for advice, counselling and more requests for a come back. TASO too has a drama group trained and facilitated by the organisation with full leadership and membership from the TASO clientele community unlike HAU which hires professional group every time they need to go out.

The TASO counselling coordinator said that they usually receive demand letters from communities that want to be visited as well as those that need a revisit. So as a team they sit and plan how to integrate the concerns in their plan and prepare their community contacts to mobilise the community. According to Harriet a field officer with TASO, sensitisation against infection to even clients is very important. This is what TASO encourages and trains all counsellors and field staff to always keep doing. The approach reduces on cross infection for married couples and prevents against infecting HIV free household members. Harriet narrated a sad scenario as explained below.

“A TASO client living with her seven year old daughter got another man who was supposedly negative and got into a relationship without ever informing him of her status. The lady kept taking drugs secretly until one day when the man chanced on where she keeps the regiment tins. He got so furious and wondered why a woman she has struggled to support and care for chooses to innocently kill him. He turned to the 7 year old girl and secretly started raping her, persuading the child never to say anything as he will give anything she wants. The mother got the shock of her life later on realising the way the daughter is walking and the revelation of being raped by the husband under her roof and testing the daughter only to find she is HIV+.”

So the organisation encouraged people to disclose their status and save innocent souls. “We don’t stop people from getting new partners, but it’s important to let them know your status and protect against re-infections” Observes Harriet, field officer TASO.



### **Monitoring client's state of health.**

This is yet another aspect for field workers and community volunteers. The CASA's and CVC's are responsible for monitoring adherence through their routine home visits, and monitor pregnancies of clients, mobilise clients to turn up at the drug distribution points, intervene in problems of clients at household and or community level, provide basic counselling to clients within the community and also supply condoms to clients in need.

The field officers in collaboration with CASA's and or CVCs for the case of HAU are fully responsible for ensuring that clients take the drugs as prescribed and that refill when they are about to get finished. Routine as well as spot visits are carried out directly by field officers to check on the situation of clients. In TASO, the CASA's and or field officers carryout either a physical pill count or self reporting from clients about the adherence to the drugs and taking note of complications the drugs might have on the clients.

Whereas most clients' adherence record is very good, others are always defaulting. On some occasions the stubborn clients are visited and find the count is right and amount of remaining drugs fine but don't actually take the drugs. That becomes a big problem for the field officer and the community based support groups. Achan, a field officer narrates that one day she visited a home expecting to refill drugs, but to her amazement found all 150 drugs untouched! In such a case she said, "We talk to them and withdraw the drugs and replace with another type for a short period of time and thereafter make a spot check to see if the client is adhering."

Follow up on adherence remains a major work of TASO as treatment and counselling are their main task, but also a very challenging work.

### ***5.3.2 Success and constraints to the strategy.***

This has helped increase the number of people who turn up for the services in the organisation. For instance the increase in outreaches for TASO from the 83 planned to 120 actually done by the end of 2007 shows that the demand for services is quite higher than it was before.

One of the key successes lies in the improvement in client's level of adherence and disclosure of status. The primary need to prolong and live a healthy life has led to this. A case in point is of Otto 43 a key respondent and a CASA who was rescued from the gates of death by TASO in 2005 when they found his CD4 count had dropped to 33 and rose to 170 after six months of anti- retroviral treatment. He has three wives who have all tested negative on all four attempts. He sticks to the condom, eats well and adheres perfectly to his drugs. Many, many more like Otto are keeping the promise to positive living and positive prevention.

However, outreaches have been faced with challenges. De-gazetting of IDP camps has made it virtually difficult for field officers to locate their clients. It would be logically taken that when clients are relocating they inform the field officer attached to their area, but most of them only remember to return when their health is getting worse, once they have settled in new places. Some of them are indeed too far away to warrant the vulnerable PLWHA to travel back and report. Basically the organisations do mapping of client's

homes. Once the clients register they have to give precise but clear direction to their homes, the counsellors then give it to the field officers who are tasked with locating their homes.

Whereas the follow up and community based services seem to be effective in combating the scourge, they are limited by adequate motivation given to the volunteers based in the communities. They complain of no pay and lack of bicycle to facilitate ease of transport in their mobilisation exercises. The field officers are bogged down by the long distances they have to ride over 200km on very bad roads- dusty and impassable when it comes to rain. This could thus affect reach of the most remote areas. HAU unlike TASO has constraints in mobility in terms of vehicles and motorcycles for field staff. They only have one vehicle and no single motorcycle. Whenever they have outreaches, they have to incur hiring costs.

The need for food by the many clients of the NGOs living in IDP's is high. Hunger is the one single factor that has affected adherence in camp communities. Local organisations are encouraging adherence well aware of the hunger situations of most of their clients who have a single meal a day and sometimes have really nothing. Some of the drugs give a lot of appetite for eating, yet they can't have food to eat, they have no gardens where to dig since they are in encampment and have no source of income. Though world food program has been providing food, it never comes in time and worst of all never enough. Even clients enrolled for special food deities' wit the food aid organisations when phased out have no alternative but to starve and forced to abscond drugs.

"I have a client who absconded for almost two months. The needy old mother with whom he lives after both wives abandoning him on realising he is HIV+ told us he is not eating, he is not taking the drugs. I summoned the counselling coordinator, the field leader and the man told us if we can't give him food he cant take the drugs. We decided to withdraw the drugs and gave him a drug holiday for a month". Reveals Achan, TASO Field officer

Because of such situations TASO has allocated emergency funds to cater for such clients. The 10,000 given ( about 5 euro) can only buy maize flour, beans and other small things once, thus the next day they comeback to square one. This money can only be approved if the situation is considered extreme. Thus rendering the scheme unsustainable. Achan further reveals that one day she came to a home expecting to refill drugs, but to her amazement found all 150 drugs untouched! In such a case she explains that, "We talk to them and withdraw the drugs and replace with another type for a short period of time and thereafter make a spot check to see if the client is adhering."

The challenge with sensitisation talks as indicated by staff and district officials interviewed is that after the sessions in the day people seem fired up with the message, eager and excited about the message, but in the evening they go drinking and become a different thing altogether, engaging in risky sexual behaviours. The respondents further argued that yes, a lot has been done in the district already about prevention messages, where everyone virtually knows about HIV/AIDS. During the war, it was quite difficult, the concern was survival first, but then after the war local organisations intensified their campaigns through radio, posters, drama and community based campaigns.

The messages are got but people are still visibly bruised by the war, too vulnerable and too poor and hungry to bother about HIV/AIDS. People are instead more concerned about how to get the next meal.

One of the respondents interviewed told the researcher about a woman in the camp who on seeing many of her HIV+ neighbours benefiting from the aid from world food program volunteered to have an HIV test with the hope that she too could be positive and get enrolled for food to save her children that were dying of hunger. When she found she was HIV negative she went mad with the counsellor who announced the results to her.

Florence Opoka, a key respondent told the researcher that hunger and poverty in especially IDP camps is a hindrance to the desired success in messages of prevention, adherence to drugs and PMTCT programs. Florence said that situations of mothers sending their daughters to shop keeper and other business money with money are not uncommon.

“The same man who has had sex with you turns around and defiles your daughter. The man, after leaving the mother, secretly turns to the elder daughter, and when the mother sends the younger daughter to him for assistance, she is raped. When the mother pursues the man, the man threatens to shoot her- leave my wife alone!! Referring to the younger daughter sent to the man for assistance”  
Narrates Florence

#### **5.4 Partnerships and collaboration with state and other actors.**

Gulu district has the largest NGO presence in the country, coupled with CBOs and FBOs totalling to over 500 of them, engaging in different interventions. Some of the organisations have concentrated on relief aid, others on Medicare, while also many of them on general social- economic services. A single organisation cannot meet all the demands of clients and in no way can it have every resource, be it human, material, technology financial to handle the ever demanding clientele system. Because of this, collaboration and partnership has been very helpful in covering a wider population of clients.

Most important has been the relationship between the state and the civil society organisations with interventions in the district. It has to a great extent helped the local NGOs achieve their targets and goals. Though NGOs have the capacity to promote local participation, implement projects in direct collaboration with target beneficiary groups, reach out to far to reach areas and that the donors still look to them for implementing projects, they still have to cooperate with local governments in their areas of interventions. (Marcussen 1996, Ndegwa 1996). Edwards and Hulme (1992) concur that no matter how strong and popular the NGOs can become, the state will and still remains a regulator and ultimate arbiter.

Through their routine coordination meetings as earlier explained in chapter three, the organisations come together, identify key problem areas, see who has an edge in it and how many, but also forge avenues for cooperation. For instance the study found out that TASO doesn't have VCT services, yet it's a very popular NGO when it comes to HIV/AIDS work. What it therefore

has done is to leave the services to the others with whom they cooperate in terms of referrals for enrolment and continued treatment. In 2007 alone TASO managed to refer about 912 of its patients for advanced medical services such as treatment and CD4 count testing. Likewise, HAU is well known for its support of women on PMTCT program. So if a pregnant woman goes for testing say in Lacor hospital or Gulu regional referral hospital, she would be advised to seek the PMTCT services from HAU.

The district local government structures are very helpful. They have graciously provided all kind of support within their means. This has ranged from providing security during field operations at the time when war was raging on, given out land for a noble cause. The case in point is TASO which got free land from Gulu district local government on which its new premises are. Other technical support as reported has been through information sharing on updates on statistics and information related to HIV/AIDS, potential project support from donors that go through the district. The office of DDHS and District HIV/AIDS focal person were seen to be very instrumental in driving NGOs to success through coordinating with local NGOs in HIV/AIDS work, notwithstanding the NGO forum and UNASO. The ministry of health provides free drugs like anti retroviral, septrine and TB drugs which are distributed to services organisations like TASO and given free to clients.

MOU's have been signed for cooperation and coordination of organisations in particular tasks like food distribution, VCT, PMTCT services and information exchange among others. TASO has had long term cooperation with WV and WFP on a special feeding program for PLWHA and are taking ARVs. From the interaction with the center manager, the researcher was informed that this usually lasts six months, and rolled out depending on the level of the client's stability, while new ones are enrolled. So far according to the 2007 annual report the partnership between WV and WFP together with TASO led to 1, 331 PLWHA to fed, and benefited 6625 children with 1,003 family members. This for TASO has been a very popular strategy for PLWHA in IDP camps as it relieves them of the burden of hunger and the possibility of not adhering to the drugs, some of which requires good feeding before actually taking them. Adherence and self disclosure are reported to have increased two fold due to the feeding program. Unfortunately HAU has no provision for food support except the popular milk support project for PMTCT mothers. The project has been supported by Save the Children since 2005.

“Those days, you look at a client, you want to enrol him on drugs but you find difficulty doing so because they don't have food or even a sustainable source of income, yet their names were not considered for the food rations given by the partner organisation. Then you get stuck!!” confirmed a clinical officer with TASO.

TASO is again in partnership with Kampala Pentecostal Church who have come out to support vulnerable mothers and children living with HIV/AIDS. 500 clients have so far been mobilised and supported by the partnership project. Visions in Action is another key partner with whom TASO does VCT. All TASO has to do is mobilise the communities using its structures, and then Vision in Action joins in for voluntary testing, while TASO does the

counselling. This arrangement has catapulted the number of people who turn up for VCT.

Collaboration has also worked well with referrals. Due to common mans agreement reached by the health service organisations, hospitals have comfortably been able to refer HIV/AIDS clients to TASO, HAU and other HIV/AIDS service organisation for specialised expert services mostly in care, support and treatment, whereas Voluntary Counselling and Testing (VCT) have referred positive clients for further engagement. In the same way, the local organisations have found it rewarding and effective to refer clients to hospitals and sister organisations that can provide services that the referring organisation can't handle.

The two organisations under study are fully donor funded, though they equally get a lot of support from international NGOs working in the district. Such organisations are save the children, WV, UNICEF, and other international donors like Global fund through the government. It was observed that many of the international organisations in the district and other parts resorted to implementing their programs and projects through local NGOs. It has been observed (Ndegwa 1996, Fowler 1995, Edwards and Hulme 1995) that working with grass root organisation is of comparative advantage due to low cost operations, targeting, innovativeness, commitment and that they have indigenous knowledge of the locality more than international organisations.

## **Chapter 6 Conclusion to the Study**

### **6.2 Introduction**

This chapter presents major conclusions drawn from the research study. They have been based on key issues earlier addressed, but also on research questions and how the study has attempted to answer them.

### **5.2 Major Conclusions.**

It has been made clear in the research study that HIV/AIDS is major development challenge across the world and among nations. Partnerships between the state and civil society organisations were shown to be the most required strategy for not only bringing down the infection rates to HIV/AIDS, but also helping those already infected live a longer and healthy life. As already seen the Uganda government took the bull by the horns in taking a shrewd approach in 1992 to put up structures and systems that would enable effective and efficient implementation of strategies aimed at combating the scourge, while at the same time bringing together all key stakeholders among which include NGOs.

It should however be noted that while the infection rates were continuing to drop across the country, the war torn Acholi region, Gulu in particular was doubly affected, first by war itself and secondly by the continually rising rates of HIV/AIDS. It has been shown in the study that armed conflict has to a larger extent contributed to the spread of HIV/AIDS in the IDP camps. This has been strongly argued on the basis of the fact that armed conflict brokeout and robbed from the Acholi people their customs and cultural beliefs that held the society together and instilled discipline. So, when the war broke up, it was hard to continue holding it amidst looming anarchy. Secondly because of lawlessness in the region at the time, cases of rape/defilement and other risky sexual behaviours would easily come along. High levels of vulnerability and desperation among IDPs due to confinement in camps with no productive work is evident of the catalysts to possible HIV/AIDS infection. If not these factors mentioned, what more can then explain the case for the rise in HIV/AIDS rates in the district?

The key strategies employed by HAU and TASO have been very instrumental in guarding against new infections through sensitisation, encouraging disclosure and promoting PMTCT. While care and support for PLWHA has been mainly done through treatment, provision of food, monitoring adherence and most importantly through counselling. The study suggests that while NGOs are becoming very influential and popular among the masses, the role of the state cannot be ignored. (Edwards and Hulme 1992) The state has the security that it extended to the NGOs during their outreaches and besides it formulates the policies that NGOs use and still develops appropriate structures that allows for NGOs-state coordination of activities, sharing and exchange of ideas.

The three key strategies employed by the local NGOs and discussed in this paper are; involvement of PLWHA as models; community outreaches and partnerships and coordination with the state and other actors. It can be concluded that the strategies have to a great extent been successful. The reason behind this has first of all been in the way they have encouraged participation of the beneficiaries, who they prefer to call clients. The clients themselves have been made to take lead in the grass root mobilisations for the prevention, care and support interventions on behalf of the NGOs but most specifically for their long term benefit. As reported in the findings, the involvement of men in the fight against HIV/AIDS saw an increase in male turn up for VCT, a reduction in marital conflicts related to HIV/AIDS genuine support for their wives and children in a ways that looked impossible before.

The sensitisation campaigns against HIV/AIDS that make use of drama and health talks that encourage a one on one encounter with the clients through education and counselling have been tremendously helpful in extending support against stigmas and discrimination. People no longer look at HIV/AIDS as the worst disease since there are more ways to go around it and still be able to live longer. The outreaches have been able to help reduce the burden for clients having to travel long distances, but also enables the NGOs contribute to longevity of their client's life through encouraging drug adherence, disclosures and living positive lives.

Meaningful collaboration and partnerships between the NGOs, state and other actors has been beneficial in that the actors have got to know who does what or have what, so they can share or partner. Prominent in this area has been the food support to TASO from WFP together with WV. This alone encouraged many clients to come out and voluntarily disclose their status, which as seen one way to not only prevent new infections, but also promote positive living.

Nevertheless, the local NGOs have faced major huddles that have to make it difficult success to be achieved. The cases in point are the lack of adequate funding leading to closure of some projects. A bigger challenge facing HAU alert is that transport especially when it comes to outreaches. The overwhelming number of clients streaming for care, support and treatment is disturbing, yet the NGOs have meagre resources, coupled with the high turn over of staff that leaves a huge vacuum and constraint on the remaining staff to handle the many clients.

Though the local NGOs have attempted to handle some of the problems, they still largely remain obstacles to NGO efforts in realising their goals through the strategies employed, no matter how appropriate or good the strategies could be.

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# Appendices

## Interview Guide: For Organisation Staff.

### Respondents Bio-data.

Name  
Occupation  
Organisation/Institution  
Profession.

### *About the organisation.*

1. The organisation's general programs/projects and or activities
2. When the organisation was established and for what purpose.(mission, goals and vision)
3. How big is its intervention on HIV/AIDS?
4. Who are the beneficiaries (children/youth, women/girls, vulnerable adults)
5. How are the beneficiaries/target group selected (whether or not the criterion targets those most in need)
6. Why the organisation chose to concentrate on the identified targeted beneficiaries.
7. How large is organisation's coverage- in terms of geographical area and target populations.

### *Strategies employed to combat HIV/AIDS in study area.*

8. What major strategies does the organisation employ in tackling HIV/AIDS in the selected areas in general? (likelihood to probe further based on activities and target population, but also specifying prevention, care and treatment strategies)
9. whether or not the strategies have been successful in realising the goals of the program/activity (further probes and review of reports will expound more on this)
10. Why do you think the strategies have been successful?
11. What have been the failures of the obstacles to the strategies? (weaknesses and strength)
12. Does the organisation still use the same strategies in its prevention interventions that it used during conflict?
13. How has the organisation's collaboration with other actors contributed to the success/failure of HIV/AIDS interventions in the area in general?

**Organisation's Budget.** (*Seeks to find out how funds may affect effectiveness of strategies employed*)

14. Sources of funding for the HIV/AIDS activities (whether or not it's tied to specific activity or target.)
15. how much funds are allocated to
 

Logistics.	}	Possibility to access& review
their budget		
Direct benefits to target group.		
16. For how long are activities funded and whether or not possibilities of renewing exist?
17. Sustainability of donor funding.
18. Whether or not there are other ways of generating income for HIV/AIDS activities.
19. What challenges has the organisation encountered during the implementation of activities using the said strategies? (financial, logistical, human resource, security, coordination with other actors)
20. To what extent has the security situation affected the HIV/AIDS intervention in the area?
21. How has the organisation been able to overcome the limitations to the strategies?
22. what is your assessment of the organisation's role in tackling HIV/AIDS in the area compared with other organisations with similar interventions
23. What lessons can be drawn (say) by other organisations/scholars in using the mentioned strategies in tackling HIV/AIDS in this community?

## **Tool for Beneficiaries and Community Leaders.**

### **Back ground information**

1. Have you heard about the organisation before?
2. Has the organisation interacted with you?
3. How did you get to know about the organisation?
4. When was the first time you heard about the organisation?
5. Are you a beneficiary with the organisation?
6. How/why were you selected to be one of the beneficiaries of the organisation?
7. Why do you think you were selected to benefit from the organisation?
8. For how long have you been getting assistance from the organisation?
9. What kind of assistance did you get in the beginning?
10. Why the assistance?
11. How often did you get the assistance?
12. How helpful has the assistance been to you?
13. Were you satisfied with the way it was done?
14. What kind of assistance are you getting now? (dwelling on issues around HIV/AIDS and strategies employed)
15. When the beneficiaries first heard about HIV/AIDS?
16. How it was delivered and if they think it has an impact on their current life?
17. Why the assistance now?
18. what is your assessment of the way in which the strategies are employed?
19. How is the assistance given/ what procedures do you go through to get the assistance? ( visited or you go to the organisation, through parents, care takers, leaders or otherwise)
20. How often is the assistance given?
21. How helpful has the assistance been to you?
22. Are you satisfied with the assistance given?
23. Do you think that your state of affairs now is because of the intervention of the organisation?
24. Why is it so? What was your condition before? What is it now?
25. Do you get assistance from other people/organisation?
26. If yes what kind of assistance is it that you get?