THE IMPACTS OF HIV/AIDS ON CHILDREN IN NORTHERN UGANDA, A CASE STUDY OF GULU MUNICIPALITY, GULU DISTRICT

BY

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REG NO: BDS/4989/31/DU

A RESEARCH REPORT SUBMITTED TO COLLEGE OF APPLIED ECONOMICS AND MANAGEMENT SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR AWARD OF BACHELOR DEGREE OF ARTS IN DEVELOPMENT STUDIES OF KAMPALA INTERNATIONAL UNIVERSITY.

January 2013

DECLARATION

I, Apiyo Nancy, do hereby declare that this report is my original work and has not been presented for any academic award or otherwise in any academic institution.

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Date.....29th/Jan/2013

APPROVAL

This research report has been submitted for examination with the approval of my Supervisor.

Signature:.....

Name: Mr Anyama Charles

Date.....29. 01. 2013

DEDICATION

I dedicate this work to all the people who died of HIV/AIDS during the insurgency in Gulu district.

ACKNOWLEDGEMENTS

I thank God for enabling me complete this study successfully. I acknowledge the academic and non-academic staff of Kampala International University Department of Development Studies for their support during my study. Special thanks to Mr Anyama Charles.

Special thanks go to my family members and friends for providing funds, which enabled me to go through the course successfully..

Lastly, I thank all my respondents from whom the necessary assistance and data was obtained and used to produce the work.

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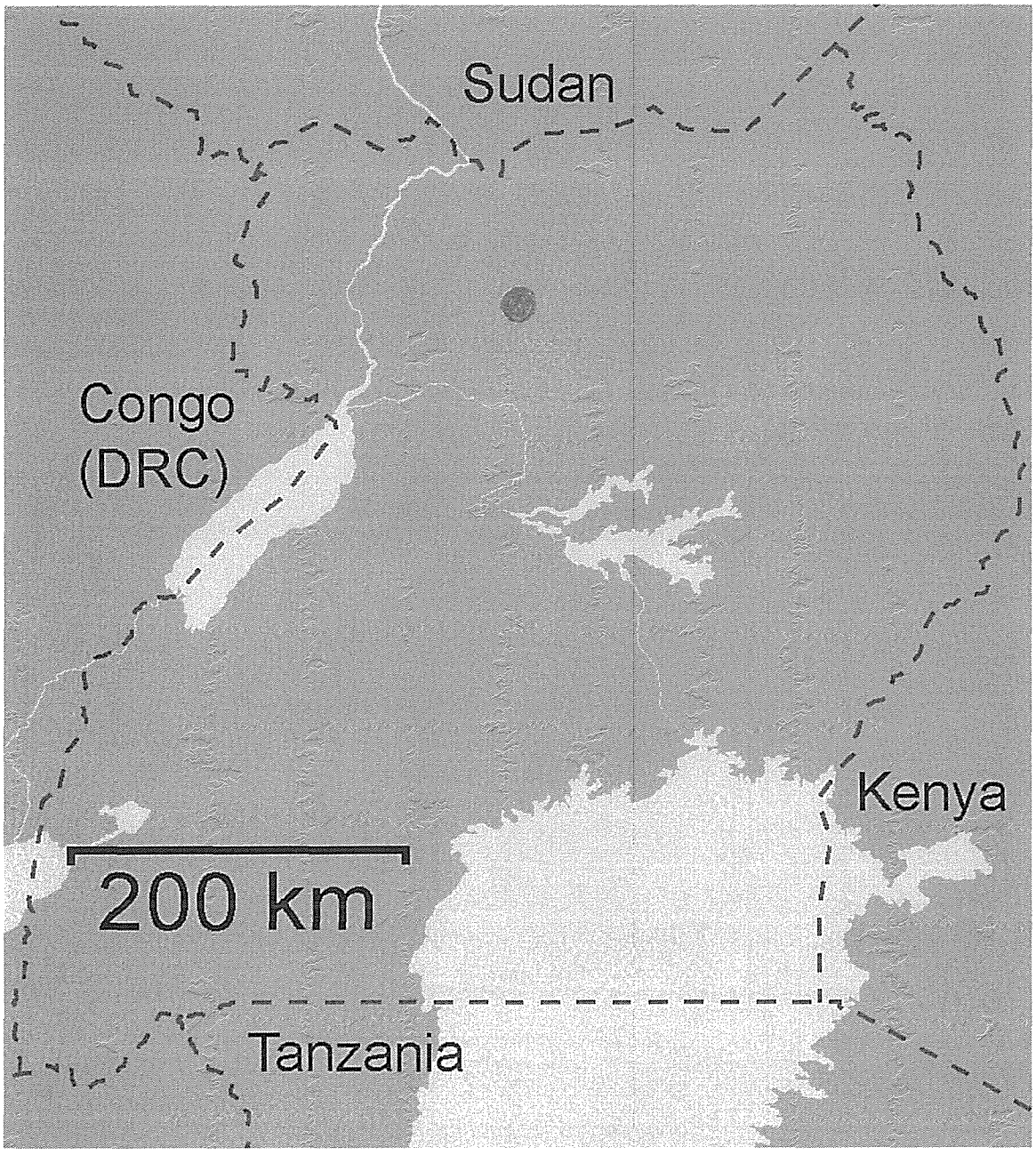
LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ART	Anti Retroviral Therapy
BCC	Behaviour Change Communication
CBOs	Community Based Organizations
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
IEC	Information and Communication
ILO	International Labour Organization
MRC	Medical Research Cohort
NGO	Non-Governmental Organisation
PIASCY	Presidential Initiative on AIDS strategy for Communication to Youth
PWA	People with AIDS
PMTCT	Prevention of Mother To Child Transmission
PY	Person Years
STD	Sexually transmitted Diseases
TASO	The AIDS Support Organisation
TB	Tuberculosis
TBA	Traditional Birth Attendant
UBOS	Uganda Bureau Of Statistics
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing

Map of Uganda showing exact location of Gulu municipality



Key

	Gulu district
	Lakes and rivers

ABSTRACT

HIV/AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age. According to an article that appeared in the New Vison Newspaper on May 25th 2010 written by Chris Ocowun, there is an upsurge in HIV/AIDS prevalence in Gulu district from 9.4% in 2008, to 16% in 2009, with Gulu Municipality health sub-district leading with 22.1%. The pandemic HIV virus and the subsequent spread of AIDS has weakened the society, especially its population and its social structures.

This study, which was done in Gulu Municipality, was cross-sectional employing both quantitative and qualitative data collection methods. The researcher conducted interviews with people who are infected and affected by HIV/AIDS and also interviewed some key officials from some organizations dealing with the HIV/AIDS scourge.

Majority of the respondents 60% (150) said they were from Child-Headed households while the other 40% (100) said they were not. Some children have been forced to drop out of school to fend for their siblings. In some of the child-headed households, the girls due to poverty are engaging in risky activities such as prostitution in order to earn a living. Some people living with HIV/AIDS are being discriminated against due to their positive status.

Gulu Municipality has made a considerable dent in the progress of the epidemic. However, compared to the magnitude of the epidemic, this can only be regarded as modest progress not 'success". There is therefore no room for complacency. There are still more gaps. AIDS must be a priority in all social and economic development efforts.

Substantial progress can only be achieved through expanding intervention and service coverage to all corners of the country by bringing all potential sectors and actors on board to fight the epidemic.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

The research was carried on the impacts of HIV/AIDS on children in Gulu Municipality. This chapter will contain general information on background to the study, problems statement, objectives of the study among others as below;

Uganda is one of the least urbanized countries in Africa, with over 90% of the population living in rural areas. According to the 1991 Population and Housing Census, about half the population of the country, that is 8.5 million is under 15 years of age, while those under 25 years make up about 67% of the population. Youth, as defined by the government of Uganda, includes boys/girls and young men/women from 10 to 35 years of age. HIV/AIDS is the most serious health problem in Uganda today and the leading cause of death for adults: About 1.5 million people (10% of the total population and 20% of sexually active men and women) are estimated to be infected with the HIV virus. Since 1982 when HIV/AIDS was first recognized in the country, 41,193 cases have been reported. However, according to the Uganda AIDS Commission, this represents only a fraction of the actual number of people infected with HIV due to under-reporting and under-diagnosis (Population and Housing Census, 1991).

According to some estimates, up to one million men and women could become infected with HIV in the next five years as sero-positive rates have been raising by about 25%-30% per year since 1988. While estimates of the magnitude of the HIV/AIDS epidemic vary the common denominator of all projections is that the demographic structure of the country is undergoing considerable transformation. Ministry of Health estimated 1.44 million people living with HIV/AIDS by the end of 1999. More than 800,000 lives have

been lost to AIDS bringing the cumulative total infections to about 2.2 million since the on-set of the epidemic. AIDS is currently the leading cause of death among adults and the fourth leading cause of death. (Uganda AIDS Commission Secretariat 2002)

Nearly 80% of those infected with HIV are between the ages of 15 and 45 - the breadwinners and parents of families which have on average more than seven children. AIDS orphans are estimated to be in the vicinity of 115,000 and rising, and some experts fear that this figure could increase five-fold in the next five years. War, an increase in children born out of wedlock and the collapse of health services account for the overall rising number of orphans, estimated at between 400,000 and 1,100,000. About 69% of all orphans in Uganda are between 10 and 19 years of age (UNICEF, 2005).

HIV and AIDS, war and civil strife have taken an enormous toll on Ugandan society in the past two decades, causing the deaths of tens of thousands of people and decimating the young and middle-aged portion of the population. The Uganda AIDS Commission (UAC) estimated in 2001 that at least 800,000 people had died of HIV-related illnesses in Uganda since the onset of the disease. The Joint United Nations Program on HIV/AIDS (UNAIDS) estimated that a further 94,000 died in 2001 alone. At least 1.7 million children have been orphaned as a result, and the numbers keep rising: UNAIDS reported in 2004 that an estimated 30,000 additional children were orphaned between 2001 and 2003 (UAC 2001; UNAIDS 2004). Children are also affected indirectly and the epidemic has had a major impact on their welfare. Thus, the infant mortality rate (IMR), which had decreased to 97 deaths of children under one per 1,000 live births in 1988–1992, rose to 101 per 1,000 live births in 2000, while life expectancy declined from 48 to 42 years during the same period.

Of the 10.4 million orphans who are alive and under 15 years of age, Africa account for 9.4 million. This is a rapidly growing trend, which will continue to stretch the extended families and communities. Uganda has 1.7 million orphans in 1999, making it the world's leading, and 10% of the children in Masaka region. These children are at a greater risk of illness, abuse and sexual exploitation. In addition they have to struggle with the stigma and discrimination, which may deprive them of basic social services and education (UNAIDS 2000). A Generation of children who have not known parenthood is emerging. This is made more complicated with illiteracy, lack of employment, low incomes, lack of basic needs leading to social strife, increasing infant/child mortality. Traditional support systems are failing to cope with the

increasing number of orphans, some of the children are taking up roles of parents at tender ages. Furthermore, a good number are experiencing various forms of exploitation, physical and sexual abuse, child labor, prostitution, defilement and others have taken on the life of living on the streets. All these have implications as the major focus of development lies in improving the welfare and quality of life for children. Thus the study shall find out the impact of HIV/AIDS on children.

1.2 Problem statement

It is estimated that there are more than 70,000 new infections every year in Uganda with children accounting for 16,000 of the total. 85 percent of these new infections are estimated to be among people aged 15-10 more than 50% of these infected are women and 15% of children under the age of 15 .420 the pandemic has had a catastrophic impact on individuals ,families ,societies and economies .life expectancy at birth is 45.7 years .421 families have been devastated as large numbers of children have lost one or both of the parents due to the pandemic creating an estimated 900,000 orphans who often left in the care of grand parents or older siblings 421 .

The country has been at the forefront of the struggle, boldly experimenting with openness and a commented and well-organized multi-sectoral approach. Substantial donor funding over the past two decades had allowed the development of myriad of government and NGO sponsored interventions including prevention information, education and communications (IEC); behavior change communication (BCC);

Despite Uganda's notable achievements, there are many urgent challenges ahead. The gender discrimination has denied children access to and getting treatment nationwide; decreased coverage of services for adolescent and women of reproductive age in rural areas; and less access to health care for populations in the conflict districts especially those living in Internally Displaced Person's Camps in North Uganda has laid high burden on girl-children as care givers for sick people at home. In addition, the HIV/ AIDS pandemic in Uganda has let to abuse of children. Many have had to take on indecent Labors in order to survive including prostitution; and many more have been forced to live in cross generations sex where they are

subjects to violence and others abuses. In Gulu District, there was an upsurge in HIV/AIDS prevalence in from 9.4% in 2008, to 16% in 2009, with Gulu Municipality health sub-district leading with 22.1%. John Charles Luwa, the Gulu district HIV/AIDS focal person, said out of the 14,424 pregnant mothers who were tested under the Prevention of Mother-to-Child Transmission of HIV/AIDS (PMTCT) in 2009, about 3,214 were HIV-positive, constituting 22.1.Thus the study was set to find out the impact of HIV/AIDS on children in Gulu municipality.

1.3 Objectives of the Study

1.3.1 *General objective*

To find out the impacts of HIV/AIDS on children between the years of 12-25.

1.3.2 *Specific objectives*

i. To examine the situations that render children vulnerable to HIV/AIDS infection.
ii. To find the problems that children who are infected and affected by HIV/AIDS face in their livelihood.
iii. To find out coping strategies for children who are both infected and affected by HIV/AIDS in the community.

1.3.3 Research questions

i. What are the socio-economic impacts of HIV/AIDS on children?
ii. What are the situations that render children vulnerable to HIV/AIDS?
iii. What are some of the problems that children who are infected and affected by HIV/AIDS face in their livelihood?
iv. How do the children cope with the burden of HIV/AIDS in the family and community?

1.4 Justification of the study

The study will help to create awareness on issues that affects children in line with HIV/AIDS, provide information on the danger of HIV/AIDS that will help to reduce its prevalence and impacts on children.

The findings from the study shall help to identify the existing gaps in service provision, factual in information on how AIDS has affected children in the

community. It will provide a chance for both the infected and affected children to open up and disclose their HIV status, share their experiences, expectations, how they have been coping with their situation and how the testimonies can be used as lessons to reduce HIV prevalence by practicing positive living.

To the researchers; future researchers will use this work as a reference and a guide to their study.

To the student, this study is a partial academic requirement leading to the award of a degree in Development studies of Kampala International University.

1.5 The scope of the study

HIV/AIDS is a dynamic phenomenon that needs a holistic approach in addressing its impact. The study was conducted in Gulu Municipality which is 332 kilometer from Kampala, the capital city of Uganda. This place was selected because during the peak of the insurgency in Northern Uganda, it hosted people from different backgrounds and cultures who moved away from their homes in the villages and settled in the Municipality for security reasons.

The study had children aged 12-17 as the main respondents and stakeholders supporting children dealing with the impact of AIDS.

1.5.1 Geographical Scope

The study is limited to Gulu Municipality in the Northern Part of Uganda , Gulu District

1.5.2 Content Scope

The study is focused on the occupational stress and organizational performance.

1.5.3 Time scope

The study took a time period of The study took a period of five months. July 2012to November 2012

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter presents the background of HIV/AIDS in Uganda and its trend through out the years. The chapter also looks at economic indicators of the Impact of HIV/AIDS, the economic and social results of HIV/AIDS, future trends of Impact of HIV/AIDS on children and the copying strategies that are in place.

2.1 Country background of HIV/AIDS

HIV/AIDS is now the leading killer of adults and youths in Sub-Saharan Africa, where over 25.8 million people are reportedly infected with the virus (1:10 adults). According to the UNAIDS report 1999, over 90% of the world's 11 million children orphaned by AIDS live in Africa. In fact two-thirds (95%) of the world's HIV positive population is found in Sub Saharan Africa, which accommodates a tenth of the world's population (World Vision, 2001-2005).

In Uganda HIV/AIDS is thought to have started spreading during the late 70s along the lakeshores of Lake Victoria, and the first AIDS patient was first identified in 1982 in the District of Rakai. Currently AIDS is the leading cause of deaths among individuals age 15 – 49 years surpassing malaria and other condition. By March 2000, the WHO estimate that 10% of the adult population in Uganda was living with HIV, the current estimates reported is now 6.5% according to the MOH June 2002 HIV/AIDS surveillance report the effects of HIV/AIDS have ravaged communities and the economy in Uganda for almost 20 years now. In Rakai and Masaka districts where the first HIV/AIDS infected persons were first reported the worst repercussions of AIDS have been registered which include social and infrastructure destruction, deaths of the parents thus living increasing numbers of orphans and over stretched extended families among others. Presently all districts in Uganda have reported HIV/AIDS infection among the populations, in the Northern part of

Uganda where insurgency has continued for 14 years, worse repercussions are likely to be experienced in future.

Some of the major unique features, which cause concern of the HIV/AIDS epidemic in Uganda, are mainly to do with its principle route of transmission, which is mainly heterosexual. The majority of people infected are the sexually active group. Sexual activity being the main defining risk factor for the variation of its incidence, and prevalence according to sex, geographical location, culture and socio-economic relations underline sexual interaction between individuals, these have strong bearing on the spread of HIV/AIDS. Furthermore, the fact that the infected people remain symptomatic for a long period before they succumb to full blown AIDS, infecting other and getting re-infected is common. Another factor is that the HIV infection can only be confirmed with laboratory tests, which are currently inaccessible to the majority of the population in the country.

The age group most affected (15-50 years) has a very critical role position in the families and communities as a whole; as heads of household, the labor force, and leaders in society. As such, HIV/AIDS has touched the very aspect of national life and development including individual behavior, roles and functions of the family, communities, economy, care and support systems (Uganda AIDS Commission Secretariat 2002). In absence of a cure and vaccine, change in behavior remains the most important approach towards preventing of HIV infection.

Nearly 80% of those infected with HIV are between the ages of 15 and 45 - the breadwinners and parents of families which have on average more than seven children. AIDS orphans are estimated to be in the vicinity of 115,000 and rising, and some experts fear that this figure could increase five-fold in the next five years. War, an increase in children born out of wedlock and the collapse of health services account for the overall rising number of orphans, estimated at between 400,000 and 1,100,000. About 69% of all orphans in Uganda are between 10 and 19 years of age. According to one estimate reported by UNICEF, half the children in Uganda under 15 years would have lost one or both parents by the year 2000 (Uganda

National Operational Plan for HIV/AIDS/STD Prevention, Care and Support, 1994-1998)

2.2 The first generation growing up with the HIV/AIDS pandemic

HIV/AIDS has found a wealth of opportunities to thrive among tragic human conditions fuelled by poverty, abuse, violence, prejudice and ignorance. Social and economic circumstances contribute to vulnerability to HIV infection and intensify its impact, while HIV/AIDS generates and amplifies the very conditions that enable the epidemic to thrive. Just as the virus depletes the human body of its natural defences, it can also deplete families and communities of the assets and social structures necessary for successful prevention and provision of care and treatment for persons living with HIV/AIDS. This is demonstrated by the estimated 30 million people living with HIV/AIDS, mostly in developing countries. The impact of HIV/AIDS extends beyond those living with the virus, as each infection produces consequences which affect the lives of the family, friends and communities surrounding an infected person. The overall impact of the epidemic encompasses effects on the lives of multiples of the millions of people living with HIV/AIDS or of those who have died. Those most affected by HIV/AIDS are children.

The children who were born in the early 1980s when HIV was first reported as non curable diseases are now in the youthful stage. This is so because by then there was no drug to Prevent Mother To Child transmission and those who failed to survive died. An informant in the interview had said that;

> *"Children and young adults currently between the ages of 15 and 24 who were born with the virus and grew up as the first generation to experience childhood during the HIV/AIDS epidemic. Today it is among this same population of 15 - 24 year olds that new HIV infections are concentrated. (The Impact of HIV and AIDS on Children, Families and Communities: Risks and Realities of Childhood during the HIV Epidemic", (Lyons,2010)*

The first generation who were born with HIV virus have reached adulthood amidst all the associated illness and other related problems that come as a result of the infection.

The recent United Nations report 2009 estimates that more than 50% of the 16,000 new HIV infections which occur daily are within this age group. An additional 10% of new infections occur among children under age 15. Since the virus was first identified in 1981, more than 3 million children have been born HIV positive and the mothers of over 8 million children have died from AIDS. By the year 2010 it is predicted that as many as 40 million children in developing countries will have lost one or both parents to HIV/AIDS. In some countries this is equivalent to one in every 4 to 6 children. The effects of HIV and AIDS on children who are orphaned, or in families where parents are living with the virus, not only include these calculable loses, but also the immeasurable effects of altered roles and relationships within families. Clearly HIV infection has its greatest impact on the young. The categories of children affected are orphans, child mothers, girl child, and children in child headed households.

2.3 National demographics current status in Uganda

According to the Uganda AIDS control programme, the sentinel sites indicate that HIV prevalence has been declining since 1989 (25%). It reached its peak in 1992 (30%) and then stagnated at 10-15%. By the end of 2001 the national prevalence rate was at 6.5% and by the end of 2001, there were 60.173 cumulative reported AIDS cases by the Ministry of Health. Of these 55,707 (92.5%) were adults aged 12 years and above, while 4,466 (7.5%) were children less then 12 years.

The cumulative number of HIV infected people in Uganda is now estimated at 1,050,000 of the population living with HIV. Data from HIV sentinel surveillance sites shows declining trends especially in rural areas.

In Nsambya and Rubaga Hospital sentinel sites, which are located in the Central region, the HIV infection rate among pregnant women has declined from 13.4% and 14.2% in 1998 to 12.4% and 10.2% respectively in 1999 and to 9.5% and 10.4

respectively in 2001. (Gilborn, 2004) In Masaka Kyamulibwa in the Southern part of Uganda, the medical research Council (MRC) cohort observed decline in incidence for adults of all ages from 7.6/1000 Person Years (PY) in 1990 to 3.2/1000 PY in 1998. Among males and females the decline was from 9.4/1000 PY and 6.0/1000 PY respectively in 1990 to 2.4/1000 and 4.0/1000PY respectively in 1998. (Gilborn, 2004)

The AIDS information Centre also reports declining HIV sero prevalence among young people seeking voluntary counseling and testing from 11% among males to 2.5% in 1999. Forty percent (40%) of the infections in Africa hospital are attributed to HIV and Tuberculosis. The World Bank predicts that 25% of infections with TB in HIV negative patients in future will be due to transmission from the prevailing infected population. In Uganda HIV and tuberculosis pose serious challenges to the health care delivery.

According to the HIV/AIDS Surveillance Report (2000), Twenty nine thousand, nine hundred ninety four (29,994) cases of TB cases were reported with 1501 of relapses in 1999 There is no doubt the health sectors will require additional costs for treatment.

2.4 Public health services

Accessibility to health care in Uganda is an eminent problem; only 49% of the population lives within five kilometers of a health services unit (DHS, 1995). While, access to health facilities varies enormously, the rural communities are particularly affected. There are also marked variations in access to health care both within and between the districts; the population within 5 kilo meters of facility varies between districts (9-100%), the North eastern and Kampala district in the Central region respectively.

Uganda is one of the most affected countries, and is among the least able to afford the increased costs of health care. One study conducted by The AIDS Support Organization (TASO) in 2005 revealed that more people (63.8%) of the people with HIV/AIDS sought for free health care from their centers. Others went to private practitioners and family members. There is no documentation on the costs of health

care for the opportunistic infections, which is complicated by the long period of struggling with frequent opportunistic infections. Tuberculosis, which is now the commonest HIV-associated opportunistic infection, is on the increase and requires long-term treatment, which is very expensive. There is now a shift to home based care versus long periods of hospitalization for TB patients. The use of herbal medicine is also steadily growing mainly because of the belief people have towards them and probably the access to the local herbs within the communities. The costs for Anti Retroviral drugs is still very high and unaffordable by the PLWAs despite recent reductions of approximately Uganda shillings 80,000 to Uganda shillings 400,000 or even over per month per person.

According to the National Strategic Framework for HIV/AIDS Activities in Uganda 2007, Palliative care by patients with HIV/AIDS has increased tremendously and is further expected to increase given the numbers infected. According to the Health Facility Inventory, the current health system is reportedly under considerable strain because of the increasing number of patients with AIDS related diseases (MoH/HPD). The annual population per hospital bed had risen to 800. Likewise, health personnel are now attending to many more patients as a result of the HIV/AIDS epidemic. The doctor to person ratio is 1:18, 700, while the nurse to person ratio is 1:4,300. There are other health providers whose ratio of patient care has increased such as the laboratory technicians, but no data has yet been documented. In 1997, 55% of the hospital beds were occupied by patients with HIV/AIDS related illnesses. It also known that health workers are experiencing psychosocial stress due to fear of being infected, and some still may be inhibiting stigma

HIV/AIDS is high on the national agenda of Uganda because of its effects on the development of the nation having traversed its Public health territory. The current National Health Sector Strategic Plan and National Health policy underscore the need to deal with the HIV/AIDS epidemic in its totality within the context of poverty eradication. All the Districts of Uganda (56 now) are in the process of making deliberate efforts to include HIV/AIDS in their plans and implementation efforts.

2.5 Culture and its impact on children

A number of factors attributed to cultural influences on HIV exist within the country. Some of the factors, which are common within the central and Western/Eastern part of Uganda, include those tribes, which share and inherit wives; other demand girls and women to be submissive and therefore can be married off or be inherited by the husband of their dead sisters. The initial reasons for the inheritance were to protect the widow and orphaned children within the clan. Barton and Bititi (1998) discovered that irresponsible sexual behavior and alcohol consumption during burials and funeral rites and other traditional ceremonies are common and they are also a source of HIV transmission among the sexually active. Polygamy is another practice that is commonly found among the society in most parts of the country. In some parts of the country (Eastern), where female genital mutilation (FGM) is practiced, increase in the transmission is likely to be increased (REACH, 1996). Some of these cultures are changing with the increased levels of awareness, which is well above 80% in the country.

Other cultural factors that are perpetuating HIV infection include inadequate family life education among the young people both in schools and out of alcohol. This is because; culturally the society was not accustomed to discussing sexuality with the young people, so there is deliberate avoidance of talking about it to the young people. There are also stereotype roles, which encourage submissiveness for the girls and aggressiveness among the boy population. For example many cultures place a high premium on the virginity in girls while promoting early active sexual behavior among boys (National Strategic Framework for HIV/AIDS activities in Uganda, 2000).

While the church has been identified as a major partner in spreading information regarding HIV transmission, certain affiliations like the Catholic Church have condemned the use of some of the methods, which have been proved helpful in reducing the rates of HIV infection for example the condom.

2.6 Economic indicators of the impact of HIV/AIDS

It is true that the impact of HIV/AIDS has been deeply felt in almost all households in the country and across all sectors of the economy.

The social progress and most of the development gain attained in the past years. This will have implications on the management of natural resources and sustaining the flow of trade (Topouzis, 1994)

It is estimated that in high HIV prevalence countries of 10% or more, 17 years of potential gains will be erased. This implies that instead of reaching, 64 years by 2010-2015, life expectancy will regress to an average of 47 years. (kibirige,1999)

The labor force will also shrink by 10% to 22%. Both domestic savings and investments will be reduced. Life insurance companies and disability insurance will soon have little money to invest. Foraging direct investment will diminish as well especially in agriculture commodity markets. This declining productivity is due to the death of skilled workers who die during their prime. Most of these are workers in companies, thus replacements and retraining of new personnel is mandatory for the continuing production and economic progress. (Bollinger, 1999)

In Gulu, poverty among households is forcing people to migrate away from their families to find employment or into high-risk activities such as commercial sex for economic survival. (Ochowun, 2010)

The illness and deaths of so many Ugandans due to HIV/AIDS is affecting the national productivity and earnings. The labor productivity is dropping, and benefits of education and skills training are being lost. The savings, which would have been used for investments, are spent on health care, funerals and related social costs. At the district level, authorities are experiencing graduated tax defaulter rate of varying degrees. In most districts, up to more than 70% of their local resources are raised from graduated tax collection which contributes 24% of the total budget revenue.

According to the MOLG 1998 report on analysis of district and urban council budgets, only three districts realized over 75% of graduated tax collection while nine districts had a rate between 60-75% collections. Seven districts realized 50-60% and the rest collected less than 50%.

2.7 Effects of HIV/AIDS on the people

HIV/AIDS has left the worst repercussions on the population of Uganda since it was recognized in the early 80s. According to the AIDS surveillance report of June 2000, 838,000 people have been reported dead due to HIV/AIDS. Of these 754,200 were

adults, 411,382 women, and 342,818 men and were 83,800 children (AIDS surveillance report, 2000). The same report reveals that 1,438,000 people are currently living with HIV/AIDS, 761,300 women and 143,800 children less than 12 years. It was estimated that in 1999, new cases would be 112,000 people of who 11,200 will be children and 54,982 will be women.

2.8 Economic and social results

HIV/AIDS is erasing the potential gains in life expectancy, and will cause a reverse of the social progress and most of the development gains attained in the past years. This will have implications on the management of natural resources and sustaining the flow of trade. It is estimated that in high HIV prevalence countries with prevalence of 10% or more, 17 years of potential gains will be erased. This implies that instead of reaching, 64 years by 2010-2015, life expectancy will regress to an average of 47 years. Uganda's current life expectancy is now at 42 years (International Labor Organization ILO, 20060).

The labor force will also shrink by 10% to 22%, both domestic savings and investments will be reduced. Life insurance companies and disability insurance will soon have little money to invest. Foreign Direct investment will diminish as well especially in agriculture commodity markets. This declining productivity is due to the death of skilled workers who die during their prime. Most of these are workers in companies, thus replacements and retraining of new personnel is mandatory for the continuing production and economic progress (International Labor Organization ILO, 2006).

In Uganda, poverty among households is forcing people to migrate away from their families to find employment or into high-risk activities such as commercial sex for economic survival. This is also causing social disruption in the communities. Studies in Uganda have shown that the chance of orphans continuing with education after the parents death is halved and those who go to school spend less time there than they did formerly. Other studies have also shown that orphans face an increased risk of stunting and malnourishment.

The illness and deaths of so many Ugandans due to HIV/AIDS is affecting the national productivity and earnings. The labor productivity is dropping, and benefits

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According to the MOLG 1998 report on analysis of district and urban council budgets, only three districts realized over 75% of graduated tax collection while nine districts had a rate between 60-75% collect. Seven district realized 50-60% and the rest collected less than 50%. There is no doubt that HIV/AIDS is among the major factors that account for the high defaulter rates in many of the districts. This reduction in graduated tax collections will affect the capacity of districts to provide the required services to the population.

2.9 Future trends of impact of HIV/AIDS on children

A declining labor force is envisaged in the future and as a result tax collections will continue to decline tremendously.

There will also be increasing numbers of poor households because of deaths of the breadwinners and also the over stretched extended families, which will have a bigger burden in raising number of orphaned children. Increase in child headed households will increase their vulnerability.

There will be low productivity leading to poor food security and increased rate of malnutrition and lower immunity.

Inability of households to afford social services, affected families will spend more time caring for the sick which in turn will affect the family's labor force and productivity (World Vision, 2001-2005).

2.10 Coping strategies that are in place

There have clearly been successes in behavioral change although not as much as one might hope for this late in the pandemic. In addition, as mentioned previously, there is evidence of plateau in prevalence and maybe even an increase in incidence among some "pockets" of the population. This suggests a degree of caution in interpreting past successes as evidence of sustained trends. Nonetheless, however, recent data suggests the following. The number of males reporting three or more

sex partners fell from 15% to 3% in-between 1989 to 1995. 27% of young women aged 15-24 abstained from sex in 1989 compared with 35% by 2000. These increases were greatest among urban women and with secondary education.

Among men aged 15-24, 47% reported abstaining from sex in 1996 and 53% reported the same case in 2000. Contrary to the finding for females, male abstinence was found to be highest among rural populations .448 in conclusion, it appears that innovative new strategies and approaches will be needed to effectively deal with prevention and behavioral change issues for each generation (UNICEF, 2005).

From the early days of the pandemic in the late 1980s, Uganda took aggressive action to disseminate HIV/AIDS information across the country. In 1986, Uganda embarked on a strategy of health education in HIV/ AIDS. The goals of the program were to inform people about modes of HIV transmission and risk reduction. IEC activities (including mass media, materials development, special campaigns and trainings seminars, etc) have been widely supported by both government and donor-funded program (UNICEF, 2005).

In order to reach young people, the School Health Education Program was established in 1987. More recently, the Presidential Initiative on AIDS strategy for communication to Youth (PIASCY) was launched in schools (2003) to complement formal health education and life skills programme. PIASCY objectives include increasing HIV/ AIDS education for school children, Youth, and further developing the capacity of parents, teachers and health service providers to engage in constructive communication with young people. At secondary level, 15% of teachers have been trained and life skills education is offered at 66% (about 1400) of secondary schools. Another 171 tertiary institutions (in 34 districts) have teachers trained in life skills education (World Vision, 2001-2005).

Currently, awareness of HIV and AIDS is virtually universal, as nearly every household has lost a relative or family member to the disease (UBOS et al, 2001. Uganda Demographic and Health Survey 2000 – 2001). Most men (95%) and women (87%) know that HIV can be prevented, yet practical behavioral change strategies to reduce the risk of transmission are far less known knowledge of

condom as a preventive measure increased between 1995 and 2000 from 21%to 54% among women and from 32%to72percentage among men. Having only one sexual partner as away to avoid AIDS was mentioned by 49% of women and 43% of men, while abstaining from sexual relations was mentioned by 50% of women and 65% of men UBOS et al, 2001. Ibid).

Knowledge of at least two method of prevention (condom use and limiting sexual partners) was reported by 75% of rural women 89% of rural men. Among urban populations knowledge is much higher and varies from 92% for women and 95% for men. Knowledge was generally highest among men and women in their twenties and thirties and lowest among those aged 15 – 19. It is important to note that approximately 15% of women aged 15- 19 and 40- 49 had not heard of AIDS or did not know of any way to prevent the disease. Among men, this figure was 8% for those aged 15 -19 and 11% for those aged 50 -54. Most men and women (about 93%) know that AIDS can be transmitted from mother to child. Approximately 53% of men and 58% of women are aware that HIV can be transmitted during pregnancy. 69% of men and women are aware that it can be transmitted during delivery. However, less than half (46% of women and 43% of men) know that the virus can be transmitted during breastfeeding (UBOS et al, 2001 Ibid.).

CHAPTERTHREE

METHODOLOGY

3.0 Introduction

This chapter discusses tools that were used in detail; it covered study design, study methods, sampling procedures, data analysis, ethical issues and possible limitations to the study. It also shows how each method helped to get information from respondents

3.1 Study design

Given the focus of the study which was dynamic in nature, the information needed to be sought was qualitative in nature, involving experiences, values, feelings and interest of the respondents. This called for in depth study that generated detailed information with open ended questions.

Qualitative study approach was used since it's most suitable in understanding the phenomena from the participation's point of view within their socio-economic settings. This enabled the researcher to get participants interpretation on the effects of HIV/AIDS on children who are either infected and or affected by HIV/AIDS. With this approach, participants' own categorization on issues rather than imposition of researcher's ideas was made possible. This enabled the avoidance of pre- judgment as researcher tried to capture the reality on the ground.

This approach was less stressful to respondents and it was participatory in nature giving opportunity for respondents to share their concerns in a relaxed atmosphere. Only those who are willing to participate were involved in the study.

3.2 The study area and population

The area of study is Gulu municipality in Gulu district. The district is found in Northern Uganda. On the east; Gulu municipal is bordered by Unyama. In the west it is bordered by Koch Ongako. In the North by Bungatira. In the south by Koro. Gulu municipal is 332 kilometers from Kampala the capital city of Uganda. It is 54.6 kilometers squared. There are four divisions that is Laroo, Bardege, Pece and Layibi.

The study had population of children as the main respondents and members of stakeholders supporting them as key informants to the study.

3.3 Sampling procedures

3.3.1 Sampling Techniques

The study population will be estimated using purposive sampling on the respondents of Gulu Municipality who will be found around in the municipality during the period of the research.

3.3.1 Sample frame work

As a standing point, the researcher compiled sampling frames from the Health Alert an NGO that supports children who are HIV positive. This information was available from their records. The total numbers that were selected for the study was 300 respondents.

3.3.2 Sample size

The sample size for the study was 250 children as the main respondents and 50 members of stakeholders supporting them as key informants to the study making the total of 300 respondents. The 250 children should in one way or the other have experienced the impact of HIV/AIDS.

3.3.3 Sample technique

The researcher sampled children randomly from database of organizations working with children to ensure that there are no biased responses. The nature of the study required an in depth understanding of circumstance that made the children affected by HIV/AIDS become more vulnerable. This was made possible with smaller study sample as a manageable and representative of a few children in the community. The study used two methods for selecting participants for the study.

The stakeholders were selected purposely since they are key informants

Table 1: the Sample Population, Sample size, sampling technique and data collection methods

Sample Population	Sample size (n=300)	Sampling technique	Data collection methods

Children	250	randomly	One to one interviews with 250 children
Stakeholders	50	Purposive	One to one interview with 50 stake holders

3.4 Methods of Data Collection

3.4.1. Instruments

Interviews

Interviews were best suited for the study. Interviews are informal and less structured. This

gave the researcher and respondents to have normal friendly type of conversation in eliciting answers to questions. The researcher observed the respondent's non-verbal communications and gave guide to the respondents while conducting the interview. A total of 8-10 interviews were conducted in a day. This was to avoid burn out and give attention to every respondent privacy and comfort. The researcher was guided by an interview guide basing on impact of, flexibility in restructuring the interview guides in to local language to suit the situation of high illiteracy level. The locations of the interviews were determined by respondents in most cases.

The advantage of interviews was that it gave a confidential atmosphere in which informants could share sensitive information. In such environments, Informants were able to provide details about their personal experiences, views, and behavior.

The private setting in the interviews also meant that peers did not influence informants' responses to study questions.

In-depth interviews also allowed me to collect a great deal of information in a short period of time. (8-10 respondents in a day)

Interviews being a mobile method allowed me to work with geographically dispersed respondents for instance moving from one part of Gulu town to another.

Finally, interviews were adaptable to different circumstances, permitting me to collect data in urban and rural areas of the Municipal.

Document review

The researcher reviewed documents that came from UNICEF, TASO, Health Alert Uganda and district HIV/AIDS offices that dealt directly with the community. This was preferred to fill the gaps and obstacles that might be missing in the data as a supplement to the findings.

Document review enabled the researcher to have a history HIV/AIDS in Uganda. The literature was very helpful in giving me an insight on the different stakeholders in the HIV/AIDS sector and the different activities that they are carrying out. All in all the documents acted as my guide on how to find the necessary information I was researching for.

3.5 Data analysis

The collected data was then analyzed critically in order to come up with actual findings of the research. Data analysis involved looking at the research findings in line with the study objectives that were organized into themes in order to interpret the situation at hands easily. Editing to check for errors or omissions to ensure accuracy, completeness in the logical flow of the findings was done before it was prove read by the supervisor.

Qualitative data analysis mainly involved reducing the raw data to a form that would be suitable for analysis/interpretation into themes that were coded into themes in line with the study objectives. The results were then presented and interpreted later to give exact situations on the ground.

3.6 Ethnical considerations

The researcher first got permission to do the field work from the University and at household levels, the household heads were first asked for permission to conduct

the research with the children. Consent to participate in the study were sought first from every respondent and only those who had consented were interviewed.

Since many people living with HIV/AIDS are stigmatized, the participants in the study were informed that their names would not be included in the findings of the study. This made the respondents felt comfortable to questions without any fear that someone may recognize their names in the final work.

Confidentially was observed always in respect to respondents' experiences shared with the researcher. Given the sensitive nature of the topic, there were emotional breakdown of some respondents during the interviews, time to relax therefore was given before continuation with the interview and feeling of empathy was applied where necessary.

3.7 Limitations

The researcher might find some limitations due to the sensitivity of the study. Some respondents may fail to cooperate because of fear of being stigmatized. It is a sensitize topic that most people do not want to talk about. Getting information about children living with HIV/AIDS might also be difficult because households and organizations working with have to keep their identity confidential. Due to ethics and confidentiality reasons most organizations give only basic information on people living with AIDS

CHAPTER FOUR
PRESENTATIONS, ANALYSIS AND DISCUSSIONS

4.0 Introduction

This chapter presents the data collected from the field, the analysis and discussions.

4.1 Number of HIV/AIDS and child headed households

Do you come from a child-headed household due to HIV/AIDS?

Responses

Table 2: Showing whether you come from a child-headed household due to HIV/AIDS

Response	Frequency	Percentage
Yes	150	60
No	100	40
Total	250	100

Out of the 250 respondents interviewed, 150(60%) said they were from child-headed households due to HIV/AIDS while the other 100 (40%) children said they were not.

Findings from this research revealed that 60% of respondents interviewed were from child-headed households. This therefore shows that HIV/AIDS has led to the increase in child headed households.

According to Uganda AIDS Commission Secretariat 2002, HIV/AIDS has led to the exploitation of children by some community members. Most child-headed households are being headed by child mothers who are poor and vulnerable to exploitation by the community.

One of the respondents in Gulu Municipality whose names I have withheld had this to say;

> *"I am vulnerable because I stay in a child headed family. Some people who were interested in supporting us normally had other hidden*

agendas. I left my home to go to school with my Uncle to Kampala. He turned me into his housemaid instead of sending me to school. This left me with no option but to stay home while seeing my future dreams vanish slowly".

This therefore shows that indeed some children have been exploited by some community members because they are vulnerable.

Poverty that has been brought about due to the loss of parents to HIV/AIDS has made girls also accept material and monetary offers from men in exchange for sex in order to earn a living and this has had negative always negative on the girl-child. A case in point is a girl (name withheld) who lost her parents to AIDS and has now become the head of the household who had this to say;

"After the death of our parents, we had no support from our relatives and feeding became very difficult. My uncle tried to support us but he had many children to support too. I had to work hard to support our siblings, I got engaged in prostitution and got pregnant in the progress, the men I used to hang out with abandoned me, and to make it worse I contracted HIV. Now, it is hard to support my child and my sibling".

This is also in line with what was portrayed in chapter 2.6 (Ochowun, 2010) where it says that due to poverty creeping into the households, many people may undertake high risk activities such as prostitution to earn a living which may in turn lead them to contract HIV/AIDS.

Another impact of HIV/AIDS on children is that it has thrust upon them adult roles yet they are too young to handle the tasks. When asked about the most critical ways in which their lives have been impacted by HIV/AIDS, the girls overwhelmingly responded that they lacked ability to care for their dependants. This response implies that not only the girl-child lacks basic needs, but also adult roles and responsibilities have been thrust upon them when they are still too young to necessarily handle the task. A girl child in Holy Rosary P7 School who chose to remain anonymous had this to say;

"I feel like I have too much responsibility since we lost both our parents to HIV/AIDS. I'm the one looking after my younger siblings and my child as the head of the household; I find it very difficult to meet the basic needs especially food".

The lack of decent accommodation is also one of the impacts of HIV/AIDS on children. Many children who have lost their parents due to HIV/AIDS and are living in child-headed households have no decent accommodation they can't manage to build for themselves huts and they are very few adults who are willing to help them.

4.3 HIV/AIDS and vulnerability

One of the clients of Health Alert Uganda whose names I have chosen to withhold had this to say;

"I am vulnerable because I stay in a child headed family. I was working as a house maid in Gulu town until when my elder sister who was heading the household eloped with the man who had promised to marry after my employer stopped paying me my salary that's when I decided to go back home.(An un-named"

This response shows that HIV/AIDS has increased the level of vulnerability in children. This is especially true with child-headed households:

"As AIDS sets in the family, the girl-child has the responsibility to stay out of school while looking after the sick parents. Most of the girls after the death of parents will drop of school under child headed households so as to look after the younger siblings since the social support network has been weakened by poverty. (Rachkara Emmanuel Ameda, Project Officer HIV/AIDS, Health Alert Uganda)"

"My parents were the only surviving relatives that we had, after their death; we were left to look after ourselves as no one in the community was willing to take four of us since we had no immediate next of kin. We could get little support from some sympathisers from the

community which was not even constant; I had to drop out of school to head the household. And it marks the beginning of our struggles. (According to one of the respondents from Kasubi Army School who preferred anonymity)"

These two interviews with a key informant from Health Alert Uganda and a pupil from Kasubi Primary School revealed that girls are most affected when it comes to challenges to accessing and being retained at school. Many of them have dropped out from school because they often fall sick and usually miss lessons and at times when they lose their parents, the older children may be forced to abandon school to go take care of the other siblings.

Children alone cannot be in position to provide for the younger children as they too are too young to plan for the future and may not be in position to cater for all the needs of the other children posing them to become vulnerable for exploitation and abuse from the community.

Vulnerable children in child headed households have no decent homes since they can't manage to build for themselves huts and they are no adults who are willing to help them. In some other situations, relatives are there but they themselves are too poor to help the children. This was a result of low social support network that has come as a result of the Northern war as people lost their assets during the war. Thus the children have no option but to stay on their own as child headed households.

The eldest child in most situations has got to take on the adult role as the head of the household especially girls. This puts them to decide on dropping out of school, doing petty jobs to earn little money to support the siblings since the possibility to further the education is very thin.

4 .4 Stigma and discrimination

Some children in school fears to associate with children who are HIV positive because of false perception that they too could get infected with the virus

through contact with them (Rachkara Emmanuel Ameda, Project Officer HIV/AIDS, Health Alert Uganda)

This interview revealed that children are being discriminated in the community because of their HIV status. Some children have a belief that they can contract the disease simply by sitting near an infected person.

> "I was isolated by my family, who deserted me. Except my mother who is my only hope. No one bothers to visit me even during the times when I have been hospitalised. I'm so disappointed and annoyed because those who matter no longer care.(According to one of the Children receiving help from Health Alert Uganda whose names I have also not included)"

This interview with a child receiving help from Health Alert Uganda revealed that some people have neglected their friends or even dear family members who are suffering from HIV/AIDS. They fear to be associated with those suffering from the disease.

A question was asked whether the respondents would be willing to associate with people living with HIV/AIDS in their households provided they knew the HIV status of the person and the following answers were drawn:

Table 3: Associating with People living with HIV/AIDS

Response	Frequency	Percentage
I have no problem associating with people living with HIV/AIDS	125	50
I do not feel comfortable associating with people living with HIV/AIDS	100	40
I am not sure about my feelings about associating with people living with HIV/AIDS	25	10
Total		100

Source: Primary data 2012

Out of the 250 respondents interviewed, 125 said they were willing to associate with people living with HIV/AIDS in their households provided they declared their status, 100 of them said they were not willing to associate with people with HIV/AIDS even if they knew the status patients while the other 25 respondents were not sure whether they were willing to associate with and care for people with HIV/AIDS.

This therefore reveals that 50% of the respondents would be willing to associate with people living with HIV/AIDS in their own households provided the person has disclosed to them that they are living with HIV/AIDS. 40% were not willing and the other 10% were not sure whether they were willing. Despite the fact that the majority 50% were willing to associate with people infected with HIV/AIDS, we still see an equally big percentage (40%) of respondents who say that they are not willing to associate with people living with HIV/AIDS. This tantamount to stigma and discrimination given the other 10% may also discriminate against people living with HIV/AIDS since they have no clear stand.

Stigma and discrimination against children infected with HIV/AIDS negatively affects the social environment and relationships which damages self esteem a lot. One of

the girls who I interviewed whose names I have not included in order to protect her identity had this to say to me;

> In my family, we are four girls who were supposed to inherit from our father. But when my dad was writing his will and distributing his property, he counted me out because according to him, I am going to die soon. I was very hurt because his decision made me feel that I'm worthless, without any future and death awaits me any time.

This young girl told me that she started falling sick frequently at the age of 17. Her father got concerned due to the symptoms she was showing and took her for a HIV test which revealed that she was HIV positive. Her father's act of not distributing to her some of his property due to her being HIV positive shows that she has not been spared the stigma that many people living with HIV/AIDS face.

Denial in the face of a dying parent and perceived shame that relates to an AIDS death particularly has harsh effects on children in schools where social acceptance is paramount. The illness or death of parents or guardians because of HIV/AIDS can rob a child of the emotional and physical support that defines and sustains childhood. It leaves a void where parents and guardians once provided love, protection, care and support.

Starting to join ART is the first initial step for children to keep their health status at the level will make them not to suffer the severe impact of HIV/AIDS. This was confirmed by a staff member who handles children cases at the ART center;

> Without proper check up of the level of CD4 count, it is difficult to know whether the child qualifies to start taking ARVs. We do it after every 6 months and we give them septrine to be taken on daily basis for those who are not yet on ART. This helps to stop other diseases from affecting the client.

Children who are on treatment tend to feel free with the burden of the infection and do not fall sick regularly since the drugs protect its immunes system to stay input.

Men usually do not want to go for ART treatment because they believe that doing so would expose them to stigma. In most cases men could leave their sick women and elope with other women leaving their wives and Children to survive on their own. This has affected the food security of the households as well as children's education.

When it comes to literacy among some children and women, many can't either write or read. A lady from Pece vanguard who preferred anonymity had this to say;

> I stopped in stopped P.2, and now I can't read or write that has affected following the time for taking my drugs and dates for going back for drug refills. Always I have got to consult a neighbour to support me.

One in five female youths in northern Uganda, have received no education whatsoever, and only one in three are functionally literate. 43% of women report complete inability to read or write and 60% say they are unable to read a book or news papers (SFYNU, pvi). Inability of women to write has affected adherence to drug taking and health seeking habits as they are not well informed about all the benefits associated with some programs that are meant for people living with HIV/AIDS especially women. In most cases, infected women are less likely to access education, information or treatment services because of their HIV status.

> I am 16 years old and HIV positive. I dropped out of school because of on and off illness. Even the fellow students used to question me a lot about why I was always sick. I tried to help my sister in her hairdressing shop, but customers could over look at me.

Stigma is often directed to children living with HIV/AIDS as a result of constant illness and symptoms as the illness advance that has hindered them in making proper means of livelihood as well as completing education yet AIDS doesn't kill immediately.

Table 4: Summarizes some of the socioeconomic impacts at different levels (USAID 2002).

:ioeconomic Impacts Of HIV And Aids On Children

Level	Potential Socioeconomic Impacts		Mitigating/Aggravating factors
	Short term	**Long Term**	
Orphan	Loss of inheritance	Reduced productivity	Cause of death of parent(s)
	Reduced health, nutrition	Reduced socialization	Family or non-family living arrangement
	Reduced school attendance		Head of Household
	Increased labour		Personal characteristics(age, health, sex)
	Increased social isolation, vulnerability and abuse		Family, community factors
	Increased homelessness		
Family	Increased dependency ratio	Entrenched poverty	Previous family income and assets
	Increased poverty	Further breakdown of traditional extended family structures	Number, age, health of orphans
	Increased workload		Cause of death of parent(s)
	Reduced per person		Head of household
	Reduced per person food consumption and uptake of services (education, health)		Availability of aid
	Increased poverty		Historical economic strength
Community and nation	Reduced child health, school enrolment	Reduced quality of human capital	Access to services
	Increased inequalities	Entrenched poverty	Availability of assistance
	Increased crime, homelessness	Increased inequalities	Effective anti-poverty programs
	Increased social instability	Reduced economic growth, development	Effective programs for orphans
	Changes in cultural practices	Increased social, political instability	
	Diversion of resources for orphan care	Diversion of resources for orphan care	

Source: USAID Report 2002

4.5 Coping strategies with the effects of HIV/AIDS

- Positive prevention. This is the involvement of HIV positive people in the forefront in the fight against HIV/AIDS.

- Compulsory HIV testing of pregnant mothers during antenatal
- Formation of post test clubs for people infected with HIV/AIDS

- Meaningful involvement of Persons living with HIV for example training them to carry out counselling, follow-up and home visits because basing on their experience, they understand the problem better.

- Male involvement in Prevention of Mother To Child Transmission because for males their involvement has been low which has discouraged women from accessing HIV/AIDS services.

- Conducting peer education programs in various schools in Gulu Municipality involving children and adolescents in age-appropriate peer education and education of others in their communities. Children work with facilitators in learning about HIV/AIDS. They design projects, create educational materials, and educate through drama and talks in schools and community meeting places. Such approaches not only provide a mechanism for educating about HIV/ AIDS but also encourage confidence and self-esteem in those children and young people who are involved.

In conclusion, a strong political commitment to the fight against AIDS is very crucial. In order for us to succeed in the fight against HIV/AIDS we need to all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.

CHAPTER FIVE
SUMMARY OF THE MAJOR FINDINGS, RECOMMENDATION AND CONCLUSIONS

5.0 Introduction

In this chapter, the researcher attempted to review and summarise significant findings of previous chapter, recommendations to various stake holders and suggestions for further research.

5.1 Summary of the main finding

Main findings in Chapter 4 revealed that 60% percent of child-headed households were as a result of HIV/AIDS that might have killed both parents leaving the children vulnerable to get external support. This has affected girl-children since they have to take on the adult roles of their parents, looking after younger siblings and becoming a child-mother with little or no external support in the struggle to survive.

Girl-children in child-headed households are also at greater risk of getting HIV/AIDS infections when they decide to engage in risky activities like prostitution to provide for their siblings.

Another impact of HIV/AIDS on children is that it has thrust upon them adult roles yet they are too young to handle the tasks. Some children begin to fend for their families at an early age.

HIV/AIDS has led to the exploitation of many children who have become orphans after the death of their parents. The relatives who normally try to support girl-child orphans have other agendas apart from support as narrated by one of the respondents in Chapter Four. Instead they are over worked as housekeepers, baby sitters and forced to join prostitution in order to earn a living.

There is weak social support network as was not in the past. This is so because of the war in Northern Uganda that left many families poorer than before and led to

death of other relatives who could have supported the children. This has made children to head their own families after the death of their parents.
The relatives of children at times have denied or rejected the children after learning that they have HIV/AIDS. This may present itself on the level of care and support given, school attendance, stigma, inheritance rights as well as not being listened to. A case in point is in Chapter four where by one of the girls testified that she was excluded by her father when writing his will and distributing his property. Stigma and discrimination against children infected with HIV/AIDS negatively affects the social environment and relationships which damages self esteem a lot.

Poverty has forced parents to marry off their daughters at an early age that exposes them to HIV/AIDS infections, pregnancy complications, being child mothers and above all dropping out of school.

In line with that also, poverty that has been brought about due to the loss of parents to HIV/AIDS has made girls to accept material and monetary offers from men in exchange for sex in order to earn a living and this has had negative always negative on the girl-child.
The available copying strategies for infected and affected children are joining the post test clubs, using ART, getting sponsorship from NGOs for fees and scholastic materials, doing vocational training for those who drop out of schools among others.

Vulnerable children in child headed households have no decent homes since they can't manage to build for themselves huts and they are no adults who are willing to help them. In some other situations, relatives are there but they themselves are too poor to help the children.

5.2 Recommendations

5.2.1 Recommendations to CSOs

Stakeholders supporting children infected and affected by HIV/AIDS should strengthen the societal structures at grassroots to be responsible for the vulnerable people affected by HIV/AIDS with care and support for it to be

sustainable . HIV/AIDS stakeholders need to try various ways of encouraging parents and guardians of children infected to allow them join the post test clubs in order to cope with the trauma, the important use of Anti Retroviral Therapy services in their daily lives in order to live healthy and much longer without constant falling sick. The able stakeholders should also provide the children faced with HIV/AIDS who are not able to support themselves with school fees, scholastic materials, income generating capital that will help them cater for basic needs of life.

5.2.2 Recommendation to Government

Government should protect the rights of children on property ownership. People who abuse the rights and welfare of children should also be punished. Vocational training should also be given to the heads of child-headed households. The country also urgently needs to develop a policy on how to administer and use ART, for the guidance of health workers and the public at large.

5.2.3 Recommendation to Local community

Community roles in combating the spread of HIV and in providing support for those already infected is paramount in order to make those infected feel accepted and important in the society. This calls for empowering of the communities on rights of those affected and infected for effective response to the pandemic, by involving in a comprehensive and systematic manner in the design, implementation and monitoring of the interventions to make the project their own.

PHA networks with children need urgent expansion in the district so as to reach those who are in need at the grassroots. The networks would mobilise, advocate for and link their members to HIV/AIDS care and support services. These networks could be crucial in ensuring access to comprehensive HIV care packages. They are typically very weak at this level because it is voluntary and there is sporadic recruitment of PHAS, lack of good governance and leadership skills, and low level of sustainability due to funding issues.

Both parents and police should really work vigorously to pursue defilement suspects. Some of the defilers are people who are close to these children for instance

teachers, neighbours and sometimes relatives. The law should not leave them unpunished.

5.2.4 Recommendation to International community

The donor community should put more benefits in place for orphans, including those orphaned by AIDS, as a way of addressing such problems as street children. They should also support campaigns against HIVAIDS. They should put resources in fighting the diseases. They should also encourage the country to use the available aid that they have to fight the disease. They should also provide livelihood options and food security to strengthen the economic prospect of people living with Aids.

5.2.5 General Recommendation

The Government of Uganda, NGOs, CBOs and the donor community should put more benefits in place for orphans, including those orphaned by AIDS, as a way of addressing such problems as street children. The response to AIDS will continue to require strong partnership and commitment on the part of the government, the business sector, NGOs, the donors and civil society, including the general population. Only a joint effort in the response to AIDS will help reduce the impact of the epidemic on children and the general population. The social and economic conditions that nurture the spread of the virus have to be confronted as essential elements in local and global efforts to stem its spread and create effective solutions to halt the pandemic.

5.2.6 Suggestions for future research

There is need therefore to know the quality of support given to children infected and those affected by HIV/AIDS and how it has impacted on them.

Child-specific data and information on sero-prevalence for specific groups of the population should be collected so that a management information system can be developed. This will help in designing specific interventions, not only for children, but also for all vulnerable groups. The information for the specific groups should also be linked to knowledge, attitudes, beliefs and practices regarding HIV, so as to establish the factors that influence prevalence trends. There is a need to carry out further

research on the cost-effectiveness of intervention programs such as large-scale use of Anti Retroviral Therapy.

5.3 Conclusions

Poverty and prolonged insurgency led to the degeneration of cultural values making the people of Gulu Municipal extremely vulnerable to HIV/AIDS. The HIV/AIDS scourge in Gulu had led to a decline in development. The disease has killed many people who would be helping in rebuilding the town. Efforts that should be put in developing the town are diverted to taking care of the sick and also spending time in hospitals. A lot of focus has to be put in fighting the disease as the rate increased a lot during the war. According to a survey by the World Health Organisation HIV/AIDS was among the top causes of death in internally displaced people's camps. The response to AIDS will continue to require strong partnership and commitment on the part of the government, the business sector, NGOs, the donors and civil society, including the general population. Only a joint effort in the response to AIDS will help reduce the impact of the epidemic on children and the general population so that the town grows and rebuilds itself from the war.

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APPENDICES;
DATA COLLECTION TOOLS

Introduction to Respondents

Dear Respondents,

I am Apiyo Nancy, a student at Kampala International University. I am carrying out a research to determine the impact of HIV/AIDS on children in Gulu Municipality. This research is a requirement for the partial fulfillment for the award of Bachelors degree of Arts in Development Studies of Kampala International University. The information that you are going to give will be treated with the highest level of confidentiality as is purely for academic purpose only. Please your views are very important for the success of the study.

Key informant interview guide

1. What are the category of children that so vulnerable to the impact of HIV/AIDS?
2. How are they being affected?
3. What challenges are they facing?
4. How are the children infected / affected by HIV/AIDS copying with the impact of the disease?
5. How has HIV/AIDS disease affected the social support network in the family and community?
6. How are the children copying with the impact of being orphan in the community?

Main Respondents' interview guide

1. How has HIV/AIDS affected your life?
2. What support are you getting from friends and family members?
3. What are the challenges that are facing as a result of the disease?
4. How are you copying with the above mentioned problems?
5. Any other suggestions?