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**ISBN:** 1 898828 52 0  
Published by: Bradford Centre for International Development, University of Bradford,  
Pemberton Building, Bradford, West Yorkshire, BD7 1DP  
Tel: +44-1274 233980 Fax: +44-1274 235280  
[www.brad.ac.uk/acad/bcid](http://www.brad.ac.uk/acad/bcid)

## **BACKGROUND TO PROJECT AND WORKING PAPER SERIES**

This paper is one in a series of working papers prepared under a research project entitled *Goodbye to Projects? The Institutional Impacts of a Livelihood Approach on development interventions*.

This is a collaborative project between the Bradford Centre for International Centre for Development<sup>1</sup> (BCID) with the Economic and Policy Research Centre (EPRC), Uganda; Khanya – managing rural change, South Africa; and, Mzumbe University (formerly the Institute for Development Management (IDM)), Tanzania. The project is supported by the UK Department for International Development (DFID) under their Economic and Social Research Programme (ESCOR).

Approaches to projects and development have undergone considerable change in the last decade with significant policy shifts on governance, gender, poverty eradication, and environmental issues. Most recently this has led to the adoption and promotion of the sustainable livelihood (SL) approach. The adoption of the SL approach presents challenges to development interventions including: the future of projects and programmes, and sector wide approaches (SWAPs) and direct budgetary support.

This project intends to undertake an innovative review of these issues. Central to this will be to question how a livelihood approach is actually being used in a range of development interventions. This will be used to identify and clarify the challenges to the design, appraisal and implementation of development interventions and changes required from the adoption of a livelihoods approach.

The research was conducted in two phases. The first phase consisted of general and country reviews on SL and development interventions. The second phase of the research involved the compilation of ten detailed case studies of development interventions in Uganda, Tanzania and South Africa. These case studies compare and contrast the implementation of a range of sector wide approaches, programmes and projects all developed with a livelihoods-orientation.

Each case study intervention was examined through what might be termed as a ‘sustainable livelihoods (SL)-grounded audit’, which uses sustainable livelihoods ‘principles’ as the basis. The results of this analysis offer useful guidance on the opportunities and challenges faced by development practitioners in operationalizing sustainable livelihoods approaches.

**This paper ‘A livelihoods-grounded audit of the AIDS/STD programme in Uganda’ the thirteenth in the series of project working papers.**

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<sup>1</sup> Formerly Development and Project Planning Centre (DPPC)

*This research is funded by the Department for International Development of the United Kingdom. However, the findings, interpretations and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed to the Department for International Development, which does not guarantee their accuracy and can accept no responsibility for any consequences of their use.*

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## PROJECT WORKING PAPERS TO DATE

**1. Annotated bibliography on livelihood approaches and development interventions.**

**Appraisal of the use of livelihoods approaches in South Africa.**

**Review of approaches to development interventions in Tanzania: From projects to livelihoods approaches.**

**Review of development interventions and livelihoods approaches in Uganda**

**A livelihoods-grounded audit of the Participatory Planning for District Development within Capacity 21 programme (Tanzakesho) in Tanzania**

**6. A livelihoods-grounded audit of the Community-Based Planning (CBP) action research project in South Africa.**

**A livelihoods-grounded audit of the Agricultural Sector Programme Support (ASPS) in Tanzania.**

**A livelihoods-grounded audit of the Sustainable Management of the Usangu Wetland and its Catchment (SMUWC) project in Tanzania.**

**A livelihoods-grounded audit of the Magu District Livelihoods and Food Security Project (MDLFSP) in Tanzania.**

**A livelihoods-grounded audit of the Sexual Health and Rights Programme (SHARP!) in Lesotho and South Africa.**

**A livelihoods-grounded audit of the Training for Environmental and Agricultural Management (TEAM) project in Lesotho.**

**A livelihoods-grounded audit of the Sustainable Coastal Livelihoods Programme (SCLP) in South Africa.**

**A livelihoods-grounded audit of the Plan for the Modernisation of Agriculture (PMA) in Uganda**

**A livelihoods-grounded audit of the AIDS/STD programme in Uganda.**

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For more details on the project and copies of recent publications please consult the project's web site:

<http://www.brad.ac.uk/acad/dppc/GTP/goodbye/html>

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## 1.0 The SL-grounded audit of development interventions

The cases studies in this research were chosen for inclusion following a first phase review of the use of livelihoods approaches in Tanzania, Uganda and Southern Africa. Data was collected using a number of methods including questionnaires, semi-structured individual and focus group interviews, collection and review of process documentation and workshop activity.

All ten case studies have been analysed according to what we term a ‘SL-grounded audit’ described below so that the emerging lessons can be compared. Each study is divided into two sections: the first a general introduction to the intervention; and the second, a structured response to a series of questions adapted from the SL-principles as defined by Carney (2002) in Box 1. SL principles are one element of sustainable livelihoods approaches. This research adopts these principles as a structuring tool and as means of pinpointing the practical implications of adopting a sustainable livelihoods approach to development.

### **Box 1. SLA principles defined by Carney (2002)**

Sustainable livelihoods approaches: Progress and possibilities for change, p14-15, London: Department for International Development

Normative principles:

**People-centred:** sustainable poverty elimination requires respect for human freedom and choice. People- rather than the resources, facilities or services they use- are the priority concern. This may mean supporting resource management or good governance, for example but the underlying motivation of supporting livelihoods should determine the shape and purpose of action.

**Empowering:** change should result in an amplified voice opportunities and well-being for the poor.

**Responsive and participatory:** poor people must be key actors in identifying and addressing livelihood priorities. Outsiders need processes that enable them to listen and respond to the poor.

**Sustainable:** there are four key dimensions to sustainability-economic, institutional, social and environmental sustainability. All are important-a balance must be found between them.

Operational principles:

**Multi-level and holistic:** micro-level activity and outcomes should inform the development of policy and an effective governance environment. Macro- and meso-level structures should support people to build on their strengths.

**Conducted in partnership:** partnerships can be formed with poor people and their organisations, as well as with public and private sector. Partnerships should be transparent agreements based upon shared goals.

**Disaggregated:** it is vital to understand how assets, vulnerabilities, voice and livelihood strategies differ between disadvantaged groups as well as between men and women in these groups. Stakeholder and gender analysis are key tools.

**Long-term and flexible:** poverty reduction requires long-term commitment and a flexible approach to providing support.

Each case study follows the structure detailed below:

**Description of the intervention:** this includes a chronological description of the evolution of the particular intervention and details the main stakeholders and activities undertaken in implementation. Original logframes and planning documents have been reviewed where possible.

**Impact:** Assessment of the impact of interventions relates to the success or failure of an intervention to achieve the outputs or outcomes that were the main focus of the intervention. The effect of this is that our understanding of impact is somewhat limited and partial. The methodology used in this research project did not allow for significant impact assessment with intervention beneficiaries at the micro-level (although this was done on a small-scale in most of the case studies). This section also includes some assessment of the costs of the intervention balanced against the number of people who benefit from it.

**Poor People as focus**

Do, or did, the objectives of the intervention include a mention of people and their livelihoods?

How central is this to the intervention's objectives?

How much were household livelihoods a focus during implementation?

**Participation**

What type of participation was used at each stage of design, implementation, monitoring and evaluation?

How and when did this participation occur?

What incentives were there for people to participate?

**Partnerships**

What was the type of partnership and collaboration between these organisations at micro-meso-macro?

Who owned the project?

**Holistic approach**

How holistic was the analysis used in design?

How does the plan for the intervention fit into the broader development plan?

How does the intervention coordinate with other development interventions in the area?

**Policy and institutional links**

How integrated was the intervention with existing institutional structures?

What evidence is there that the intervention addressed linkages between policy at micro, meso and macro levels and across sectors?

**Building on strengths**

Does the intervention build on existing strengths at the different levels?

**Dynamic and flexible**

Did the objectives and activities of the intervention change to respond to a changing environment and/or demands?

What further interventions have arisen from the intervention? How did this take place?

### **Accountability/ responsiveness**

How were those implementing the intervention accountable to the public and intervention's beneficiaries?

Who reports to who and what about?

Do beneficiaries (micro) or partners (meso) have an influence on the intervention and how?

### **Sustainability**

#### Economic

Is the system able to be sustained financially?

Are the "technologies/services" economically viable for beneficiaries?

#### Social

*Are vulnerable groups able to access and use effectively the systems of the intervention?*

Are the institutions created/used by the intervention able to sustain themselves beyond the life of the intervention?

#### Environmental

*Are the technologies/services environmentally beneficial?*

Are the systems (meso level) beneficial/neutral?

#### Institutionally

*Are the capacities and systems established in such a way so that the system will continue (beyond the life of the intervention)?*

Will they continue to generate the outcomes envisaged?

### **Critical factors**

What were critical factors affecting the performance of this intervention?

### **Comparing Cases**

Each case study can be read as a stand-alone document as the SL-grounded audit is in itself a useful means of understanding the strengths and weaknesses of an intervention. However, the broader aim of this research is to compare lessons across all ten case studies in order to identify more generally the challenges and opportunities faced by development practitioners in operationalising a sustainable livelihoods approach.

## 2.0 THE AIDS/STD PROGRAMME IN UGANDA: WITH EVIDENCE FROM LUWERO DISTRICT

### 2.1 Description of the Programme

Perhaps one of the greatest health challenges that Uganda has faced in the recent past, and which has severe implications for national development and people's livelihoods is the HIV/AIDS epidemic. Almost every household in Uganda has had an experience with the disease, either through an infected person or being affected indirectly by such a person. Since 1982 when the epidemic was first reported in the country, an estimated cumulative number of 1.9 million people have been infected, of whom 0.5 million have died. In the year 2000 it was estimated that 8.3 percent of the 22 million people in the country were infected by HIV/AIDS. This represented a decline from 30 percent in 1992. Government statistics indicate a population of about 2 million orphans, most of who are a result of war and HIV/AIDS.

The major purpose of this study was to track the various HIV/AIDS interventions in the country, with a view of establishing the extent to which they represent the sustainable livelihoods principles, and their nature of impact on people's livelihoods. However, specific attention was given to the AIDS/STD Programme, which was a national programme but implemented at all the lower levels of government and communities.

Apart from national level institutions, the scope of the study was restricted to Luwero district. The district, like many others in the country, had several primary implementers, other than the Ministry of Health, who were operating programmes and projects directly linked to the HIV/AIDS interventions. These include the Association Francois Xavier Bagnoud (AFXB) programme for AIDS care and support, United States Agency for International Development (USAID), Plan International project for an Integrated Community Efforts against Aids (ICEA), African Medical Research Foundation (AMREF), Ministry of Health - Kasana HIV/AIDS clinic for treatment, counseling and provision of supplementaries (food, soap, sugar and other basic necessities of HIV/AIDS victims) and religious organizations mainly Church of Uganda. Several of these organisations and institutions were found to be operating at all the three levels, national, district and sub-district but with different specific roles. The national level was dominated by policy issues, programme design and funding. Actual implementation issues including training, counseling, treatment and support for income generating activities were more visible at the lower levels.

A number of HIV/AIDS interventions were identified at the various levels. Some interventions were jointly run by more than one organisation, mainly in a complementary manner. For example, USAID was mainly engaged in the funding of activities of other organisations including training of trainers, counselors and purchase of supplementaries. A summary description of each of these interventions in the form of programmes and projects is presented in appendix 2.1.

As noted above, the AIDS/STD programme is a national level programme but which was implemented at the lower levels of government within a decentralised framework comprised of the national, district and sub district levels. The programme component that was specifically most relevant to this study was implemented under the title of “Health Care and Support”.

The origin of the intervention lies in the broad based government campaign against the HIV/AIDS epidemic that was launched as early as 1986. A structured government response to the HIV/AIDS epidemic dates back in 1986 when an Aids Control Programme (ACP) was created in the Ministry of Health. This was partly a result of the work of a committee constituted in 1985 to promote mobilisation of resources for health care. At that time, the Ugandan government launched an intensive campaign against the epidemic mainly through public awareness programs. These included educating the population on how the disease is contracted, and caring for and counseling those who were already infected. Other programme components included the promotion of preventive methods such as the distribution and use of condoms.

Over time, the HIV/AIDS epidemic became a big national issue that was looked at as more than a medical problem such that a new strategy to address the problem had to be devised, preferably following a multi-sectoral approach. In 1992, a statutory body, the Uganda AIDS Commission (UAC) was established, under the auspices of the President’s office, to actualize the multi-sectoral approach to combating HIV/AIDS. Thus, the UAC was expected to provide leadership in the coordination of HIV/AIDS programs and activities of all stakeholders for the eventual control of the HIV/AIDS scourge in the country. Its roles included mobilizing local, national and international support, setting up technical resource networks, and rallying stakeholders around identified key issues. The fact that the commission was to report directly to the President gave it ability to act swiftly with little or no bureaucratic procedures.

In 1993 the National Operation Plan (NOP) operationalised the implementation of the multi-sectoral approach to the HIV/AIDS epidemic, which was adopted to widen the response beyond the health sector. Since then, several initiatives on HIV/AIDS have come up in the country involving several stakeholders and actors at the various levels of government and other social structures. In fact, the success gained against HIV/AIDS could largely be attributed to the adoption of an open policy of campaigning against the epidemic and use of a multi-disciplinary approach involving several stakeholders.

The AIDS/STD programme, which was started in 1995 by the Ministry of Health (MoH), has the following objectives:

- Provision of comprehensive care policies and guidelines,
- Mobilization of human and financial resources to implement care across a continuum,
- Integration of HIV/AIDS care with existing services, and
- Prevention interventions as part of health care
- In terms of outputs, the programme was expected to:
- Produced policy and operational guidelines,

- Set standards of conduct and operation,
- Addressed training components directly and through partnership with NGOs, and
- Supervised and monitored delivery and use of anti retroviral drugs, testing kits and reagents.

### *Activities*

The main goal/aim of the programme was to promote a continuum of comprehensive health care, which included the following activities:

1. Clinical management, which was comprised of early diagnosis, rational treatment and follow up care of illnesses related to the HIV/AIDS infection,
2. Nursing care including promotion and maintenance of hygiene and nutrition, provision of palliative care, and practice of infection control by observing universal precautions,
3. Counselling support such as psychosocial support for reducing stress and anxiety, promotion of positive living and helping individuals make informed decisions about HIV/AIDS testing. This component also included planning for the future such as writing of wills for succession purposes, and behavior change aimed at preventing transmission, involving multiple sexual partners, and
4. Social support through the provision of information and referral to support groups, welfare services and legal advice for individuals and families - including surviving family members.

### *Stakeholders*

The early stages of the programme benefited from participatory methods involving the communities and staff of the District referral hospitals especially in the identification and definition of the problem. However, the later stages including needs assessment, detailed design of programme activities and format of implementation, were done by the MoH and World Health Organisation (WHO).

The MoH, through its headquarters at national level, and the referral and lower level health units, in addition to Non-governmental Organisation (NGOs), implemented the programme, including monitoring and evaluation, at various levels. The bulk of the initial funding and other forms of support such as technical support came from the Global Fund Program through the WHO, the World Bank and the Government of Uganda. Appendix 2.2 provides a summary of types and roles of the different stakeholders.

### *Beneficiaries*

The programme beneficiaries include communities and the health staff. The later benefited through training and easing of the work burden under the referral health and home care management system. A number of families have been trained in how to carry out basic care for the sick including provision of appropriate feeding. Families and relatives of the affected people have also benefited as some of the orphans have been supported in schools and tertiary institutions. Significant synergies have also been developed among the various participating institutions, which should also have benefited from the increased and improved levels of cooperation and inter-organisational dialogue.

Appendix 2.3 provides information about the key stakeholders, most of whom also double as beneficiaries of one kind or another.

### **Costs**

The Estimated budget of the programme was US\$ 106.3 million and was to be allocated in a multi-sectoral manner according to the format described in table 2.1 below.

**Table 2.1: Distribution of the Budget among Sectors (US\$ millions)**

	<b>Item Description</b>	<b>Amount</b>
1	Prevention of sexual transmission	39.60
2	Mitigation of the impact of HIV/AIDS and Tuberculosis	25.40
3	Reproductive Health	12.55
4	Institutional Development	14.90
5	Economic sector	0.90
6	Education sector	3.50
7	Agriculture sector	1.00
8	Gender, labor and social development	2.15
9	Public service	0.10
10	Transport	1.50
	Total	106.30

Source: Ministry of Health.

## **2.2 Impact**

The impact of the programme can be assessed both at purpose and output levels. Based on the objectives of the programme and the nature in which it was to be implemented, multi-pronged and multi-institutional, the task of identifying impact quite easily runs into the problem of attribution. Nevertheless, there has been substantial impact in the country in the areas that the programme set out to address. In particular, the programme activities were expected to impact on peoples' lives in the following ways:

1. Improved quality of life,
2. Decreased social impact of HIV/AIDS,
3. Enhanced prevention activities,
4. Prevention of secondary spread of infectious diseases such as tuberculosis,
5. Maintenance of working capacity of people living with AIDS (PWAs), and
6. Strengthening of the existing health care system.

Presently, it is evident that Uganda has made significant strides against HIV/AIDS including stabilisation of the rate of infection. The strong political will and the open approach of Government on HIV/AIDS have combined with an almost overwhelming support from development partners to generate a major asset in the prevention and control of the epidemic.

According to the HIV/AIDS surveillance reports, prevalence rates continued to decline in the different parts of the country both in the rural and urban areas. The data, based on

pregnant mothers attending antenatal clinics, indicated that the weighted overall prevalence rate declined from 6.8 percent in 1999 to 6.1 percent in 2000. However, the rate was skewed towards the urban sites where the weighted average dropped from 10.9 percent to 8.7 percent in 2000 compared to respective figures of 4.3 percent and 4.2 percent in the rural areas over the same period.

Additional programs have come up in the areas of caring for orphans, supporting income-generating activities for the homes of infected and affected persons, treatment for the sick, and formulation of mobilization and awareness raising groups such as PLAs and Post Test Clubs (PTCs). The PTCs are formed by people who have had a test for HIV, on a voluntary basis, regardless of whether they were found to be positive or not.

As already noted, the government policy of openness and political commitment to HIV/AIDS control contributed significantly to the creation of high levels of awareness in the population about the dangers of the epidemic and possible means of prevention. The establishment of the UAC led to the creation of programmes beyond the health sector, which have strengthened the multi-sectoral response to the epidemic. For example, in addition to establishment of a number of voluntary testing and counselling centers, HIV/AIDS education has been introduced in the primary education system.

In the case of Luwero district, and to an extent the national level, the multi-sectoral response to HIV/AIDS is reflected in appendix 2.3. Different organisations have mobilised resources and linked up with each other to deliver a range of services to the population. Whereas some organisations are responsible for the policies that govern the operational framework, other organisations have taken on the responsibility for delivering of medical and/or other supportive goods and services.

Whereas one can advance a number of reasons to explain the level of success attained by the AIDS/STD programme, some of the most outstanding reasons include political commitment, a policy framework that promoted a multi-sectoral approach, and effective mobilization of both financial and human resources, which received an adequate response, at the local, national and international levels.

The programme has enjoyed widespread political and community support from all levels. As earlier noted, the housing of the UAC in the President's office was a strategic location that gave it the ability to act swiftly with little or no bureaucratic procedures. In addition, the President has on many occasions been personally involved in practical ways that are aimed at advancing the objectives of the AIDS/STD programme. Similar inclinations could be found at all other levels of political leadership. The degree of openness portrayed by the country's political, social and cultural leadership has been a great asset for the fight against HIV/AIDS, an aspect that the AIDS/STD programme must have benefited from immensely.

Secondly, the programme has operated in a policy framework that allows multi-sectoral and multi-institutional approaches to take root. This was one of the assignments given to the UAC. A number of stakeholders have been able to contribute to the programme

objectives based on their interests, mandates and roles as described in Appendix 2.3. The multi-pronged approach has enabled mitigation of both immediate and protracted effects on the dependants of the infected person(s). Interventions have been directed to sensitisation, training of trainers, funding, provision of home care support, treatment, the distribution of supplementaries, and providing education for orphans.

Finally, there has been an effective mobilisation of both financial and human resources to implement the different strategies. Funds have been availed by international organisations, NGOs, Government and several other charity organisations. The case of Luwero (appendix 2.1 and 2.3) shows a rich blend of different sources of funding for the various activities by different organisations.

The human response too, has been nothing less than enormous. Volunteers, and charitable organisations alongside government activities have done the bulk of the work in the HIV/AIDS associated interventions. Some of the most outstanding stories of effectiveness, such as TASO (an AIDS support NGO), have been based on individual initiatives of people who came face-to-face with the effects of the epidemic and wished to make a difference. In this particular study several people who are members of such groups as PLAs and PTCs were interviewed. It was clear that much of what had worked in terms of programme components was based on local responses to the opportunities offered by the programme, and not just grand strategies of a global nature.

### **2.3 Poor People as Focus**

Given the broad nature of livelihood structures, it suffices to say that the interventions had a positive contribution to people's livelihoods albeit in a non-predicated manner. No specific mention was made of livelihoods though the programs addressed such issues as poverty eradication through generation of income, improvement of human capital through health and educational support, and strengthening of social capital by formation of PTCs and PLAs for joint action towards a given common cause.

Coverage, however, was not comprehensive as most areas received certain components of the programme and not all. In particular, the NGOs were operating in selected areas and offering specific services, which were different from one NGO to another. With the exception of the MoH, the choice of service to be offered was largely dependent on the individual implementers' national or global mandate while the selection of the areas to operate in was largely based on prior engagements and involvement. It is, therefore, possible that coverage was not entirely based on the magnitude and/or intensity of the problem. However, since both the magnitude and intensity of the HIV/AIDS problem was so widespread, it is highly likely that the choice of area to operate in or service to deliver, did not matter that much.

### **2.4 Participation**

The elements of participation by the communities were strongly reflected in most of the interventions, especially during the problem/needs assessment and implementation stages. Communities were mainly involved in the initial stages of the projects especially in needs assessment, and later on at the implementation stage. Individual organisations

did not seem to have interacted with each other in the initial stages of problem identification and design as opposed to the implementation stage. Most designs were based on self-organisational systems at the district office and the national or even international headquarters. However, in the case of ICEA, there was ample participation in the regular decision making processes by the people through their representatives.

## **2.5 Partnerships**

The partnerships, unlike participation, did not seem to blend so strongly to allow communities to feel that their involvement was part of the intervention and that they too were part of the programme. In some cases, the people taking care of the infected persons (own-family members and/or relatives) did not fully comprehend their roles and obligations and continued to tell the nurses that **“your patient was not fine last evening”**. In a similar manner, the children supported by Plan International in schools were referred to as **“Plan children”**. Some partnerships, therefore, tended to translate a complete “hand-over” of responsibility and ownership from families to the NGOs or other implementing agencies.

Similarly, the partnerships between organizations appeared to evolve more strongly at implementation as opposed to the design stage. For example, the Ministry of Health largely dealt with the WHO while the district office for Plan International had a lot of upward liaison with the country head office. The project for the Delivery of Improved Services for Health (DISH), in particular, was a joint venture by the MoH and USAID. However, as indicated in appendices 2.2 and 2.3, the core activities and services of DISH were at the same time shared and benefited from by several other organisations.

Strong partnerships, however, evolved where the interests converged as different partners were quickly incorporated in the planning and management committees of the different interventions or called upon regularly to make different forms of inputs.

One of the great challenges arising from the review was the need to show the population that their ideas at the problem analysis stage have indeed been incorporated in some way into the entire programme. Otherwise, the process of consultation would simply look as an exercise of extracting information from the communities. Given that not everyone can participate in the design, it would require ample and sustained sensitisation including communication to the populations of what became of their initial ideas and how these have been incorporated in the design.

## **2.6 Holistic Approach**

A holistic approach in problem analysis, solution design and implementation would require recognition that HIV/AIDS is a broad based and long term incidence that goes beyond the infected person to the entire family and society, and with great potential to leave a lasting impact that may change other people’s livelihoods for ever. For example, the children will continue to grow, need education, require legal protection especially for the properties. In addition the sick person(s) would require both medical and social care and support. HIV/AIDS tends to alter access to work, financial assets, and other social activities for entire households thus, exposing them to a big possibility of a permanent

shock. It would therefore be necessary to look at all the different aspects and possible effects in the analysis of the problem and design of solutions.

In the Ugandan case, most of the interviewed persons indicated little or no knowledge of sustainable livelihoods approaches. This partly explains the reason why holistic approaches to problem identification and design of interventions, as would be expected of an SLA approach, did not feature explicitly in any of the interventions. Thus, where elements of SL approaches were used, it was more of an overlying outcome than an underlying part of the design process.

The logical framework was the main design tool used in all interventions and by all organisations. After the design stage, which followed the problem or needs assessment in some cases, the projects or programmes went straight into implementation without any serious appraisals. The extent of social economic impacts was not duly evaluated and appraised though the results indicated positive outcomes. In particular, PTCs appeared to have made a significant contribution to improve both individual and community attitudes towards living with HIV/AIDS and hence gave the people living with Aids a new dimension in life, with a great potential to improve their livelihoods. The aspect of social stigma was positively being tackled.

It follows, therefore, that dealing with the HIV/AIDS epidemic will require mitigating the immediate impact of the disease but also promoting prevention and coping strategies. The programme design would require more than an annex that recognises long-term and other impacts that may seem abstract. Much as the STD/AIDS programme did not seem to take this approach, the policy framework by the UAC had provision for such an approach to be adopted and implemented, albeit through partnerships with other organisations.

## **2.7 Policy and Institutional Links**

Given that the HIV/AIDS epidemic has wide ranging impacts including those of a medical, social and economic nature, it was anticipated that a wide range of stakeholders were to be involved. Thus, the UAC had the overall responsibility for co-ordination much as the implementation lay with several other stakeholders. At the time of conducting this study, there were ongoing efforts by the UAC to enlist all the various actors in the HIV/AIDS interventions and the form of their involvement. This was, partly, expected to strengthen identification of weaknesses and strengths of the system and hence improve the policy and institutional linkages.

Perhaps, one of the greatest aspects that introduced the linkages between the macro, meso and micro levels in the Ugandan programme was the decentralisation framework. The mandate for service delivery is given to the districts and sub districts with the central government ministries largely taking up the co-ordination and monitoring roles. Thus, there was an already existing structure, which was being built and strengthened for the purpose of linking up the lower and upper levels of the national socio-economic structure. The same structure was being utilized to come up with policies that incorporated the views of the poor. Appendix 2.3 may also be used as a review of the hierarchical categorisation of the actors at the different levels.

More so, the broad nature and level of integration in Uganda's policy framework, made it easy to find linkages in whatever was being done by the different stakeholders. For example, interventions such as income generation activities (IGAs) and educational support, especially in the acquisition of technical skills by ICEA and AFXB were in line with macro level government policies as prescribed in the poverty eradication Action Plan (PEAP). Since government is focusing on primary level education, the support of technical education should be looked at as a complementary initiative with good and strong implications for sustainability. Though the meso and micro level issues of local demand for the skills being offered by the training institutions did not feature in the original designs, it is easy to presume that such aspects could have been addressed by the initiators of the training institutions where orphans were being seconded for study.

The above observation introduces an aspect of institutional linkages whereby those who supported education did not offer it on their own but linked up with already existing institutions to which the students were sent. There were several other interactions noted between the different organisations in a number of areas. The district office of Plan International, for example, provided supplementary foods to Kasana HIV/AIDS clinic, while DISH provided funding for training by the Ministry of Health and other organisations. As noted above, the church vocational training colleges were used to train orphans under the funding by ICEA. AFXB also liaised with Government schools implementing the Universal Primary Education (UPE) program to provide the necessary addition counterpart funding that is expected from parents and/or guardians.

Table 2.2 below shows the different interventions and the respective organisations that were involved in the delivery of the related service(s). The column for the Ministry of Health (MoH) represents the headquarters, the District head office and the Health Sub-District. Though Kasana (HIV/AIDS Clinic) would also fall in the Ministry's perspective, it was singled out because of its unique and specific objective and the fact that it attracted special funding from DISH and Plan International for provision of treatment materials and supplementary foodstuffs. Despite the focus on formal organisations, there was an underlying participation by the communities in all the activities in the form of individual persons, households and groups such as PTCs. There was also participation by other organisations such as Churches and Schools.

Table 2.2 Key Interventions and Respective Organisations

Intervention/activity/Organisation	MoH	Kasana	AMREF	AFXB	PLAN	DISH
Strategic leadership, policy formulation and resource mobilization	X		X	X	X	X
Community sensitization and awareness raising	X	X	X	X	X	
Treatment of opportunistic diseases	X	X				
Application of retroviral treatment	X					
Training of both health and community workers	X		X	X	X	
Counselling before and/or after carrying out tests to establish people's HIV/AIDS status	X	X	X		X	
Support to infected and affected communities which may be in form of:	X				X	
Provision of supplementary assistance (e.g. food, soap and sugar)						
Provision of education requirements for orphans				X	X	
Income generating activities				X	X	
Home care visits		X	X	X	X	

X indicates Organisations participating in the given activity

Source: Compilation from Field Reports

## 2.8 Building on strengths

It is clear from the budget lines that the programme had an institutional development component and support to other sectors, which was mainly intended to incorporate capacity building aspects. Since the programme was to be implemented through existing and evolving institutions, it was expected to benefit from the capacity components of these organisations. For example, the curriculum changes that were taking place in both primary and tertiary institutions were bound to lend themselves positively to the programme. The introduction of UPE, contributed to the improvement of the methods and means of reaching out to thousands of teenagers and teenage bound children, who would otherwise be hard to reach outside the school system.

It should, however, be noted that the none explicit adoption of a holistic approach, which would also have led to a deeper involvement by more stakeholders, could have led to little comprehension of the capacity requirements especially in the partner organisations. The approach, which was followed, is bound to have yielded an inadequate perception of all the resources available for implementation of the various interventions and hence undermined efforts to build capacities in response to the identified strengths and weaknesses within individuals, households, communities and organisations.

The practice of beginning to solicit for partners and resources to carry out the implementation after the problem analysis and design stages may result into sustainability problems if the initial resources are only availed for a given period, or worse still, for only one of the many activities involved in the intervention. In a situation where funds have been availed for training but not the field travel for the trained persons, it is likely that the envisaged benefits will not be fully realised as the trained persons would not interact adequately with their intended subjects. A possible example may be described by the case where DISH provides facilities for training but not the eventual movement for the trained persons to reach out to the communities. The arrangement was that such counterpart funding would come from other stakeholders such as government. In the event that such complementary funding was not realised, it is likely that the programme objectives would not be realised as well.

### **2.9 Dynamic and flexible**

The purpose of incorporating aspects of dynamism and flexibility was partly to establish whether the objectives and activities of the intervention had changed as a result of the changing environment and/or demands. In addition, there was need to establish whether new interventions had arisen from this particular intervention, and whether this was a result of monitoring, evaluation and feedback. In a typical SL approach, one would expect emerging issues from monitoring and evaluation (M&E) reports to be incorporated in one way or another as the programme progresses.

The evaluation and monitoring of programme activities were mainly done by the staff of the organisations though with some limited input by the communities. With regard to impact evaluations, where it is not possible to attribute any given outcome to specific activities by a given organisation, reliance was made on records collected both through surveys and individual organisation records but which were compiled and analysed at either the district or national level. For example, the decline in infection rates could be due to sensitisation of communities, use of preventive methods such as condoms or change of sexual behavior. National and district figures were therefore relied upon to gauge progress in such areas. In terms of localised outputs, outcome and impacts, however, individuals organisations were able to compile their reports.

The low level of access to reports, especially those of individual organisations, by the general public and other counterpart organisations, should be seen as limiting the enhancement of the dynamic aspects of the programme. The reports were largely treated as internal organisational documents and yet they would be a valuable tool to the communities and other organisations. This may therefore have constrained any feedback messages, which could have resulted into positive changes to the overall programme design and implementation.

Rather than having fundamental changes to the program designs, most of the interventions had only experienced incremental appendages. For example, there was an addition of distributing supplementary foods to the sick on the activities of Kasana HIV/AIDS Clinic, which originally, only, included counseling, testing and treatment. The clinic still has an additional potential of starting a PTC or making greater linkages with

those who have established PTCs. Matter of fact, one the primary beneficiaries of the clinic indicated a wish to be availed land in the neighborhood to support income generating activities. The clinic could also advocate for the infected members to have relief of certain demands, such as the payment of graduated tax, given that it has the test-results of people's HIV status.

### **2.10 Accountability/ Responsiveness**

In terms of delivery of services, one could say the interventions by the government were accountable to the people mainly through their elected leaders. Where such a system was not functioning effectively, then the entire process of reporting and being sensitive to the people's needs could easily break down. However, the great desire to have a change, especially on the medical and social side of reducing infection rates, led government and several other stakeholders to be accountable to the population, at least, to a reasonable degree. Nevertheless, as indicated in the case of evaluation reports, the interventions were largely not accountable to the general population beyond a certain level of detail. Reports were availed to selected stakeholders such as funding agencies and supervising institutions.

### **2.11 Sustainability**

Sustainability may be looked at from several contexts including the economic, social, environmental and institutional. In most cases the medium to long-term sustainability of the interventions was not considered at the design stages. This section looks at each of these aspects in a more detailed manner.

#### Economic

All interventions had a strong component of external financial support and little reliance on their own local/internal funds. The activities of PTCs within the ICEA project areas of operation were directly linked to ICEA office, which had to provide costumes and transport to different places. In addition the provision of supplementary foodstuffs for Kasana HIV/AIDS clinic had, by the time of conducting this study, been suspended due to delayed deliveries by the district office of Plan International. These examples show pending difficulties of activities being able to continue after the external input was withdrawn. It would be necessary to take a holistic approach and cost all these interventions and establish all the available resources from different organisations so as to identify the true resource gap and funding needs.

#### Social

There were strong implications for social aspects of sustainability given that a number of interventions were built around communities and had strong linkages with existing social networks. For example, community sensitisation and increasing levels of awareness involved training of both local trainers and participants who were part of the local social structures.

#### Environmental

The programme was largely neutral to the environment given its main focus to the health sector, strengthening of community social structures, improvement of skills and

corporation, and limited focus on production for increased incomes. Thus, there was no noticeable danger that the programme would have no environmental sustainability.

### Institutional

Organisations such as AMREF, through focusing on schools, benefited from the already established framework enabling them to reach out to large groups in a cost effective manner. Thus, partnerships with other institutions were bound to offer a stronger case for efficiency, cost effectiveness and sustainability. In this way, it is even possible to incorporate the AMREF program into the schools programme for institutional continuity and sustainability.

A special case for continued institutional sustainability was identified in the ICEA project, which was in the process of introducing capacity building aspects in the PTCs. The leadership of PTCs had depicted high turnover rates mainly because it was comprised of people who were already sick of AIDS and would therefore die, soon or later, leaving new ones to take over. The presence of non-infected persons in these clubs was considered a potential strength, which could be utilized in developing capacity for sustainable leadership.

However, certain programme components were in the danger of having no institutional home for continuity. Where organisations like DISH funded the training, there were problems of trainers failing to obtain operational resources to enable them to move out to the communities.

### **2.12 Critical factors**

The high level of success attained by the AIDS/STD programme in several in several of its set objectives, which were implemented in a manner similar to the SL approach, is a clear testimony of the great potential for such an approach. The actual factors for the success of the programme included an all-embracing design that allowed several stakeholders to participate based on their mandates, abilities and interests. The programme also enjoyed strong political support at all levels of government. Finally, the subject matter of combating the HIV/AIDS epidemic called for immediate response and less rhetoric, as it affected so many people, that it was easy to secure universal consent and action. Any bureaucratic delays were kept to the minimum.

The SL approach seems to raise several cross-cutting issues that can hardly be addressed in a sector approach. There was evidence that some programme aspects, which were very crucial for success in some sectors were not prioritised by the sector(s) where they belonged. For example, capacity building, at the district level, lay in the area of Local Governments, which had to wait for funding through the Local Government Development Programme (LGDP). The sequencing of such training activities, if not well synchronised, can impact negatively on the performance of several other programmes. The Ministry of Health, has in particular, raised the concern of lack of adequate numbers of paramedical personnel and whose training now lies in the Ministry of Education, to which the medical training institutions had been transferred.

It has been shown that the adoption of a holistic approach in the analysis and design of the policies to address development concerns can help to incorporate all the various interrelations between strategies, sectors and programmes and to evaluate the effect on any one component on the entire framework. This is not to mean that there will not be conflicts between objectives of different policy components. There is always a clear possibility that selected strategies will favor certain livelihoods against others.

**References and Documents used**

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Ministry of Health: Various Luwero District Health Reports.

Uganda Aids Commission (2001), Annual Report

## Appendices

### Appendix 2.1: Summary of Primary Implementers of AIDS/STD Programme

#### Association Francois Xavier Bagnoud (AFXB)

Name/Title: Aids care and support

Type: Program

Period: 10yrs

Sectors: Health, Education, Production (Agriculture and Livestock), and Justice Law and Order

Scale/Level: District

Goal/Aim: Assistance to HIV/AIDS infected persons and affected guardians and orphans.

#### Summary and scope of intervention:

- Medical support to the sick in form of treatment
- Awareness creation about HIV through sensitization
- Children's rights
- Provision of Income Generating Activities (IGAs)
- Education Support to Aids orphans

**Objective:** Improve the standards of living of a targeted group

Results/Outputs/Incomes

- Improved levels of income - provided 1700 households with IGAs
- Provision of treatment to 300 infected people
- Provided education assistance to 6,000 orphans

**Beneficiaries:** i) Community as a whole  
ii) Aids orphans and their guardians  
iii) Schools (indirect beneficiaries)

#### Funding

AFXB-Switzerland

**Supporting agencies:** District team

#### Implementing Agency (ies)

AFXB-Luwero

District Health Units

Schools

Community based health care systems

Local Councils

Methods/processes used in design

Participatory methods were employed with both the community in general and target beneficiaries in particular getting involved in needs assessment and proposals of approaches to possible problem solutions. A logical framework was used in the design for implementation.

### **Monitoring and Evaluation**

This was done by AFXB staff through own-meetings for monitoring progress and also meetings with the community. Community based health care personnel were also involved in reviewing the progress made and offered feedback to the staff.

### **Plan International**

**Name/Title:** Integrated Community Efforts against AIDS (ICEA)

**Type:** Project

**Period:** 3yrs

**Sectors:** Health, education and production – through provision of IGAs in the form of a start-up grants for students who have completed vocational training.

**Scale/Level:** District

**Goal/aim:** Aids care, prevention and awareness.

### **Summary and scope of intervention:**

- Counseling-Psychosocial support
- Succession planning
- Sensitization about HIV/AIDS through PTCs
- Offer Vocational skills to Aids orphans
- Offer start-up grants for vocational students
- The District Plan office also provided drugs and supplementary foods to households of infected persons through the HIV/AIDS clinic at Kasana.

### **Purpose/Objective:**

- Enable people advocate for their own needs and rights
- Develop capacities to enable proper service delivery by:
- Equipping units with drugs
- Subsidizing drugs.
- Providing Supplementary foods and other patient-care items
- Break silence about HIV/AIDS in families
- Strengthen social status of Aids orphans

### **Results/Output/Outcomes**

- Easy accessibility to improved health services
- Increased community awareness about HIV/AIDS and its implications

### **Beneficiaries:**

Members of PTCs

Communities

Vocational Schools

Funding/Supporting agencies

DFID

Elton John Foundation

**Supporting agencies:**

PLAN international-Uganda

District Health Service team

Implementing Agencies

PLAN International-Luwero

Church of Uganda-Luwero (Training vocational students)

AFXB-Luwero (Training Aids orphans)

TASO and MoH-Provide skills

PTCs

**Methods and processes used in the design**

Participatory methods were employed at the problem identification and needs assessment stages, which were done by the community with facilitation from Plan International. Having gone through that preliminary stage, the community together with Plan International officials wrote a proposal, which was forwarded to DFID. Participants from the community included people living with AIDS (PLAs) and community leaders. In fact, the board of management is still reflective of this participation as the people elect their own representatives who include community leaders and district health personnel.

**Monitoring and Evaluation:**

Field monitoring reports

MoH HIV/AIDS surveillance reports

NGO operational research studies

Community surveys

Seminars and workshop reports

Demographic and household surveys

**Indicators:**

Project goals and purpose

Variable indicators-Life expectancy

Quality of HIV care and prevention services

Accessibility to health services provided

**Livelihood:** Partial in the sense that the problem is incorporated in the analysis but not in the implementation.

**Documents collected:** Design reports

**Kasana Health Centre HIV/AIDS Clinic**

**Name/Title:** HIV/Aids clinic  
**Type:** Program  
**Period:** 7yrs  
**Sectors:** Health  
Production (IGAs)  
**Scale/Level:** District  
**Goal/Aim:** Aids care, support and awareness

**Summary and scope of intervention:**

- Treatment of opportunistic infections
- Voluntary counseling and testing

**Objectives:**

Sensitization  
Control of opportunistic diseases  
Establishment of IGAs through PTCs

**Results/Outputs/Income:**

Increased awareness about HIV and its implications  
Improved general health  
Improved welfare through IGAs

**Beneficiaries:**

HIV patients  
Communities  
PTCs

**Funding/supporting agencies**

PLAN International  
District

**Implementing Agencies:**

ICEA- Integrated community Efforts against Aids  
PTCs  
District  
Kasana Health Centre

**Participatory methods**

Community involved in problem identification  
District officials and In-charge of Kasana wrote the proposal and sought funding from PLAN

**Monitoring and Evaluation:** Monthly Reports to Plan International and the District health office.

**Indicators:**

Number of clients counseled

Number of clients tested

Number of clients given supplements

Number of homes visited by counseling Aides

Number of group talks made by counseling Aides

**Social:** Community participation through PTCs

**Appendix 2.2: Organisation, Types of Stakeholders and Roles**

ORGANISATION	NAME OF STAKEHOLDER	TYPE OF STAKEHOLDER	ROLE OF INTERVENTION
Plan International (Integrated Community Efforts against Aids: ICEA)	Community	Primary	Implementers/beneficiary
	Members of PTC's	Primary	Implementers/Beneficiary
	Ministry of Health/TASO	Primary	<b>Implementers/Beneficiary</b>
	Plan International-Luwero	Secondary	Implementers/contributor.
	Church of Uganda-Luwero	Secondary	Implementers
	AFXB-Luwero branch	Secondary	Implementers
	DFID	External	Contributor
	Elton John Foundation	External	Contributor
Ministry of Health (Health care and Support)	Ministry of Health	Primary	Implementer, Beneficiary and Contributor (Finance/Technical)
	<b>Community</b>	Primary	Beneficiary
	World Health Organisation	Secondary	Implementers
	World Bank	External	Contributor
	Global Fund Program	External	Contributors
AFXB (Aids Care and Support)	Community	Primary	Beneficiary/Implementers
	Local councils	Primary	Implementers
	Schools	Primary	Implementers/Beneficiary
	District Health Units	Primary	Implementers/Beneficiary
	AFXB-Luwero	Secondary	Implementers
	AFXB-Switzerland	External	Contributor
	Ministry of Health (District Level)	DISH II	Secondary
Health Staff		Primary	Implementers/Beneficiaries
USAID-INTRA		External	Contributors
AMREF - Luwero	AMREF - Luwero	Primary	Implementer
	AMREF - Luwero	Secondary	Contributor
	DISH	Primary	Implementer
	DISH	Secondary	Contributor (Material)
	AFXB	Primary	Implementer
Ministry of Health Kasana Health Center (HIV/Aids clinic)	Community	Primary	Implementers/beneficiary
	PTC's	Primary	Implementers/Beneficiary
	Plan International-Luwero	Secondary	Implementers/Contributor
	District	Secondary	Implementer/Contributor

**Appendix 2.3: A Hierarchical Description of Key Programme Actors**

Level	Stakeholders and Beneficiaries	Implementers	
		Organisation	Role/Activities
National	General population Political and civil leadership Donors NGOs Religious bodies	Min of Health	Program design, treatment, counseling, testing, training, sensitization and funding
		UAC Secretariat	Policy framework and coordination
		AMREF	Program design and funding
		Plan International	Program design and funding
		USAID	Program design and funding
		AFXB	Program design and funding
		Churches	Treatment, counseling, testing, training and sensitization
District	General population Political and civil leadership NGOs (and Donors) Religious bodies	Min of Health	Program design, treatment, counseling, testing, training, sensitization, support to homes of victims and funding
		Plan International	Training, sensitization support to homes of victims and funding of other implementers
		DISH (USAID)	Training, sensitization and funding of training activities of other implementers
		AFXB	Training, sensitization, education support and income generating activities for persons who are directly affected by HIV/AIDS
		AMREF	Training, sensitization and funding
		Church of Uganda - Kiwoko Hospital	Treatment, counseling, testing, training, sensitization and support to homes of victims
Sub district	Communities Political and civil leadership NGOs (and Donors) Religious bodies Schools	Min of Health (Health Sub-district)	Treatment, counseling, testing, training, sensitization, support to homes of victims and funding
		Plan International (ICEA)	Training, sensitization support to homes of victims and funding of other implementers
		DISH	Training, sensitization and funding of training activities of other implementers
		AFXB	Training, sensitization, education support and income generating activities for persons who are directly affected by HIV/AIDS
		AMREF	Training and sensitization
		Community Initiatives	Sensitization and income generation

Source: Compilations from field reports

**Appendix 2.4: Details of Some of the Key People Interviewed**

	<b>Name</b>	<b>Title</b>	<b>Organization</b>	<b>Location</b>
1	Baingana Hashaka (Dr)	Commissioner (Planning)	AIDS Commission	Kampala
2	Bekunda Remigious	Project Manager	AFXB	Luwero
3	Genza Charles	Health Assistant	Kasana Health Center	Luwero
4	Kamugisha Cyprian	Medical Assistant	Bamunanika Health Center	Luwero
5	Kiiza Paul	Project Officer	Ministry of Health	Kampala
6	Mugarura Chris	Economist/Planner	Ministry of Health	Kampala
7	Muwa Beatrice	Project Coordinator	ICEA (Plan International)	Luwero
8	Nakyoga Alice (Dr)	Director, District Health Services	Ministry of Health	Luwero
9	Odong (Dr)	Medical Officer	Ministry of Health	Kampala
10	Sekabira Umaru	Health Assistant	Kasana Health Center	Luwero
11	Semujju Robinah	Project Manager	AMREF	Luwero

**Acronyms and Abbreviations**

ACP	Aids Control Programme
AFXB	Association Francois Xavier Bagnoud
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
DISH	Delivery of Improved Services for Health
HIV	Humane Immunodeficiency Virus
ICEA	Integrated Community Effort against Aids
IGA	Income Generating Activity
LGDP	Local Government Development Programme
MoH	Ministry of Health
NOP	National Operational Plan
SL	Sustainable Livelihoods
SLAs	Sustainable Livelihoods Approaches
STD	Sexually Transmitted Diseases
TB	Tuberculosis
UPE	Universal Primary Education
USAID	United States Agency for International Development
WHO	World Health Organization