THE IMPACT OF KNOWLEDGE AND PRACTICE ON HIV/AIDS PREVENTION AMONG LEADERS ON THE SOCIAL WELFARE OF PEOPLE: A CASE STUDY OF KAMPALA CENTRAL DIVISION, 2000 -2012

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DECLARATION

I Mulerwa Robert do hereby declare that the contents of this dissertation are a result of my own findings. To the best of my knowledge it has never been submitted to any University or Institution for any academic award whatsoever.

Signed…………………………………………………………..

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Date………………………….

The work has been submitted with the approval of the supervisor

Signature…………………………………………
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Date…………………………………………

DEDICATION

This book is dedicated to my beloved wife Allen Mulerwa Kabagenyi, children, Darlton, Daniel and Darius for their patience and resilience during my physical and emotional absence. I also owe a lot to my parents Alex and Mary Kayumba and my late grandparents, Mr. & Mrs Kambanda and Mr & Mrs Kakuba, for their guidance and generational wisdom. We are because they were.

ACKNOWLEDGEMENTS

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Abbreviations

ABC	Abstinence, Being Faithful and Condom use
AIDS	Human Immune Deficiency Syndrome
BCC	Behaviour Change Communication
FBO	Faith Based Organisation
HBHCT	Home Based HIV Counselling and Testing
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
MOH	Ministry of Health
MPs	Members of Parliament
NCC	National Council for Children
NCW	National Council of Women
NGO	Non Government Organisation
PLD	Philly Lutaaya Day
PMTCT	Prevention of Mother to Child Transmission
RTC	Routine Testing and Counselling
SMS	Safe Male Circumcision
SRHR	Sexual and Reproductive Health and Rights
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Diseases
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UN	United Nations
VCT	Voluntary Counselling and Testing
VCT	Voluntary Counselling and Testing
WAC	World Aids Campaign
WAD	World Aids Day
WHO	World Health Organisation

MAP OF KAMPALA DISTRICT

MPERERWE

KAWEMPE II
KOMAMBOGA

KYANJA

KAZO
KAWEMPE I
KANYANYA

KIKAYA

BUKOTO II

BWAISE II
BWAISE I
KYEBANDO

KYAMBOGO UPP

BUKOTO I

BWAISE III
MAKERERE III

MULAGO III
UPK
NABISUNSA

NTINDA
KYAMBOGO

MAKERERE I
MULAGO II
KAMWOKYA II

KAMWOKYA I
NAGURU II
BANDA

KASUBI
MAKERERE II
MULAGO I

MULUKA II
WANDEGEYA
NAGURU I

MULUKA IV

MBUYA I

MULUKA I
KOLOLO III
KOLOLO II
KOLOLO I

NAKAWA INTIT

LUBYA
NAKULABYE
NAKAWA
MBUYA II

KAGUGUBE
KISWA

BUKESA
NAKASERO II
KOLOLO IV

NAKASERO III
NAKASERO I

MUTUNGO

OLD KAMPALA
INDUSTRIAL A

BUSEGA
LUNGUJJA
NAMIREMBE
NAKIVUBO
CIVIC CENTRE
BUTABIKA

KISENYI
NAKASERO IV
WABIGALO
BUGOLOBI

KIBULI

MENGO
KISENYI II
NSAMBYA POLI
KISUGU

NATEETE
NSAMBYA RAIL

KISENYI III
KATWE II

RUBAGA
NDEEBA
KABALAGALA

KATWE I
NSAMBYA CENT
LUZIRA PRISO

LUZIRA

KIBUYE I
NSAMBYA ESTA

BUKASA

KIBUYE II

MAKINDYE I
KANSANGA

MUTUNDWE
KABOWA
NAJJANANKUMB

MAKINDYE II

NAJJANANKUMB
LUKULI

LUWAFU

GGABA

SALAAMA

BUZIGA

Legend

	CENTRAL
	KAWEMPE
	MAKINDYE
	NAKAWA
	RUBAGA

Kilometers
0 0.5 1   2   3   4

μ

Inset is the Map of Uganda

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ABSTRACT

The study focused on the impact of knowledge and practice on HIV/AIDS prevention management on the social welfare of the people in six parishes of Kampala Central Division. It was premised on the assumption that when leaders are knowledgeable on HIV/AIDS, they play their role effectively and thus HIV prevention improves. However, changes in sexual attitudes and behaviours and resurgence of the sex industry in Uganda have increased concerns about HIV/AIDS and sexually transmitted infections (STI) epidemics. Leaders have put little attention to the significant and growing sex industry in Uganda in general and Kampala Central Division in Particular. In view of that, the study sought to shed light on the emergent and salient roles leaders play in imparting knowledge and awakening the people they led towards the knowledge and practice of HIV/AIDS

prevention and management.

Kampala Central Division being the centre for business and administration in Uganda has the highest and most diverse population. The leaders in the area are more economically and politically influenced than socially concerned. They are not sufficiently skilled to handle the HIV/AIDS concerns of the diversity of the people in their area. Leaders in the area also espouse immoral behaviours, that distance them from the traditionally assumed responsibility of being role models in society. The research therefore served to highlight the fore mentioned issues and suggest solutions to them, and identify strategies that would enable leaders to actively involve themselves in HIV/AIDS prevention management.

Methodology of study adopted both qualitative and quantitative approaches. Primary and secondary data was collected through the use of Interviews, documentary sources, questionnaires and Oral Informants. A questionnaire was answered by randomised respondents in six parishes in Kampala Central Division. The closed items in the questionnaire were analysed using frequency counts and percentages whereas the open ended were analysed using content analysis. The qualitative approach was adopted whereby the analysis and interpretation of the data proceeded conceptually(see appendix III & IV, references and list of oral informants).

It was found that Knowledge of HIV/AIDS was very high and widespread in the division. In terms of HIV prevention strategies, women and men are most aware that the chances of getting the AIDS virus can be reduced by limiting sex to one uninfected partner who has no other partners or by abstaining from sexual intercourse.HIV Counselling and Testing was identified as the most important service in HIV/AIDS prevention and care, particularly for couples. The ABC approach is particularly pertinent for young adults. It was noted that culture influences attitudes and behaviours related to HIV/AIDS. A Multi-Sectoral approach to HIV/AIDS prevention and management remains the very core implementation and, as such the Leaders serve to guide stakeholders of all kinds on deciding priority interventions in their respective areas of competency and interest.

Mainstreaming gender, sexual and reproductive health rights was observed as crucial and enables strategic positioning to address the phenomena of; high discordance rates, vulnerability of women and the observed increasing new infections within marriage.

Based on the overall findings hinged on the devastating effects of the HIV/AIDS pandemic, it is worth concluding that each new infection should be a concern to leaders. As the HIV/AIDS pandemic continues to rage on, there is need to utilise the knowledge, diversity of experiences and expertise of leaders to support men and women take up their responsibilities and acquire the power to protect themselves from HIV infection. Children and young adults must be formally and informally educated to get empowered with analytical qualities and acquire values of the family institution.

A couple of recommendations were made. One recommendation concerned The Government which should devote its efforts to provide the necessary environment for all leaders and stakeholders at various levels to participate and contribute to the achievement of the goals of the National Strategic Plan of substantially reducing new infections especially among youth. Leaders, married couples and youths are urged to take personal responsibility to avoid risky sexual behaviours that could contribute to an upsurge in new infection and increase the burden of the epidemic. There is need to retrieve the status of moral education, with stress on promoting morality of personal responsibility and involving the youth in general.

Government and civil society should train councillors and grass root leaders, to ensure communities have accurate and current information, and can ably engage in advocacy for a strong policy environment that promotes reduction of HIV/AIDS related stigma and improves implementation of HIV/AIDS prevention and management.

CHAPTER ONE: GENERAL INTRODUCTION

1.1   Introduction to the Study

This study focused on the impact of knowledge and practice on HIV/AIDS prevention among leaders on the social welfare of people: a case study of Kampala Central Division. The study established people's understanding of issues relating to HIV/AIDS prevention. The actions taken by leaders in the endeavour to avoid the spread of HIV among the community were investigated. Exploration of HIV/AIDS prevention management entailed the methods utilised by leaders to ensure that they themselves and other people do not get infected with HIV, as well as ensuring that the already infected do not spread infection to the uninfected. The study revealed that HIV/AIDS knowledge and practice creates the wellbeing of people particularly on their health. This confirmed the common saying that "A healthy mind dwells in a healthy body". The study was conducted in six parishes which form part of central division, Kampala district, these included; Kamwokya I, Mengo, Kamwokya II, Kagugube, Kisenyi I, and Kisenyi II.

1.2   Background to the Study

HIV/AIDS has emerged as the single most formidable challenge to public health, human rights and development in the new millennium. UNAIDS estimates 38 million people across the world as living with HIV/AIDS. Immediate and vigorous action must be taken now to prevent further spread of HIV among groups at high risk and to stop the infection from taking a foothold in the larger population (UNAIDS Report on the Global AIDS Epidemic: 4th Global report).

The scale and future impact of HIV/AIDS in Uganda can only be understood by examining its effect upon her population. For instance, the Youth aged 10-24, account for the biggest of new HIV infections in the country. Girls and women are at especially high risk. Leaders have not had adequate population-based data to develop program strategies for the people they lead.

Uganda has braved a severe and devastating epidemic of HIV infection and AIDS for almost a quarter of a century. The epidemic started on the shores of Lake Victoria in Rakai district, the initial epicentre of the illness. Thereafter, HIV infection spread quickly, initially in major urban areas and along highways. By 1986, HIV had reached all districts in the country, resulting in what is classified as a generalised epidemic. HIV infection continued to spread relentlessly throughout the 1980s and early 1990s and soon gave rise to a wave of AIDS as more HIV-

infected people succumbed to opportunistic infections arising from their suppressed immune systems. As in other countries in Sub-Saharan Africa, Uganda's HIV/AIDS epidemic is predominantly spread through heterosexual contact. Throughout the 25 years of the epidemic, people living in urban areas have had higher prevalence relative to those in rural areas. In all, it is estimated that about 2 million people were infected by HIV during this period, of whom about 1 million have died and another 1 million are living with the infection today.

The impact of the disease has been mainly felt through the escalating morbidity and mortality that disproportionately affect women and men during the prime of their productive life. The consequences of the epidemic span across all spheres of life (individuals and communities nationwide). It has imposed a severe and unsustainable burden on the meagre health sector resources, as funds are diverted from other areas to HIV prevention and AIDS care and treatment services. HIV infection has also given rise to an epidemic of opportunistic infections, including tuberculosis (TB). Treatment of some of these opportunistic infections is more expensive than that of AIDS.

The HIV/AIDS epidemic has also had far-reaching social consequences. By depriving families and communities of their most productive population, it has caused untold suffering to individuals and communities. At the community level, mortality of individuals in the prime of their productive lives has imposed unsustainable strains on the extended family structure, leading to a massive burden of orphans and other vulnerable children that are now estimated at almost 2 million in the country, as well as other social consequences such as child- and widow-headed households. Morbidity and mortality of parents has severely affected the schooling of children, especially girls who are forced prematurely into the labour market, further aggravating the vicious cycle of vulnerability.

The micro- and macro-economic consequences are diverse. Economic productivity has been adversely affected by the premature death of women and men during their most productive age, leaving orphans and widows. The loss of critical human capital has affected industrial and private sector growth, and the development of institutional capacity, all of which require skilled workers and leaders. Morbidity and mortality also results in the loss of skilled manpower for

teaching, medical care, agricultural production, and other professions that are not easily replaced. Indeed, it is for this reason that the attainment of human development in areas of economic growth, poverty reduction, and improved quality of life indicators is below what it would have been in the absence of AIDS. The demographic consequences of the epidemic are reflected in the quality of life indices in the country, such as infant mortality and life expectancy that are currently lower than what would have been achieved in the absence of HIV.

Uganda realised the gravity of the epidemic right from the outset and mounted public health interventions to counter its spread. The first National AIDS Control Programme in the world was started by the Ministry of Health, Uganda. The programme piloted and implemented several interventions to avert the further spread of HIV. Specifically, the programme initiated public education campaigns about the epidemic, promoted safer sexual behaviour, including abstinence, mutual faithfulness, and condom use, ensured safe blood transfusion in health facilities, and initiated programmes for care and treatment for infected individuals. It also implemented surveillance activities to monitor the magnitude and dynamics of HIV infection. The interventions evolved over time as more knowledge about the epidemic emerged. As a consequence, it appears that after the seemingly relentless spread of HIV infection in the late 1980s, the epidemic peaked in the early 1990s, particularly in urban areas with antenatal prevalence ranging between 25-30 percent in the most affected urban areas.

Subsequently, antenatal HIV sero-prevalence steadily declined throughout the remainder of the 1990s in both urban and rural areas, but particularly in urban areas. However, there is emerging evidence that during the early part of the 2000s, HIV sero-prevalence has stabilised at 5-10 percent in urban areas and below 5 percent in rural areas (Demographic and Health Annual Report, 2006).

The conclusion reached by AIDS Information Centre (2003) was that as in other countries in Africa, most knowledge about the magnitude and dynamics of HIV infection in Uganda is based on antenatal HIV surveillance and a few sub-national, population based studies. While providing useful information for informing strategic planning and evaluation of programmes, these data

sources are either limited in geographical coverage or the population groups that they cover, and therefore the data that are obtained may not be fully generalisable to the whole country.

1.3   Statement of the Problem

Uganda like any other country has a problem of HIV/AIDS in her society. In all circumstances the leaders are at the helm and play the driver's role in addressing the challenge in their respective areas and yet on several occasions the leaders themselves and their families are directly infected with HIV/AIDS. Traditionally, people think that leaders should embody good moral values such as being exemplary, respectful, and faithful in their relationships, caring and relate with other people in the community as role models. This is not the case today with some of the leaders. This has not only bred irresponsible citizens but also leaders themselves. The knowledge levels and practices on prevention management of HIV/AIDS among local community leaders have not been clearly established. Leaders in Kampala are more politically driven than socially motivated to engage in HIV/AIDS related programs and activities. Therefore there is need to harmonise the traditional roles community leaders play in order to enhance social welfare in the community.

1.4   Definition of Key Terms

Community: It is a heterogeneous group of people living and/or working together sharing norms, values, concerns, with common systems and structures for leadership, problem-solving and communication.

Moral values: These are acceptable behaviours of the community.

Leadership: In this study the word leadership is used to refer to the process of directing the behaviour of another person or persons towards the accomplishment of some objectives.

Leader: This term refers to a person holding a position of authority in a community.

Harmony: Agreement of facts, opinions, manners and interests.

Ethical character: Means accepted standards of social behaviour

Welfare: In this study the word welfare is used to mean the wellbeing of people in the society i.e. social wellbeing and health.

Knowledge: Skills bequeathed to individuals on how to handle aspects of life in the social, economic and political spheres. Herein, Knowledge will refer to individual's skills on how to handle HIV/AIDS prevention, care and support.

Prevention: A process of mitigating the occurrence of phenomena that affects life in various aspects. Herein, prevention is a process of mitigating infection to HIV.

Spread: The act of passing on characteristics from one individual or object to another normally common in diseases. In the study proposal, it is the passing on of HIV from one person to another.

Practice: A consistent behaviour in an individual or a group of people that normally affects individuals and communities positively or negatively. In the study, it is any action undertaken by individuals or community to mitigate or pass on HIV.

Campaign: Activities and efforts aimed at increasing, reducing or establishing the impact of a phenomenon. Herein, a campaign is a series of activities aimed at reducing the spread and negative impact of HIV/AIDS.

Transmissions: The process of changing from one aspect to another. In the study, it is a process of spreading HIV.

Best Practice: A process that has been carried out by an organization/ community to address one or more specific problems.

1.5   Scope of the Study

The study was carried out in Kampala Central Division, Kampala district. It is one of the five divisions forming Kampala district, the smallest and most centrally located. It is administratively divided into 20 Parishes and 135 zones. For the purpose of this study, six parishes were chosen, these included: Mengo, Kamwokya I, Kamwokya II, Kisenyi I, Kisenyi II, and Kagugube. These parishes have been chosen because of their social and economic status. For example Kamwokya I mainly hosts office and accommodation facilities, Kamwokya II and Kagugube are majorly slum areas housing the urban poor, Kisenyi I, Mengo and Kisenyi II are also slum areas with some light commercial activities including metal works, maize mills, lodges and garages. The parishes have higher chances and vulnerability of experiencing the effects of the pandemic, and their leaders have been key contributors to the HIV/AIDS prevention campaigns. The study covered the period 2000 – 2012. This is because HIV/AIDS pandemic has been on the increase in spite the various intensive campaigns and interventions to address it within the period.

1.6   Objectives of the Study
(a) General Objective

The main objective of this study was to investigate the impact of the knowledge level and practices on HIV/AIDS prevention management among leaders on community welfare in Central Division, Kampala district.

(b) Specific objectives

1. To establish the knowledge levels of HIV prevention among leaders in Kampala District.

2. To establish HIV/AIDS prevention measures undertaken by leadership in Central Division, Kampala District.

3. To identify the practices that leaders can adopt and apply to realize a positive change in HIV prevention leading to improved social welfare in the Division.

1.7　Research Questions

1. What are the knowledge levels of HIV/AIDS prevention and management among leaders in Central Division?

2. What are the HIV prevention management measures being taken by leaders in Central Division?

3. What are HIV prevention practices that can be adopted and applied by leaders for improved social welfare in Kampala Central Divison?

1.8　Justification of the Study

Kampala Central Division as a centre for business and administration in Uganda has the highest population. The leaders in the area seem to be more economic and politically influenced than socially concerned. Amidst the efforts of various Non-Governmental Organisations and government efforts to fight AIDS. More HIV/AIDS infected people moved from rural areas to town in search for trauma free environment and easy life in regard to psychosocial aspects.

The leaders of Kampala district seem not fully skilled to handle the HIV/AIDS concern of the diversity of people in their area. Based on all the mentioned factors there is need to conduct a thorough research on the knowledge and practice on HIV/AIDS among leaders in Kampala district. For instance the researcher observed some immoral behaviour of leaders such as adultery. The leader is supposed to be a role model to those he or she is leading. As the saying goes, "If a blind man leads a blind man, they both fall in the ditch." Instead of leading by example, the leaders portray irresponsible behaviour. Therefore the research served as a strategy to highlight such issues and suggest solutions to hindrances that may deter leaders to live fully to their expected morals and roles. The study sought to identify strategies that would enable leaders to actively involve themselves in promoting HIV prevention among the people they lead.

1.9   Conceptual Framework

```
┌─────────────────────────────┐              ┌──────────────────────────────┐
│ Socio- Demographic          │              │ Intermediate Factors:        │
│ Characteristics of          │              │   • Abstinence               │
│ Leaders:                    │              │   • Faithfulness             │
│                             │              │   • Voluntary HIV            │
│   • Age                     │              │     Counselling and Testing  │
│   • Gender                  │─────────────▶│   • Sex Education/Life Skills │
│   • Levels of education     │              │     training                 │
│   • Leadership position     │              │   • Home Based Care          │
│   • Marital Status          │              │   • Advocacy                 │
│   • Cultural practices      │              │                              │
└─────────────────────────────┘              └──────────────────────────────┘
                    │                                      │
                    │        ┌────────────────────────┐   │
                    └───────▶│ Dependent Variables:   │◀──┘
                             │   • Knowledge          │
                             │   • Practice           │
                             └────────────────────────┘
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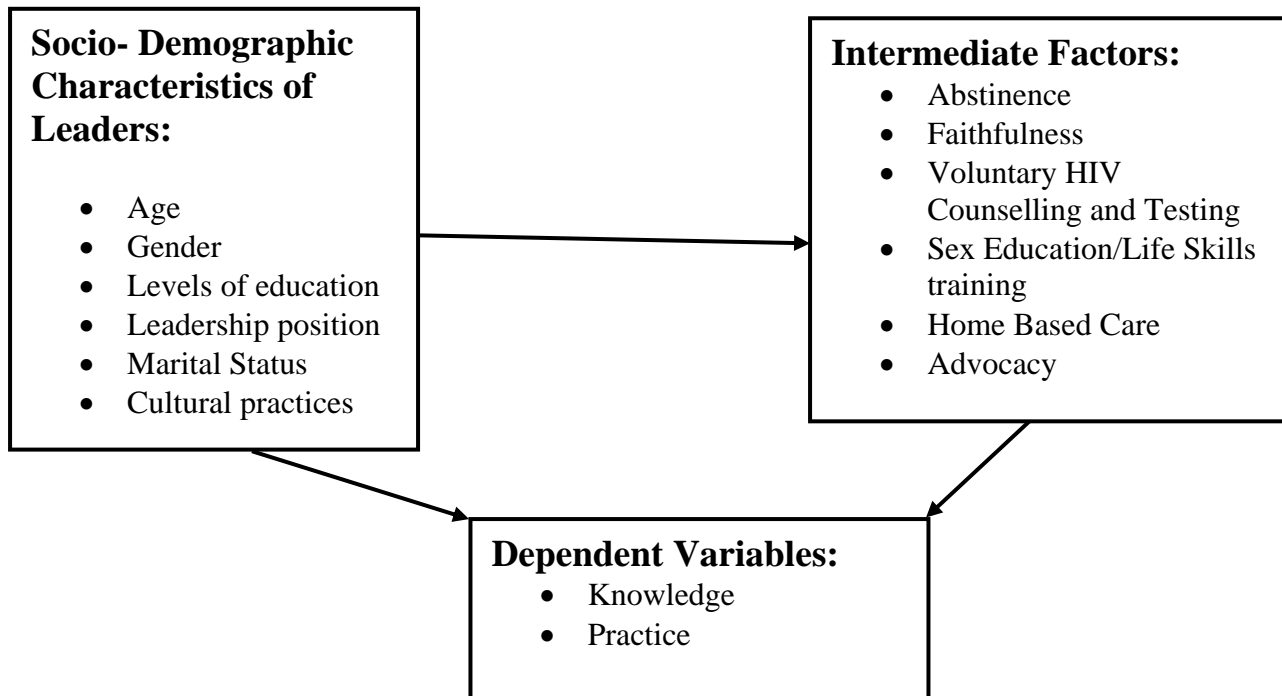
Explanation of the Conceptual Framework

The background characteristics of the leaders which include age, gender, marital status, cultural practices, leadership position and levels of education work through the intermediate variables to affect the dependent variables, that is, knowledge and practice.

The intermediate factors; these will include knowledge about HIV/AIDS prevention, through use of condoms, abstinence and faithfulness. Through advocacy leaders are expected to be at the forefront of the fight against HIV/AIDS.

Age and gender of leaders were analysed in respect to their knowledge and practice about the ABC prevention approach (Abstinence, Be faithful and Condom use), young leaders born in this era of HIV/AIDS epidemic era are more likely to be more knowledgeable about HIV/AIDS than their counterparts. As reinforcement in the prevention of HIV/AIDS, voluntary counselling and testing plays an important role.

The ideal is that the leaders should have knowledge on HIV/AIDS, how it is spread mainly through unprotected sex/safe sex and other minor cases like blood transfusion and accidents.

The framework looked at the preventive means like use of condoms, and abstinence and being faithful in marriage. Then as leaders of HIV/AIDS prone people there is need to manage the conditions of those already affected. This can be done through care and support both medical and psychosocial.

1.10   Constraints Encountered

It was an expensive study in terms of transport costs into the slum Zones of the six parishes. Some of the respondents were too busy, and at times they could not honour the appointments given to the researcher.

Some of the respondents refused to provide data because they assumed that the study was too delicate, whereas others indulged in positive reporting. The researcher relied heavily on primary sources of data collection. This might have created a bias.

1.11   Ethical Consideration

Ethical consideration was upheld. Participation of the respondents was voluntary and the information obtained was confidential and private.

CHAPTER TWO: REVIEW OF LITERATURE

2.1   Introduction

In this chapter, information is presented about the existing literature that is related to the study. The information about the contribution of the various streams of research pursued by other researchers was reviewed. Each of these streams was reviewed individually in the following order, HIV/AIDS Situation, Practices regarding HIV/Aids prevention, HIV/AIDS and leadership and traditional healers and HIV prevention. In this review nine scholars' works and theoretical framework have been reviewed. These include Zaccaro (2007), Beyond (2003), Gupta (2006) D'Souza (2001), Douglas (2001), MacGregor (1975) Elias and Heise (1993), Gupta (2006), Lewis (1998) and Reid (2000). Their works have been reviewed because; they articulated the subject of management and knowledge of HIV in a broader perspective. The chapter further identifies the existing gaps in the field of research.

2.2   Theoretical Review

Trait Leadership Theory

The study was conceived on the premise of the Trait Leadership Theory developed by Ralph M. Stogdill (1974). The theory suggests that effective leaders share a number of common personality traits or characteristics. Trait leadership is integrated patterns of personal characteristics that reflect a range of individual differences and foster consistent leader effectiveness across a variety of group and organizational situations (Zaccaro, Kemp, & Bader, 2004). The theory of trait leadership developed from early leadership research which focused primarily on finding a group of heritable attributes that differentiated leaders from non-leaders. Leader effectiveness refers to the amount of influence a leader has on individual or group performance, followers' satisfaction, and overall effectiveness (Derue, Nahrgang, Wellman, & Humphrey, 2011). Many scholars have argued that leadership is unique to only a select number of individuals and that these individuals possess certain immutable traits that cannot be developed (Galton, 1869). Although this perspective has been criticized immensely over the past century, scholars still continue to study the effects of personality traits on leader effectiveness. Research has demonstrated that successful leaders differ from other people and possess certain core personality traits that significantly contribute to their success (integrity, empathy,

assertiveness, good decision making skills, and likability). Understanding the importance of these core personality traits that predict leader effectiveness can help organizations with their leader selection, training, and development practices (Derue et al., 2011). This is in agreement with MacGregor Burns (1975) theory of Decision and Dissent Leadership generalise with a measure of confidence about the behaviour of leaders who undergo common socialising experiences. Often leaders do not behave like leaders they cannot. To take the lead is to act in terms of certain values and purposes.

Leadership is the reciprocal process of mobilising, by persons with certain motives and values. Leadership can also shape and alter and elevate the motives and values and goals of followers through the vital teaching role of leadership. This is transformational leadership. The premise of this leadership is that, whatever the separate interests a person might hold, they are presently or potentially united in the pursuit of "higher" goals, the realisation of which is tested by achievement of significant change that represents the collective interests of leaders and followers
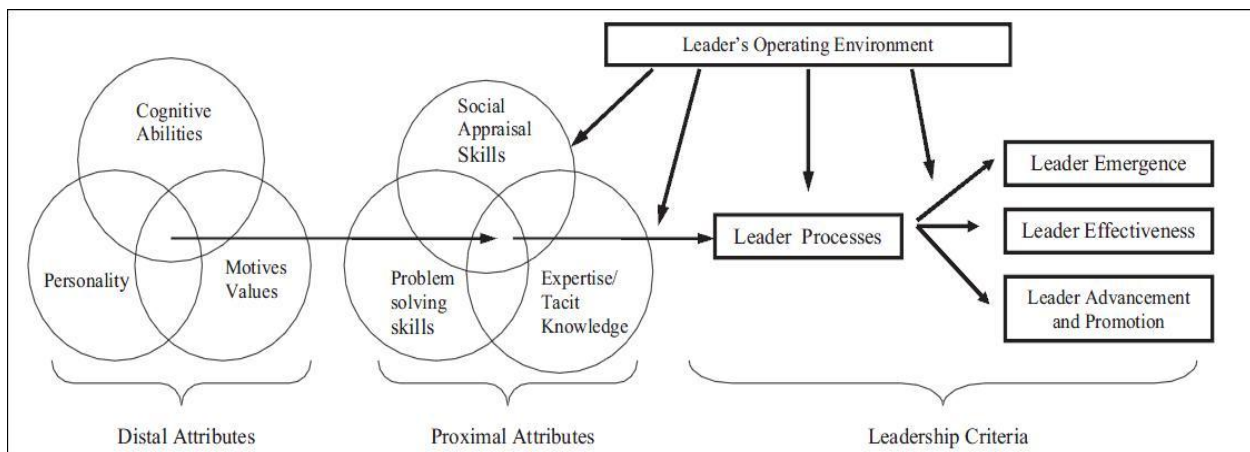
Zaccaro's (2004) Model

Zaccaro and Kempa (2004) created a model to understand leader traits and their influence on leader effectiveness/performance. This model, shown in the figure above, is based on other models of leader traits and leader effectiveness/performance (Mumford, Zaccaro, Harding, Fleishman, & Reiter-Palmon, 1993; Mumford, Zaccaro, Harding, et al., 2000) and rests on two basic premises about leader traits. The first premise is that leadership emerges from the

combined influence of multiple traits as opposed to emerging from the independent assessment of traits. Zaccaro (2001) argued that effective leadership is derived from an integrated set of cognitive abilities, social capabilities, and dispositional tendencies, with each set of traits adding to the influence of the other. The second premise is that leader traits differ in their proximal influence on leadership. This model is a multistage one in which certain distal attributes (i.e., dispositional attributes, cognitive abilities, and motives/values) serve as precursors for the development of proximal personal characteristics (i.e., social skills, problem solving skills and expertise knowledge) (Ackerman & Humphreys, 1990; Barrick, Mitchell, & Stewart, 2003; Chen, Gully, Whiteman, & Kilcullen, 2000; Schneider, Hough, & Dunnette, 1996; Kanfer, 1990, 1992; Mumford, Zaccaro, Harding, et al., 2000). Adopting this categorization approach and based on several comprehensive reviews/meta-analysis of trait leadership in recent years (Derue et al., 2011; Hoffman et al., 2010; Judge et al., 2009; Zaccaro, 2007), we tried to make an inclusive list of leader traits (Table 1). However, the investigations of leader traits are always by no means exhaustive (Zaccaro, 2007), which means absolutely more leader traits should be added to this list by future researchers and readers of this article

Although there has been an increased focus by researchers on trait leadership, this approach to leadership is "too simplistic" (Conger & Kanugo, 1998), and "futile" (House & Aditya, 1997). Additionally, scholars have noted that trait leadership theory usually only focuses on how leader effectiveness is perceived by followers rather than a leader's actual effectiveness. Furthermore, Derue (2011) found that leader behaviors are more predictive of leader effectiveness than are traits.

Another criticism of trait leadership is its silence on the influence of the situational context surrounding leaders (Ng et al., 2008). Kempa (2007) found that persons who are leaders in one situation may not be leaders in another situation. Complimenting this situational theory of leadership, Murphy (1941) wrote that leadership does not reside in the person, and it usually requires examining the whole situation. In addition to situational leadership theory, there has been growing support for other leadership theories such as transformational, transactional, charismatic, and authentic leadership theories. These theories have gained popularity because they are more normative than the trait and behavioral leadership theories (Schaubroeck, Lam, & Cha, 2007).

Further criticisms include the failure of studies to uncover a trait or group of traits that are consistently associated with leadership emergence or help differentiate leaders from followers (Kempa, 2007). Additionally, trait leadership's focus on a small set of personality traits and neglect of more malleable traits such as social skills and problem solving skills has received considerable criticism. Lastly, trait leadership often fails to consider the integration of multiple traits when studying the effects of traits on leader effectiveness (Zaccaro, 2007).

2.3   HIV/AIDS Situation

As regards HIV/AIDS situation, AIDS Information Centre Annual Report (2003:18) observed that it is more than two decades ago when the first HIV/AIDS case in Uganda was diagnosed in 1982. Since then, the epidemic spread like a wildfire killing everyone who gets it irrespective of age, religion or background. As the Luganda saying goes 'Mpaawo atalikaaba', AIDS has emerged as a serious threat to health, security and development of the country and for that reason issues regarding its prevention and management are a major concern for the government (Republic of Uganda, 2000).

The Uganda AIDS Commission Secretariat established that through collective efforts of the government and non-government sectors at various levels and with sustained political support right from the highest office, the country's response concurrently tackled all possible ways of preventing the spread of HIV and mitigating the impact of the epidemic at individual, household, community and national levels (UAC, 2000) but a lot still needs to be done.

2.4   Practices Regarding HIV/AIDS Prevention

The Republic of Uganda through its Ministry Of Health as well as other stake holders doing HIV/AIDS work, have developed a number of programmes and activities which are implemented in areas of massive awareness and education as well as voluntary counselling and testing. It has further supported prevention of mother to child HIV transmission through the provision of Nevirapine and encouraged blood safety to promote positive behaviour and reduce on the transmission of HIV infection. This is supported by Lewis, (1998:18) who asserted that, care and support activities targeting impact mitigation mainly focused on treatment of opportunistic infections, psychosocial support and income generating projects for affected households. Other partners ventured into ARV therapy, vaccine trials, social and biomedical research.

Reid (2000) carried a study on knowledge and attitude towards HIV/AIDS and prevalence of HIV/AIDS among Tea seller's women in Khartoum state. This was a descriptive based study conducted to determine tea seller's women risk behaviour change interventions. The study concentrated on ways of how the disease is transmitted. However the study did not tackle issues of management and practice, hence a gap this study bridges. The multi-sectoral approach to the control of AIDS provides the overall national policy guidance. This has been evidenced through sustained political support and a conducive policy environment in the areas of women empowerment, freedom of press, universal primary education and decentralized governance and poverty eradication (Republic of Uganda, 2001). The country's response has gone through the stages of fear, panic and denial, commitment and action; fatigue and complacency and now renewed action as the epidemic matured. Ugandans have demonstrated a high level of commitment and innovativeness in fighting the epidemic at various levels with tremendous support from different development partners. Their efforts moved Uganda from the world's epicentre in the early 90's to a success story. The Uganda AIDS Commission report further states that stopping the proliferation of HIV/AIDS infections requires a comprehensive strategy that addresses the many factors that contribute to the spread of the disease. They will be most effective when people living with HIV/AIDS are involved in designing and implementing them. Prevention efforts do not happen in a vacuum. They will be more successful when linked to care and support interventions such as anti-retroviral therapy.

2.5   HIV/AIDS and Leadership

Save the Children carried a study over three months highlighting low levels of awareness and lack of information in terms of quality reproductive and sexual health within both rural and urban communities. The study confirmed that children start first sexual contact as low as eight years old. The study did not envisage the impact of knowledge and practice on HIV/AIDS prevention among leaders on social welfare of people. This study narrows this gap by highlighting the management practices. A physician's fact sheet for human rights April (2003) on best practices in HIV/AIDS prevention asserts that political leadership is essential at every level of society, from top leadership to community leadership. Strong leadership is a common thread in countries that have achieved significant successes in reducing their HIV prevalence or have maintained a low prevalence such as Senegal, Brazil, Uganda and Thailand. Where strong political leadership exists, successful programs will be expanded, efforts to reduce stigma and

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discrimination against people living with HIV/AIDS and groups that engage in unfavourable behaviour are most likely to succeed and the people will receive frequent, consistent prevention messages. In Uganda, the drop in infection rate has largely been attributed to a strong political commitment, with broad societal involvement, to the ABC approach which stands for Abstinence, be faithful and condom use. A review of nationally representative surveys by Uganda Aids Commission from 1988, 1995 and 2000 reveal that each element of this integrated approach appears to have contributed to the decrease of HIV prevalence, which fell from 18% in 1995 to 8% in 2000. Abstinence; sexual activity was lower among women ages 15-19 and men ages 18-19 in 2000 compared to 1988. Be faithful; the proportion of unmarried sexually active women of all ages with multiple partners, and of unmarried sexually active men ages 18-19 with multiple partners, was less in 2000 than in 1995. Condom use in the unmarried sexually active population rose significantly from 1988 to 2000.

In his speech at the 1st annual general meeting of the AIDS Information Centre (AIC) Uganda, Alex Coutinho, praised the involvement of a broad partnership involving government, civil society, communities, and international agencies and donors as crucial in sustaining the fight against AIDS (The New Vision, Friday 21st February 2003, P.12). The early establishment of a multi-sectoral response as well as a national coordinating structure- Uganda AIDS Commission since 1992 saw perceptions change and in turn people were more receptive to campaigns for safer sex. Successful HIV programs can only take place in free societies. He also pointed out that the liberalization of the media to produce a vibrant and extensive print and radio media throughout the country is pertinent. The particular contribution of FM stations in the fight against HIV/AIDS has not been properly acknowledged but these could be the major source of information on health and HIV/AIDS in Uganda. He went further to comment on the development of strong national NGOs like TASO, AIC and UWESO that have been allowed by government to obtain independent funding from donors in order to support government interventions like care and support of HIV and AIDS, VCT and orphan support. Another important thing he pointed out was the acceptability of people living with HIV/AIDS as part of the wider society. This is supported by Gupta, G.R. (2006, P.17) who observed that this lowers the levels of stigma and discrimination in Uganda. This has not been achieved through legislation but through consistent advocacy for the rights PLWHA. This is however a battle that

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is far from over and we all need to intensify efforts against stigma and he finally pointed out that the mobilization of national and international research institutions as early as 1985 to carry out research on HIV/AIDS and apply the results to solutions generation has enabled Uganda to apply lessons that are relevant to its situation.

Lisa (2003:22) points out Uganda's experience; over the years, a wide range of media has been used to carry messages about AIDS and children have been taught at least the biological facts in school. These efforts quickly succeeded in raising basic awareness, but many misconceptions have remained. Nearly a quarter of adults thought that mosquitoes can transmit HIV; one in five think they can avoid Aids through witchcraft while others believe that sharing a meal with an infected person puts them at risks. Yet even as knowledge improves, this in itself is not enough. The real challenge is to change people's attitudes and behaviour, so as to prevent new infections and to stop stigmatization. This means not only making people better informed, but also empowering them with life skills that enable them to have safe and responsible sexual relationships. Increasingly the availability of condoms has been a key part of national policy since the mid-1980s and the health department aims to distribute condoms. However, many church leaders and politicians say that condoms cause promiscuity and immorality, and have opposed the promotional campaigns. This phenomenon is supported by Fredrick Chiluba (Former president of Zambia) who said that, "I don't believe in condoms myself because it is a sign of weak morals on the part of the user; the only answer is abstinence." (Aids Information Centre Annual Report, 2003, p.18). I think the active involvement of leaders at all levels will enable building consensus and harmonising positions on the appropriateness and relevance of strategies in tackling the HIV/AIDS pandemic among the leaders. This hinges on the knowledge levels and practice by the leaders themselves.

2.6   Traditional Healers and HIV Prevention

HIV sero-prevalence is among the world's highest disease in Uganda. In the early 1990s; two NGOs, the Ministry of Health and the National AIDS Commission launched an initiative called Traditional and Modern Health Practitioners Together against AIDS. The aim was to promote the true collaboration between traditional healers and biomedical health providers in the area of treatment, care support and prevention of STDs and AIDS (Homsy & King 1996).

In 1992, the first THETA project attempted a collaborative clinical study to evaluate herbal treatment for HIV/AIDS symptoms for which few or no therapeutic options were available in the region (Homsy et al 1995). When this study began healers were willing to discuss AIDS with their clients because they feared losing them with this terminal diagnosis. These challenges motivated a second project to empower traditional healers to provide STD/AIDS counselling and education. The project had particular emphasis on the healers' women clients in Kampala where the prevalence of HIV had levelled around 30% in pregnant women at the time (Uganda Ministry of Health, 1996).

It has been formally recognised since the late 1970s that, for developing countries, it is imperative to include traditional healers in primary health care (WHO, 1978), as discussed above, since the early 1990s, the same had been agreed upon for AIDS, especially in sub-Saharan Africa, where ministries of health cannot pay for adequate healthcare services. In addition, the debilitating direct and direct costs associated with AIDS in many countries make the prospect of cooperating with traditional healers all more appealing.

HIV/AIDS is now the number one overall cause of death in Africa, and has moved up to place among all causes of death world wide according to the latest annual World Health Report. As the epidemic continues to ravage the developing world, it becomes increasingly evident that diverse strategies to confront the wide-ranging and complex social, cultural environmental and economic contexts in which HIV continues to spread and must be researched, tested, evaluated, adapted and adopted traditional healers are well known in the communities where they work for their expertise in treating many sexually transmitted diseases (Green, 1994). Consequently, the world health organisation has advocated the inclusion of traditional healers in National AIDS Programmes since the early 1990s.

Today, interventions to stem the spread of HIV/AIDS throughout the world are as varied as the contexts in which we find them. Not only is the HIV pandemic dynamic in terms of treatment options, prevention strategies and decrease progression, but sexual behaviour, which remains the primary target of HIV prevention efforts worldwide, is widely diverse and deeply embedded in social and cultural relationships, as well as environmental and economic processes. This makes prevention of HIV/AIDS very complex. Most preventive interventions have relied on giving

correct information about HIV transmission and prevention intervention and imparting practical skills to enable individual to reduce their risk of HIV infection. More recently, social cultural factors surrounding the individual have been considered in designing prevention interventions.

In addition, beyond the individual in and his or her immediate social relationships, larger issues of structural and environmental determinants also play significant role in sexual behaviour and thus are addressed in intervention design and implementation. Monitoring and evaluation of prevention programmes have shown that prevention does work. In countries that have implemented quick, well-planned efforts with support from political and religious leaders, including sex in schools, treatment of STDs, and widely promoted condom use, HIV prevalence has been kept consistently low and has been decreased in some countries in the last five years (UNAIDS 2004). Yet, cases of decreased HIV prevalence are still the exception and many developing countries are struggling to find innovative cost effective strategies that are relevant to their AIDS situation. In a resource constrained settings, one avenue that has still been rarely travelled is cooperation with the indigenous health system.

Traditional healers represent a broad range of practices, including herbalism and spiritualism, as well as a range of individuals who call themselves diviners, priests and faith healers, among other terms. Although many of the initiatives reviewed here did not differentiate between these categories, the traditional healer used refers to either herbalists, spiritualists or to those involved in both practices.

African traditional healers mirror the great variety cultures and belief systems on the continent, and posses equally heterogeneous experience, training and educational backgrounds. This diversity is further enhanced by their adaptations to the dramatic social changes that have affected much of the country since colonisation, such as urbanisation, population migration and displacement, and civil conflict (National Strategic Plan 2007 and 2008). The cost of traditional medical care varies with the nature of treatment, the type and severity of ailment and the relative wealth of the client. Whenever African healer's knowledge, attitudes, beliefs and practices about HIV/AIDS have been explored, findings have reflected the stage of the epidemic, the amount information traditional healers have been exposed to, and their pre-existing belief systems about health and disease in general, and STDs and AIDS in particular.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1   Introduction

This chapter shows how the research was conducted and it included the following; study population, sample selection, study design, data collection instruments, and procedure and data analysis.

3.2   Research Design

In this study, the researcher used the cross-sectional survey method for collecting data, which enabled him to easily collect the data pertaining to the study at one particular time. The researcher also used both the qualitative and quantitative research approaches. Specifically, questionnaires containing questions related to the issue of knowledge and practice on HIV/AIDS prevention management and their impact on peoples' social welfare in Kampala Central Division, Kampala District were administered. This enabled the researcher to collect a sizeable amount of information about prevention management of HIV/AIDS, the attitudes, opinions, and perceptions on the issue of HIV management among leaders in the six parishes of Mengo, Kamwokya I &II, Kagugube and Kisenyi I & II. The choice of parishes selected was based on vulnerability as they have the biggest slum areas in the Division.

The qualitative descriptive and quantitative research approaches were preferred because of their reliability in providing clear information on subjects being studied without subjecting them to manipulation, and also because they are cheaper to administer in terms of costs and money.

The qualitative approach also enabled the researcher to give in-depth description and analysis of the views of the different respondents regarding the impact of knowledge and practice on HIV/AIDS prevention management among leaders on the social welfare of people in Kampala Central Division. On the other hand, the quantitative approach facilitated the quantification of the respondents' responses and the presentation of the findings.

3.3   The Study Area and Target Population of the Study

The researcher chose to conduct this study in Kampala District because it is within the proximity of the researcher, and also because whereas several other Divisions, Kampala Central experienced a similar problem, some studies have reaffirmed that knowledge and practice on

HIV/AIDS prevention management has been very core in the Division. Also the people within the city are from diverse backgrounds.

3.4   Sample Size and Selection

There were four types of subjects for the study, and all of them were regarded as the opinion leaders in the Division. They are the following:

i) Type one consisted of teachers, local council chair persons, councillors and secretaries for education, gender and social welfare and secretary finance and administration.

ii) The second type included the religious leaders, and influential elders, from the six parishes.

iii) The third type consisted of special groups like youth representatives and people with disabilities.

iv) The fourth type involved the community leaders from the several zones within the parishes.

This study included: 20 influential leaders, 15 religious leaders, 40 community leaders, 20 teachers, 12 councillors 10 youth representatives 10 local council chair persons, 20 health workers and 3 government officials.

Table: 1 This shows the number of subjects involved in the study from each of the targeted groups in Kampala Central Division:

Sample Determination Diagram:

Target Group	Number of participants	Sampling Technique
Influential Leaders	10	Convenience Sampling
Religious leaders	15	Convenience Sampling
Community leaders	40	Convenience Sampling
Teachers	20	Convenience Sampling
Government Officials	3	Convenience Sampling
Councillors	12	Convenience Sampling
Youth representatives	10	Convenience Sampling
Local chairpersons	10	Convenience Sampling
Health workers	20	Convenience Sampling
Women representatives	10	Convenience Sampling
TOTAL:	**150**	

3.5   Data Collection Methods

The instruments used included questionnaires and interview guides. The study was aimed at determining the attitudes of opinion leaders towards the impact of knowledge and practice on HIV/AIDS prevention management among leaders on the social welfare of people in Kampala central. The researcher felt that these were the most appropriate instruments that could ensure a wide coverage of opinions. The questionnaires were divided into three sections:

 Section one (a) involved attaining information regarding the respondents' background (b) was on knowledge and practice on HIV/AIDS and (c) was for HIV/AIDS management for all the respondents, and its aim was to find out whether leaders' knowledge and practice on HIV/AIDS influence behavioural change and enhances social welfare of the people they lead.

3.5.1 Interview Schedule

The researcher developed the interview schedule from the objectives of the study as well as the research questions. Face-to-face interviews and group discussions were conducted, and were intended for the opinion leaders under the categories of the clergy, the community leaders, health workers, influential elders as well as government officials. This was designed to obtain more information that was not provided by the documents, and to confirm the document information. Thus, these interviews supplemented the analysis of the documents. This helped the researcher to elicit much of the information from the respondents, who in some instances possessed a lot of critical data, useful to supplement the one got from the questionnaires. The interview schedule was also used due to the fact that the respondents were of different background. The method was also adopted because many people were apparently more willing to communicate orally than in writing.

The respondents were also asked questions whether leader play a vital role as regards HIV/AIDS prevention and management practices on the welfare of people, the various HIV/AIDS preventive methods, and suggestions were made on how leaders should be vigorously involved in the campaign against HIV/AIDS in Kampala central in particular and Kampala district in general.

3.5.2 Documents

The period between 1980 and 2000 formed the background of the study, whereas 2000-2012 was the period under study. This implies that both the primary and secondary sources on the two periods were closely studied. Their contents were scrutinized and subjected to internal and external criticisms. The documents included both the published and unpublished materials, as well as Education Reports.

3.5.3 Published Documents

These included books on the history of HIV/AIDS in Uganda basically Rakai district and the world, basically in America, Europe, Africa. Special attention was given to those documents concerning the Government control of AIDS, AIDS commission and other relevant documents in Uganda, and the world following the origin of the disease.

3.5.4 Unpublished Materials

These included dissertations and theses by various researchers on HIV/AIDS in Uganda generally, and Kampala District in particular as an area of study. Some of the seminar papers were also analysed.

3.5.5 Reports

These included the Uganda AIDS Commission reports, Kampala District reports, Ministry of Health statements and circulars, Health Committee minutes, Newspaper reports, Articles, Journals and magazines.

3.5.6 Questionnaires

Questionnaires containing probing questions were used during oral interviews, and also some were sent to the subjects who could not be reached. These were carefully filled sent back by the respondents, and were analysed to supplement the interviews and documents.

3.6   Procedure of Data Collection and Analysis

 The researcher personally travelled to the selected Parishes and zones, District Health offices, and the Community-based Health centres. Six parishes were visited to analyse documents on HIV/AIDS, and to interview the selected subjects.

In all the above-mentioned places, relevant documents were analyzed and the information extracted was recorded. Conclusions and recommendations were drawn from the contents of the findings of this study.

The data collected was edited with the view of checking for completeness and accuracy. The questionnaires were edited as soon as they were collected so as to facilitate follow up of the respondents for clarifications/corrections, before analysis was made. The data was also edited to ensure accuracy after coding. This helped the researcher in getting reliable data that could easily be analyzed. Data was entered into the computer and analyzed.

CHAPTER FOUR: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF LEADERS

4.1 Introduction

The HIV epidemic is a leadership issue. There is evidence and documentation that countries which demonstrated effective leadership were able to control the prevalence levels as it was with Uganda in the 1990s because of visible committed leadership at the highest and lowest community levels. Advocacy is a tool and weapon used by leaders, interest groups, networks and individuals to advance an agenda to realize a desired goal. Therefore this chapter focuses on the social-demographic characteristics of leaders.

4.2 HIV and Leadership

In this study, the role played by leaders in HIV/AIDS prevention management and social welfare of people in Kampala Central Division is pegged to the values and modelling people are exposed to. Leaders were conceptualised to mean councillors, Local Council chair persons, government officials, women representatives, teachers, youth representatives, religious leaders and representatives of people with disability. The study sought for values they espoused and their implication to the moral character development in relation to welfare. A lot of progress has been made by many African countries in stabilising and decreasing the incidence of HIV infections. The number of people accessing antiretroviral treatment has increased. Communities in Uganda are faced with challenges of high levels of stigma and discrimination, which are key determinants to social and legal barriers to effective demand and uptake of quality and sustainable HIV services. Socio-economic, cultural structures and networks influence behaviour that breeds multiple sexual partnerships, commercial sex, improper and or none use of condoms that drive the HIV epidemic in Uganda. Access and uptake of proven bio-medical HIV prevention interventions such as prevention of mother to child transmission of HIV (PMTCT), safe male circumcision (SMC), HIV counselling and testing (HCT) and post-exposure prophylaxis (PEP) and coverage of preventive behavioural interventions is low. The national response falls short of focus and targeting. Hence factors outlined above require renewed and effective leadership to bring back Uganda to the once gained centre of excellence.

The HIV epidemic is a leadership issue, as regards this matter, Museveni Kaguta Yoweri, President of the Republic of Uganda asserted that:

> There is evidence and documentation that countries which demonstrated effective leadership were able to control the prevalence levels. For example, Uganda registered remarkable progress in the 1990s majorly because of visible committed leadership at the highest and lowest community levels.

The President further reports:

> The community is the front line in the fight against AIDS. Community leaders and their groups play an essential role in a nation's response to HIV/AIDS by organising grassroots' action; imitating education, prevention and care giving services; and helping to shape local norms of behaviour.

The global response recognises advocacy as a critical strategy to ending the worldwide HIV and AIDS catastrophe. Advocacy constitutes one of the five key functions that were articulated in the Statute that established Uganda AIDS Commission in 1992. Advocacy is a tool and weapon used by leaders, interest groups, networks and individuals to advance an agenda to realize a desired goal. Advocacy therefore goes hand in hand with leadership because it enables identification of issues, accords opportunities for positioning identified issues and influences budget provisions for financing advocacy to execute their work. Leadership and advocacy for HIV and AIDS response is affected by global challenges where countries are characterised and challenged by internal constant civil strife and pre-occupied by addressing and containing economic squeeze, struggling to address food security, among others.

When HIV was rapidly spreading through the population of Uganda in the late 1980s, President Yoweri Museveni, unlike most other African leaders at the time, recognised the danger and took swift action showing forceful leadership. Uganda's response was powerful and wide-ranging. The government launched an aggressive media campaign involving posters, radio messages and rallies; they trained teachers to begin effective HIV and AIDS education; and most importantly, they mobilised community leaders, churches and indeed the public in general.

The government worked alongside many independent organisations, using different messages to address different groups of people according to their needs as well as their ability to respond. Young people were encouraged to wait before first having sex, or to return to abstinence if they

were not virgins. All sexually active people were given the message of 'zero grazing', which meant staying with regular partners and not having casual sex. Those who did not abstain were encouraged to use condoms, which were promoted to the population as a whole.

In order to encourage people to take up such strategies and to make them effective, action was taken to encourage candid discussion of HIV and AIDS, to reduce stigma, to better the status of women, to improve testing facilities, to treat other sexually transmitted infections and to provide better care for those already infected.

While it is evident that where effective leadership is demonstrated significant achievements are realized; economic and geo-political challenges divert leadership attention to focus on HIV prevention and address the effects of HIV and AIDS effectively as Katahoire and Kyadondo (2006:18) observes;

> Uganda offers a good example as once a world leader in reducing HIV from a very high rate (18%) of the national prevalence to a stable level of about 6-7%. Whereas no scientific study was undertaken to establish factors that played a key role in reducing the infections, leadership stood out as a major component that constituted best practices. Unfortunately, it the leadership of that time was neither replicated nor sustained to scale up the response, hence the stagnation.

4.2.1 World AIDS Day (WAD)

The WAD is the most recognised international health day in the world. It is a platform and opportunity to raise awareness on current trends of the epidemic in the world, countries and local governments. It is an aggregated commemoration of those who have passed on and celebrate victories such as increased access to treatment and prevention services. It focuses on the annual struggle to raise awareness about the status of the epidemic, breakthroughs and a beginning of a new campaign that evolves annually.

WAD in Uganda, like anywhere in the world, is observed every 1_{st} of December each year. The day provides the most needed opportunities to disseminate important information, highlight national and international achievements, share notable research findings and increase awareness of access to care and treatment, social support and prevention. The event offers fora to show case national interventions, facilitate access to free services such as HIV counselling and testing, reproductive health and referrals services in a stigma free environment. Most uniquely, the event brings leaders to the fore of the response.

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WAD is usually guided by a two-year theme. Uganda AIDS Commission adopts global themes but occasionally, in collaboration with its partners develops local themes to guide the campaign.

> The AIDS campaign theme for the year 2011 for Uganda was selected locally, based on and informed by deliberations and outcomes of the June 2011 UN High Level meeting in New York and the current national focus on HIV Prevention. Thus, Uganda's WAC theme is, "Re-engaging Leadership for Effective HIV Prevention".

In the campaign perspective, leadership was broadly defined to include all leaders ranging from individuals, households, communities and institutions to national political and technical cadres. The study observed that, Uganda AIDS Commission (UAC) decentralised WAD way back in 2001. The decentralization aimed at empowering local governments to own up the event and increase awareness of the activity amongst grassroots communities. Since then, every district is charged with a responsibility of ensuring district based commemorations in partnership with district based actors, at a venue of their choice and performing activities of their choice based on existing capacities and HIV situations.

4.2.2 Philly Lutaaya Day 17 October

Philly Lutaaya Day on 17 October of every year, is one of the major AIDS campaign events when Uganda underscores the importance of *"Positive Living"*. It is close to thirty years of AIDS in Uganda, but the status and trends of the epidemic remain significantly challenging. HIV rose steeply between 1989 and 1992, peaking at 18% and rapidly declined between 1992 and 2002, stabilizing between 6.1 and 6.5% between 2002 and 2005. The current epidemic is mature, generalized and heterogeneous and exhibits varied transmission dynamics. Currently about 1.2 million people are estimated to be living with HIV in Uganda. New HIV infections average at 124,000 annually; with sexual transmission accounting for over 80% and over 18% of the new infections due to mother-to-child transmission(Uganda Aids Commission, 2011).

It is evident that uptake and practice of preventive behaviours in the general population is low and as a result, practices such as multiple and concurrent sexual relationships and inconsistencies in condom use during casual sex encounters are prevalent. In addition, life styles among certain population groups such as fishing communities, sex workers, migrant workers and long distance drivers among others put them at a higher risk of HIV infection.

This situation is attributed to complacency and laxity in leadership at all levels including individual and couples. It is thus critical that we rethink and recast approaches and interventions to address known and documented drivers of the epidemic to prevent new HIV infections.

Advocacy is one such intervention that needs revamping and scaling up to engage everybody in their leadership roles at all levels to promote uptake of services that have proved to be effective towards HIV prevention. The World AIDS Campaign (WAC) is one such great opportunity to re-engage leaders to commit themselves to achieve universal access to HIV Prevention, treatment and care and support and protection because there is evidence that where effective leadership is exercised, significant results are realised. Uganda's tremendous progress in the HIV national response in 1990s largely benefited from the top political commitment by President Yoweri Kaguta Museveni. Unfortunately, this commitment did not adequately trickle to lower leadership cadres

In line with the above, the June 2011 UN high level meeting in New York where leadership was underscored, Uganda AIDS Commission (UAC) with partners have decided to promote advocacy for intense HIV prevention, the mainstay of the national response; hence the theme, "**Re-engaging Leadership for Effective HIV Prevention".** The theme is premised on the assumption that when leaders play their role effectively, HIV prevention will improve.

Uganda annually commemorates Philly Lutaaya Day (PLD) in October. PLD is a local AIDS advocacy initiative when Ugandans remember Philly Bongole Lutaaya (RIP), the first Ugandan to give AIDS a human face at a time when stigma was high with soaring discrimination and denial due to lack of adequate information at the time. Philly is known to be the father of *"positive living",* a notion that propels the international principle of Greater involvement of people living with HIV, which is the foundation for the *"Prevention with the Positives strategy".*

The researcher observed that this event is the very core as it is celebrated every year; this should be a platform for church leaders, community leaders, and political leaders among others to intensify awareness of the pandemic to the public. In the same way all district leaders are mandated and advised to partner with AIDS actors operating in their districts to plan and mobilise their communities for implementation and participation in the various activities. Theophane Nikyema the humanitarian coordinator and community leader said:

> A strong sector is essential if HIV programmes are to achieve their expected impact. In Uganda, working with District HIV/AIDS committees centres is developing comprehensive prevention care and support programmes that meet the complex issues facing communities.

In order to reinvigorate leadership commitment and hold all leaders accountable, Uganda AIDS Commission has come up with the following guidelines for Philly Lutaaya Day (17th October), World AIDS Day (1st December) and International Candlelight Memorial Observance (First Sunday May) events:

Members of Parliament, through the HIV/AIDS Parliamentary Committee and the Parliamentary Commission should organise to innovatively observe the advocacy events mentioned above;

Line ministries, under the leadership of the Permanent Secretaries and with strategic guidance from the sectoral ministers should mobilise and engage employees and their partners for

respective sectoral engagements and action; The Ministry of Gender, Labour and Social Development as a special ministry, in liaison with the National Council of Women (NCW) and National Council for Children (NCC) should ensure community awareness of linkages and relationship between women, girls and HIV so as to enable leaders to identify strategies to bridge gender gaps in the response; The Faith Based Organisations have a key role to contribute spiritually to the AIDS Campaign; specifically, special prayers should be conducted focusing on '*Positive living*' and all accounting officers at every level are requested to share activity reports with Uganda AIDS Commission Secretariat.

Activities vary based on situations such as location, partnerships, ability and capacity to mobilise people and resources and above all, appreciation and the Will to contribute to the national response. They range from; special prayers, community support, processions, debates and dialogues, drama, exhibitions, visiting patients, concerts, sports gala, to offering HIV services like counselling and testing among others.

Uganda AIDS Commission is committed to coordinating stakeholders' efforts directed at HIV prevention, care and treatment, social support and protection, as per our mandate. Therefore the study appeals to 'all leaders' to cooperate and embrace Leadership for Effective HIV Prevention initiative in order to refocus and scale up the national response with a focus to attain zero new mother to child infections and zero AIDS related deaths, as Director General for Uganda Commission puts it:

> Leadership worked for Uganda when we had less information, limited capacity and fewer resources. Today we have more leaders, more resources, vast experience and advanced knowledge about the epidemic. Let us use leadership to Prevent HIV and halt the epidemic.

4.3   HIV/AIDS Pandemic and its Gender Implications

In Uganda's culture young girls grow up with the knowledge of the importance of having children. Children are a symbol of wealth, investment and social security in the African context. In relation to this, Beatrice Were a Coordinator National Community of Women living with HIV/AIDS reports:

The desire by an HIV positive woman to bear children is perhaps stronger than that of an uninfected person whose ability to have children is not hampered by the complexities of HIV.

A woman is therefore expected to bear children and if she does not, then she is not a respectable woman. We need to bear in mind that in Africa, the idea of marriage in our culture was to have children. With these kinds of expectations from society and from within herself as woman, the question is; How does an HIV infected woman hope to cope with the challenges and barriers that arise as a result of being HIV infected and the desire to have children. Beatrice further asserted that:

There are hard facts today, these include: the epidemic still rages on, silence and denial is still a major issue and the epidemic has disproportionate impact on women especially in Sab-Saharan Africa. Unfortunately today there seem to be no alternatives or practical solutions due to the complexity of the matter.

Science and research has confirmed beyond reasonable doubt the risk of MTCT. While in the developed countries HIV positive mothers have the benefit of eradication of MTCT through new treatments (ARVs). In Uganda like most African countries HIV positive mothers have no options. The drugs (ARVs) are very expensive. This situation is worsened by the lack of information on the available alternatives for infant feeding and the high cost for infant feeding formula. The clear message sent to HIV positive women has been, forget about motherhood if you are HIV positive. The AIDS epidemic and its overwhelming impact on families calls for the involvement of men more than ever before. Kihumuro Apuuli Director Uganda AIDS commission on this issue reported:

Women infected with HIV are faced with such challenging issues like safer sex (condom use), to breast feed or not, caring for their infected children, husband and fending for the family when one's spouse is sick and after his death. Experience from Uganda demonstrates that women come to terms much easier and are keen to seek medical care, counselling, information and support. On the contrary men shy away from the reality of HIV/AIDS and are not very enthusiastic about counselling and testing.

Therefore the researcher observed that this situation complicates leadership and decision making in a family and is bound to curtail positive living. For women especially, this could easily lead to blame, stigma, rejection and violence. The reality however is that most women are often infected by the single partner they have. The study found that, most HIV positive women in Uganda find

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themselves in a position where they are burdened by caring for their partner/spouse, HIV positive baby, having to provide care and support to the sick and to orphans. Normally the HIV infected woman is forced to ignore her own health needs due to her traditional role as a woman, this is supported by Mbiti (1969) a Woman is obliged to provide care to her family.

4.4   Community Level Interventions on HIV/AIDS

The gender dimensions of HIV/AIDS are glaringly obvious at the community level. Women bear the major burden of HIV/AIDS because of their traditional roles within the family and the community. Since care giving and domestic chores are still predominantly women's responsibilities, an increase in the prevalence of HIV/AIDS in the society directly and indirectly increases the burden on women. Women's subordinate status, especially in sexual decision-making, is another factor that makes women more vulnerable to HIV/AIDS infection. Coupled with these are negative and harmful socio-cultural beliefs and practices, which vary from community to community.

Paradoxically, women's emerging and emancipating roles within the family and the community also increases the burden of HIV/AIDS on them. The fact that women are taking on men's traditional role of breadwinning is worsening the situation for women(UNFPA, 2000). The combination of productive activities outside the home with domestic work, including care giving to the infected, puts additional strain on women's physical, mental and emotional health. Many women have to divert a significant part of their financial resources into care giving. When the infected woman who heads a household herself becomes ill and unable to earn a living, the situation of the house hold could become hopeless.

> Poverty is a key consideration in community-level interventions on HIV/AIDS from a gender perspective. It constitutes a great challenge indeed for leaders everywhere, at international, national and local levels. Poverty is a major driving force of HIV/AIDS. It is both a motive force and a consequence. Poverty leads to migrant labour, mostly from the rural areas to the cities, separating couples and increasing the incidence of multiple and casual sexual relationships. It also forces women to trade sex for material gratification.

The situation is compounded by the feminization of poverty occasioned by so-called Economic Recovery Policies or Structural Adjustment Programmes. The cut in public spending on social services, health education, transportation, etc., and the retrenchments and the introduction of

costs for medical care and education cause more unemployment, insecurity in family relations, more school drop-outs and poorer reproductive health, increasing the burden of poverty on families and communities. Naturally, women who are among the poorest of the poor are the worst hit. More girls are denied the opportunity for education, and more women are forced to trade sex for survival. Secondly, the strain put on the health care system and the introduction of costs further increase the burden on women who are mostly responsible for caregiving. The social unrest that ensues creates a climate of political instability, encouraging dictatorships and undemocratic coercive governance and driving away investors whom the "austerity measures" were meant to attract in the first instance -- a vicious cycle.

The plight of women in the face of HIV/AIDS requires strategic responses. Interventions at the community level need to effectively address both the vulnerability of women as well as the impact of HIV/AIDS. To do so, there is a need for a shift in paradigms. Policies and programmes need to move beyond reaching women alone. A gender perspective needs to become much broader than the feminization of interventions. In addition to direct assistance to women to ensure livelihoods for them, access to treatment and reduced burden of care giving. Bold, fresh responses are needed by leaders and other stakeholders to proactively address root causes and the unjust structures which perpetrate the vulnerability of women to HIV/AIDS.

The leaders, especially at community levels have a moral obligation to ensure that resources are equitably distributed in their respective constituencies. Nyakaana L.C III Chair person Kampala noted that:

> In terms of HIV/AIDS prevention and control, there is an increasingly greater political will on the part of leaders to acknowledge HIV/AIDS as a serious development issue. The focus on HIV/AIDS by the Special Session of the United Nations Security Council in January 2000 is evidence of this. This political will has not always been translated into concrete actions, nor has HIV/AIDS prevention and control received the kind of priority attention it deserves.

However the above is contrasted by UNFP Report (2000) which says:

> With all the attention that HIV/AIDS is receiving as a development and security issue, world leaders and heads of Governments have fallen short of treating HIV/AIDS as a natural disaster. The fact that the millions of people infected and affected are dispersed in

relative obscurity in their respective families and communities has encouraged a rather leisurely approach to HIV/AIDS interventions.

When it comes to HIV/AIDS intervention at the community level, women, the community and religious organizations have demonstrated a great deal of leadership. Leaders everywhere are challenged to treat HIV/AIDS as a priority, a global catastrophe and holocaust. The time for words is over. Governments everywhere should learn from local communities and women about what needs to be done and proceed to do the will of the people.

4.5   HIV/AIDS and the Role of Leaders

The rapid spread of HIV/AIDS has created challenges for everyone who is involved in the fight against it. In the study, the researcher observed that, many of the strategies to prevent the spread of the pandemic have focused on promoting condom use, reducing the numbers of sexual partners and treating sexually transmitted diseases (STDs). However, by failing to address the social, economic and power relations between men and women, such strategies have not been effective in tackling women's and men's risk of infection, their ability to protect themselves effectively and their respective share of the burdens of the epidemic. This is supported by Beatrice Were (2000) who says:

> HIV/AIDS has vastly different implications for men and women. Not only is the probability of transmission between men and women different, but so are the opportunities for diagnosis and the consequences for those who are seropositive. These differences can be attributed largely to the socially constructed gender roles that are assigned to men and women in every society. In Africa, the prevailing gender roles at the household, community and even at the national level have relegated women and girls to a subordinate status, which limits their abilities to protect themselves from infection by the HIV/AIDS virus. It is, therefore, not surprising that HIV/AIDS is fastest rising among women.

Indeed addressing the HIV/AIDS pandemic requires social mobilization to remove the structural underpinnings of gender inequalities.

Few policies and programmes in response to HIV/AIDS are informed by the real-life situations of men and women: how they live and work in urban and in rural areas, and the complex network of relationships and structures that shape their lives. Yet, these experiences are all well known and well documented. Both men and women live in accordance with widely shared notions of what it is to be a man, or to be a woman. These ideas about typically feminine or masculine characteristics, abilities and expectations determine how men and women behave in various situations. Such ideas and expectations are learned from families, friends, schools, the workplace, religious and cultural institutions, the media and opinion leaders. Since these are learned responses, it is evident that leaders can and should play an aggressive role in changing those norms about femininity and masculinity that support the spread of HIV/AIDS.

Among the learned behaviours that make the response to the HIV/AIDS pandemic in Africa difficult are those related to power in relationships between men and women, and those related to sexuality, as well as those related to the division of labour. These need to be addressed openly and transparently by leaders to halt the spread of HIV/AIDS(Human Rights Watch, 2005).

With regard to power, there is a perception in many cultures that a woman's sexuality is owned not by the woman herself but by other male members of the family. Bride wealth is often the symbolic manifestation of this perception. In too many instances, women do not exercise the choice, but are instead told, when to become sexually active, through various rites of passage, often at too early an age. They are told when and whom to marry; how to have sexual relations, which may involve using dangerous herbs; when to have children and whether or not they can use contraception; and even what to do about household expenditures. This type of male power is supported by tradition and social norms. So, women learn that their first loyalty is to kin and families, causing them to act in ways that reinforce rather than challenge their own subordination. Such control and power over women's sexuality and reproductive behaviour also leads to women's abdication of responsibility over their own sexual and reproductive health

because of the powerlessness that they experience. This has dire consequences with respect to HIV/AIDS.

Prevailing ideas about sexuality contribute significantly to the spread of HIV/AIDS. Men are often made to believe that male sexual needs are strong and that because of this they can easily succumb to the seduction of women. Such notions make men appear to be governed by their instincts, unable to control their sexual behaviour, and the victims of female power.

As a result, men are often excused for not behaving responsibly for example, not using condoms and women themselves are reluctant to buy or carry condoms because of their fear of being accused of wanting to entice or seduce men. At worst, such perceptions also condone aggressive sexual behaviour whereby men believe that coercing women into sexual intercourse, including rape, is part of normal masculine behaviour. In fact, social rules usually deprive women of the freedom to move about freely and lead to situations in which women, not their attackers, are blamed for sexual abuse. Women are also very reluctant to report sexual abuse because it may affect their position in society. The June 2000 UNAIDS report notes that the incidence of HIV/AIDS transmission in the context of coerced sexual intercourse is exceptionally high.

In many societies in Uganda, women's primary role is still seen as that of bearing and nurturing children. Men's role, on the other hand, is perceived to be that of earning a living and dealing with the broader issues of society on behalf of the family. Responsible fatherhood, wherein the man takes an active role in looking after and nurturing his children, is not widespread. This division of labour is extended to other aspects of men's and women's lives. The expectation that women must care for children is extended to all household members needing support, that is, the elderly and those with long-term illnesses, including those living with HIV/AIDS, as well as orphans. Women's nurturing role also involves unpaid labour on family land. One of the major consequences of the prevailing division of labour is women's economic dependence on men as economies in Africa have evolved. This is at the heart of women's low social and economic status that is associated with their lack of opportunities, including those related to access to education and literacy. This contributes significantly to women's ignorance in obtaining

information that can help to protect them against HIV/AIDS. Such economic vulnerability also fuels women's recourse to selling sex.

In most cases, if selling sex enables them to survive today, long-term concerns remain out of focus.

The examples given above demonstrate some of the reasons why a gender-based response to the HIV/AIDS pandemic is essential. Such a response focuses on how different social expectations, roles, status and economic power of men and women affect, and are affected by, the pandemic. The dominance of male sexual needs and the denial of female needs impede open discussions between the sexes and limit people's chances of achieving a mutually trusting and satisfying relationship. Men's violence against women has now emerged as a major risk factor for HIV/AIDS and it is sustained by notions of, and about, men and women's behaviour that are learned through socialization. Women's economic precariousness, which feeds the sex industry, has its foundations in the gender division of labour and the opportunities, rewards and benefits that accrue.

Collective action is required to ensure wider development and implementation of gender sensitive strategies. This is where the role of leaders is critical because they can mobilize people for the type of social change that challenges the deeply embedded cultural beliefs and practices about men and women that promote the spread of HIV/AIDS. To this end, leaders need first of all to create an environment in which dialogue about gender equality and the protection of women and girls can take place in a constructive manner. Such a dialogue would help to create a better understanding of how men and women define personal risk in different types of relationships which, in turn, could be used in the development of policies and programmes to decrease vulnerability to infection, reduce stigmatization and curb the socio-economic impact of the disease.

Leaders need to ensure that short- and long-term gender-sensitive strategies are developed, from the community level all the way to the national level. Short-term strategies may focus on

people's immediate needs, especially those pertaining to obtaining information about HIV/AIDS, for both literate and illiterate populations, support to home-based care, and access to treatment of STDs and counselling services. Long-term strategies must address the underlying cultural and social structures that sustain gender inequality. They should promote mutual respect between men and women and equal access to opportunities and resources, and should empower individual men and women to exercise responsible choices about their own sexual behaviour.

4.6   Leadership Structure of Kampala Central Division

Below is a figure showing the organizational structure of Kampala Central Division.

Chart1: The Summarized Organization Chart of Kampala Central Division:

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                          ┌──────────────┐
                          │    LC111      │
                          └──────┬───────┘
                          ┌──────┴───────┐
                          │    LC111      │
                          │  EXECUTIVE    │
                          └──────┬───────┘
                   ┌─────────────┴─────────────┐
                   │  DIVISIONAL HEAD - SENIOR │
                   │   PRINCIPAL ASSISTANT     │
                   │       TOWNCLERK           │
                   └───────────┬───────────────┘
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ENGINEERING DEP'T	PLANNING DEP'T	HEALTH DEP'T	FINANCE DEP'T	WELFARE DEP'T	EDUCATION DEP'T
ENGINEERS, TECHNICIANS ,.ETC.	PLANNERS, INSPECTORS. ETC	DOCTORS, MEDICAL OFFICERS, .ETC	ACCOUNTANTS, ETC	WELFARE OFFICERS	EDUCATION OFFICERS, INSPECTORS
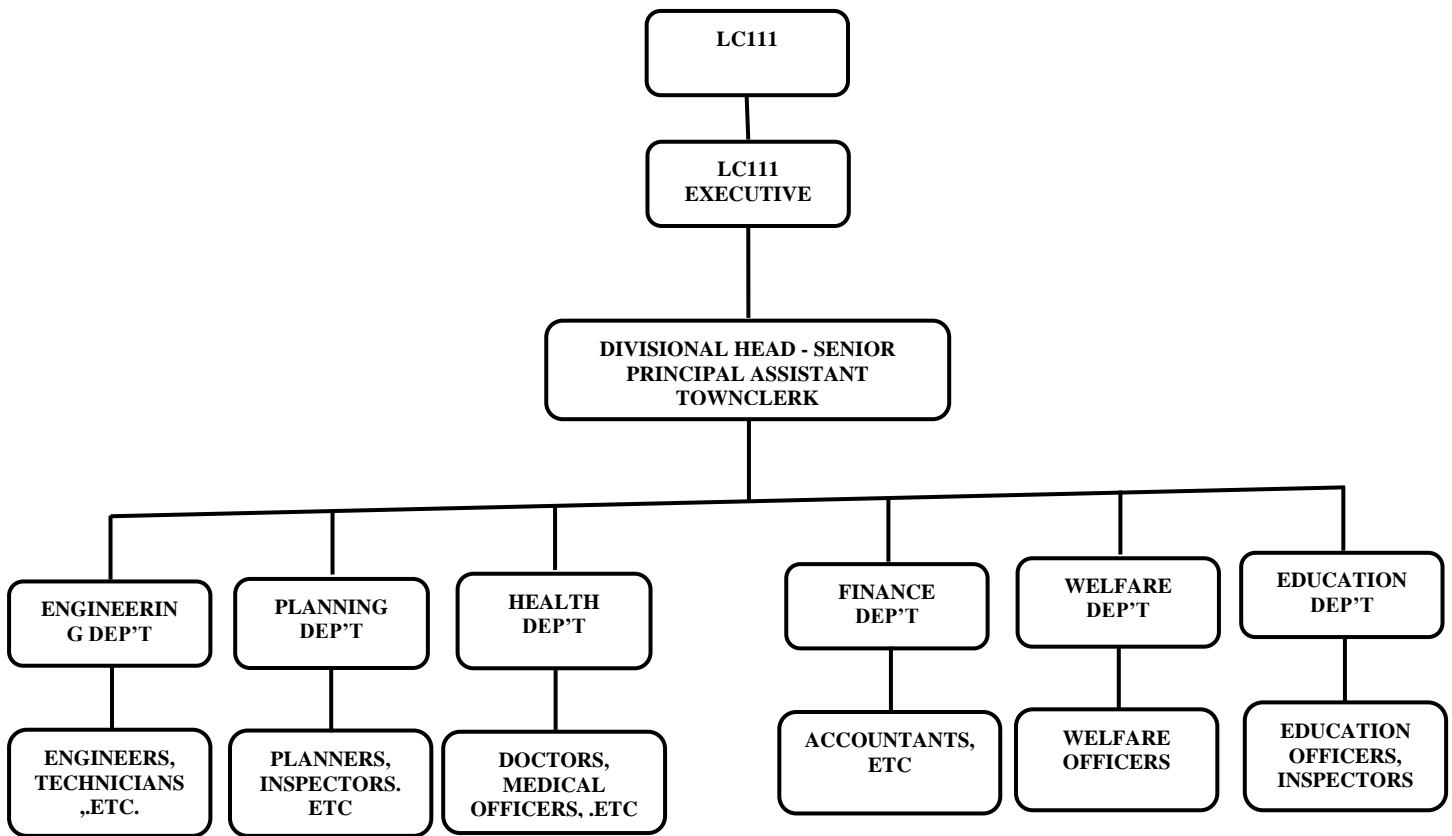
The chart above shows that, L.C.III chair person is on top, followed by L.C.III executive and then Divisional Head-Senior principle assistant town clerk.

This study found that literacy of any kind empowers one with analytical qualities, which in turn enable one to acquire the skills to manage human beings, most especially organising them to develop as Sheikh Rajab Kakooza puts it: 'kings College Buddo was constructed to train children of chiefs to become leaders.'

Leaders must be educated formally and informally if we are to keep the values of communities. Leaders are acting as role models by inculcating traditional customs and values among the people they lead. The demands on leadership role are more taxing because leaders of today deal with the literate, urbanised community, the illiterate and the rural community. A contemporary leader, therefore, acts as a link between the two different communities and in turn links both to government.

4.7   Marital status of leaders

Marriage is a complex affair with economic, social and religious aspects which often overlap so firmly that they cannot be separated from one another (Mbiti, J.S 1969:133). For African peoples, marriage is the focus of existence, for instance in African context in general and Uganda in particular, one cannot assume leadership position when he/she is not married as Mbiti Puts it:

> Marriage is a drama in which every one becomes an actor or actress and not a spectator. Therefore, it is a requirement and duty from the corporate society, and a rhythm of life in which every one must participate. Otherwise, he who does not participate in it is a curse to the community, he is a rebel and a law breaker, he is not only abnormal but 'under human'. Failure to get married under normal circumstances means that the person concerned has rejected society and society rejects him.

This is because Marriage is the centre where all members of a given community meet: the departed, the living and those yet to be born.

Gunsinze Robert (2006) asserts that:

> the family is the unit that produces and nurtures human life. For this reason people multiply and become many within the family. Basic responsibilities are properly fulfilled

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and maintained within family circles. This is because the family's contribution to the society is to ensure stability and enhance moral quality.

One scholar, Holmes F Arthur (1984:110) asserts that, relationship originates from with in the family. Spouses who are married become best friends and they enjoy the reciprocal benefits of good friendship (Ibid p.112). Therefore this means that, in the family there exists unselfish loving service.

Whereas there is no universally acceptable and applicable definition of a family, this study shows that there is a broad consensus on the role of the family institution in society as regards leadership. Bidandi Ssali puts it: 'My family background has had a great impact on my way of behaviour', and the functions it performs such as procreation, socialisation, providing food, shelter, clothing, sense of identity and a feeling of belonging, language for communicating with others, cultural heritage, economic support, rules for appropriate behaviour, survival skills, values and traditions, education, affection and emotional support for its members. The family still retains a central role of nurturing and upbringing, education, socialisation and care for the children. However all these values shape an individual into a responsible citizen and thus leadership development.

The family is the oldest institution on earth and it plays a vital role in human society. Throughout history, strong families help to make strong societies. The family is the best arrangement for bringing up children to be mature adults. A contemporary and religious leader, sheikh Rajab Kakooza observes that, the wife in a family/home is more than just submissive. She is a real helper, supportive of her husband in the decision he makes. She can help her husband to be a good leader in other ways. She expresses appreciation for his efforts in taking the lead instead of criticising him. Bishop Luzinda observes that a happy family is the beginning of safety and security. Children chatter excitedly as they tell their father and mother about what happens to them. This strengthens the values of love and communication when they grow mature. In a family a child knows that his/her parents will care for him/her when he/she gets sick. In a family, parents, foster open communication and character training as Ojiambo (1977:62) put it: One of the important things for children to learn are the behavioural characteristics displayed by every person in the society. Modesty and good behaviour is taught through constant advices. Plenty of emphasis is placed upon undue respect of elders. A parent has a duty to see that the child is educated in the way he/she likes. This role surpasses other people's role because of the parental

love and obligation. These parents encourage clear and open expression of thoughts and feelings in the family as a key to developing honest and trusting relationships. It provides a base for the care for its dependants (the aged, the sick, and the handicapped). This is very core for leadership as Rev. Michael a relationship counsellor at all saints' church asserts that, honesty is the key to sending the message home (Daily Monitor, 2005).

Parents foster individuality within a supportive family unit. These parents strive to accomplish this individuality and independence by each member having individual interests and building individual skills. The family institution maintains rituals, traditions and relationships.

The study findings indicate that, the feminine and masculine duties are imparted by mothers and fathers. Both parents keep a close watch over their children's growth and development. Their advice is quite wide in scope and covers various topics including customs, sex education and morality. If any of the parents fails to play his/her role then he/she accepts the blame for the child's failure. The development of a child depends upon the situational surroundings where the child is being brought up. Whether the family is polygamous, extended or monogamous; the child learns most of the early experiences from the members of the family. 70.4% of the leaders contacted assert to the belief that the child who has grown up in a large family is sociable and fits in the group easily. The one who comes from a home where there are very few people tends to be self centred and individualistic.

A tradition is any event with special meaning to the family. When a family has been disrupted, maintaining traditions becomes a stabilizing force, something that can be depended on. This study emphasises that the family teaches us an acceptable way to behave, and traditions of our society called socialisation, a responsible basis for having and rearing children. The family is praised for upholding morality, preventing crime, maintaining order and perpetuating civilization. As former Minister of local government Ssali observes: the family plays an important part in controlling sexual behaviour and to bring up children in a secure and loving home.

Ssekiboobo, a traditional leader observes that, Leadership can be cultivated and nurtured from a young age, and good leaders continue to learn and hone their skills while they are in office, Kayongo a community leader, gives an account of how the food is prepared and served in a home in a traditional way, People sit on mats in a circle while eating and the food is placed in the

middle where every one picks their share and eats with their hands. This does not only encourage unity and discipline among children, but the rules and regulations observed during the eating session inculcates responsiveness.

4.8   Socio-cultural Practices of the Leaders

Culture is critical for the establishment of social order and stability in society. AIDS is a complicated global problem. It is a global health crisis. From the foregoing definition, it is clear that culture influences attitudes and behaviour related to the HIV/AIDS epidemic. There is need for leadership training to avoid sexual recklessness. This is because Leaders are role models to those they are leading. Need to develop a culture of modesty is a cultural practice that should be enhanced by leaders, for example girls to avoid wearing dresses that expose parts of the body to minimize incidents of indecent or disgusting bodily exposure in public places. Indecent dressing is immoral dressing. Indecent dressing has been banned on some campuses in Uganda (Mbale University) and thus the study observed that; there is a growing worry about female students dressing in a sexy manner which exposes them to sexual harassment.

African minds are products of unique "cultural edifices" and "cultural streams" that arose from environmental conditioning and long-standing cultural traditions. Within the African cultural stream, are psychological and moral characteristics pertaining to African identity, personality and dignity. African communities are linked by shared values that are fundamental features of African identity and culture. These, for example, include hospitality, friendliness, the consensus and common framework seeking to enforce the principle of human-beingness, ubuntu. They have an emphasis on community rather than on the individual.

Social-culture practices of a leader play a vital role in determining the level of health of the individual, the family and the community. This is particularly relevant in the context of Africa in general and Uganda in particular, where the values of extended family and community significantly influence the behaviour of the individual. The behaviour of the individual in relation to family and community is one major cultural factor that has implications for sexual behaviour and HIV/AIDS prevention and control efforts. As the impact of HIV/AIDS in Uganda and Africa remains unabated, a culture-centered approach to prevention, care and support is increasingly recognised as a critical strategy.

Most political and religious leaders are men. Men in positions of power have many advantages, including increased access to sex. Leadership roles in social mobilization (UNFPA, 2000) note that:

> Men who are community and national leaders may be reluctant to promote policies that will enhance the status of women, because such policies appear to threaten the status of men. Yet men also benefit from equal status with women. Most men who treat women as equals find that their lives are more rewarding and less stressed: at a personal level, instead of a servant, they have a partner for a wife, and at community level they benefit from the insights and strengths that women bring. HIV/AIDS prevention depends on equal gender status, but equal gender status will result in much greater benefits.

Political leaders must have the courage to place the needs of their communities above their personal desires. Steps that political leaders can take include: Publicity campaigns discouraging sex between older men and young women; Support for explicit sex education, within a broader framework of life skills, within the national school curriculum; Support for policies and laws that enshrine gender equality;   Publicity campaigns encouraging condoms within all relationships; Widespread provision of voluntary counselling and testing facilities for HIV;

Political and religious leaders should also set a clear example in their personal lives, by having no extramarital relationships. Ideally, leaders should make a public statement to such an effect, although it is recognized that this is an extremely difficult and sensitive area.

It has been said that HIV/AIDS is intricately woven into the fabric of our society. Its spread is often fuelled by the way we live and relate to one another as individuals, as well as the way we relate within our families and in communities. It 'rides on the back' of our socio-cultural practices, relationships, values, beliefs, norms, and gender and power relations. It rests on misunderstandings and false beliefs about the epidemic. In order to enable sustainable social change, to reverse the spread of HIV and lessen its impact on individuals and communities – it is essential to address the epidemic's underlying causes. President Museveni of Uganda referred to the socio-cultural factors fuelling the epidemic as 'dry grass'. Just as dry grass burns widely and quickly when lit by even the smallest spark, so can certain socio-cultural factors predispose communities to the quick spread of the epidemic. There are also factors within our cultures that

mitigate the spread of HIV and reduce the suffering associated with it. President Museveni referred to this as 'green grass'. It is valuable to identify how socio-cultural beliefs and practices affect the way communities respond to the epidemic

4.9   Developmental Leadership Moral Orientation

The developmental moral orientation is essentially social and dynamic. It is identified with following conceptions:

a.   Rational moral autonomy, i.e., the morality of personal-social responsibility and involvement.

b.   Reasoned principles in the context of personal-social experience (social living) as the basis of moral standards.

c.   The inductive or developmental moral approach whose starting point are the human beings and their situations.

d.   The humanistic mode of social control associated with psychological discipline and legal-rational authority.

The developmental moral orientation is psychologically humanistic and sociologically change oriented. Thus, its mode of learning is process-centred and its mode of social control is democratic, favouring self discipline of the free, morally responsible individual.   In this connection, the aim of moral training and education is to help leaders in this case the educand to attain to the highest level of moral maturity of which he/she is capable, i.e., to fulfil his moral potentialities.

In other words, the goal of moral training is not to condition the leaders in terms of a set pattern of beliefs but to foster his/her personal moral growth so that he/she may attain leadership equipped to play a responsible part in a perpetually changing, challenging, inter-communicating and pluralistic society.

As to the criteria of conduct, what makes conduct right or wrong, in particular, there follow logically certain practical principles for moral living from a variety of conceptions of the highest

good (Summum bonum) according to different philosophical orientations, the major of which merit mention at this point;-

1. Acts are right because God commands them, i.e., morally consists, essentially, in obedience to God; hence the virtuous attitude of questioning loyalty to a Higher (Divine) will.

2. Acts are right because conscience commands them, i.e., inner prompting and admonition, inner urges and inhibitions checking and re-directing an individual's primary impulses towards the better kinds of conduct.

3. Acts are right because approved by community, i.e., to be moral is to be true to the code of the group to which one belongs.

4. Acts are right because they conduce to the maximum satisfaction of desire (a synthesis of felt and potential desires, and unrealised needs), i.e., each person's desires and needs in a society should be regarded as equally deserving, whereby the social ideal should be the maximum of co-attainable satisfaction for every one.

5. Acts are right because they conduce to the greatest attainable happiness for all concerned, i.e., being moral consists in securing the greatest possible human happiness for oneself and for every one around one.

6. Acts are right because they conduce to self-realisation, i.e. , each individual has his/her life to mould, his/her own happiness to secure to develop or realise his/her (latent) potentialities, to make the most of himself /herself, at most, in (social living) interaction with others.

According to the adherents of the traditional religious moral orientation, the precepts which they find themselves approving are justified in the light of the first principle mentioned above, that acts are right because of the divine status of their underlying authority. They also tend to entertain the second principle in their belief of an innate voice of conscience, the tradition allied with rigid dogma of original sin, which is at variance with the conception of conscience as a product of one's particular environment and leadership, as superimposed upon one's own particular blend of hereditary tendencies. They even somehow find the third principle, law deriving from society (socionomy), relevant given their proneness to conformity.

In contrast, the   exponents of the developmental moral orientation, unlike the religious moralists inclined towards heteronomy (law imposed by others), embrace the last, sixth, principle which accentuates autonomy (law deriving from the self), whereby moral conduct is considered desirable in so far as it harmonises with the ideal of growth and social-welfare – development of each of the community's specific personalities, the generation of a great many fine types of men and women. That is, whatever acts expand individuals' horizons, enrich their experience, bring out what is in them for the realisation of their highest potentialities, are morally good. It may be as well to note that the developmentalists, given their subtle accommodation of individualism and altruism, tend in some degree to range with the fourth and fifth principles mentioned above.

4.10   Knowledge about HIV/AIDS Prevention Management

Acquired Immune Deficiency Syndrome (AIDS) is caused by a Human Immunodeficiency Virus (HIV), which weakens the immune system. This makes the body susceptible to opportunistic diseases that often lead to death. The predominant mode of HIV transmission is through heterosexual and homosexual contact, followed in magnitude by prenatal transmission, in which the mother passes the virus to the child during pregnancy, delivery or breastfeeding. Other modes of transmission are through infected blood and unsafe injections.

4.10.1   Awareness of AIDS

The study investigated the level of knowledge regarding transmission of the AIDS virus among the leaders in Kampala Central Division. The respondents were asked if they had ever heard of AIDS, about their main source of information, about specific means of transmission of the virus, and if they were aware of mother-to-child transmission. Respondents were also asked about HIV discordance within couples, antiretroviral therapy, and stages of mother-to-child HIV transmission. The 1995 and 2000-2001 Uganda DHS surveys as well as the 2004-2005 Uganda HIV/AIDS Sero-Behavioural Survey have shown that general awareness of HIV/AIDS among men and women is almost universal. It is not surprising; therefore, that Table(2) below shows that in Uganda today, knowledge of HIV/AIDS is very high among all sub-groups of men and women by various background characteristics.

Table 2

Awareness of AIDS and main source of information in Kampala Central Division

Awareness/Source	Women	Men	Both gender
	18-55	18-55	
Main source of information (% distribution)	Percentage of who have heard of Aids		
Radio	52.6	59.4	55.7
Television	0.6	0.9	0.7
Drama/Film	0.6	1.4	0.9
News Paper/Magazines	1	3.3	2
Community Notices	1	0.7	0.8
Family	7	1.5	4.5
Friends and peers	13	8.9	11.1
Health workers	13.3	11.3	12.4
Teachers	4.6	5.9	5.2
Political/Traditional leaders	0.4	0.4	0.4
Religious leaders	1.5	0.8	1.2
Meetings/Seminars/Workshops	0.5	0.9	0.7
Experience with Aids Patient	1.2	2.4	1.7
Never heard of Aids	2.7	2.4	2.6
Total	**100**	**100**	**100**
Number of respondents	**60**	**90**	**150**

The study results indicate that 99 percent of the female and male aged 15-55 years have heard of AIDS. By far the most important source of information about AIDS is the radio, cited by 56 percent of respondents. Health workers, friends, teachers, and family are the only other main

sources of information. The only major gender difference is that women are more likely than men to cite family as the main source of information about AIDS.

Table 3 Most important HIV/AIDS message learned from main source

Message	Female 18-55	Male 15-55	Both gender
Abstain from sex	21.6	20.3	20.8
Use of condoms	20.7	36.6	28.7
Limit sex to one partner	28.2	21	25
Limit number of partners	3	3.1	3.5
Follow ABC	1.4	1.2	1.3
Avoid sex with many partners/prostitutes	0.9	0.7	0.8
Avoid blood transfusion/injections	0.4	0.3	0.4
Antiretroviral drugs available	0.3	0.1	0.2
Prevent Mother-to-child transmission	0.5	0.1	0.3
Avoid discrimination against those with HIV	0.7	0.2	0.5
Any one can get AIDS	1	0.5	0.8
Get tested for AIDS	10.3	9.6	10
Aids is a killer	5.5	3.2	4.4
Don't take chances	1.2	9.8	5.5
Other	4.3	0.6	2.5
Total	**100**	**100**	**100**
Number of Respondents	**60**	**90**	**150**

The most important messages obtained from the sources cited were related to the ABC strategy, namely, abstinence, being faithful to one partner, and using condoms, with condom use being slightly more commonly mentioned than the other two messages, especially among men (Table 3). The message that AIDS is fatal was also commonly mentioned, by one in twenty respondents. Although other messages may also have been widely received, the question asked about the most important message only, so the other messages were not so commonly cited. There are only minor differences in the types of messages mentioned by women and men

4.10.2 Knowledge of Means of Avoiding HIV/AIDS

Abstaining from sex, being faithful to one uninfected partner, and using condoms are important ways to avoid the spread of HIV/AIDS. To ascertain the depth of knowledge about modes of HIV/AIDS transmission, respondents were asked specific questions about whether it is possible for people to reduce their chances of getting AIDS by having just one sexual partner who is not infected and has no other partners, by using a condom at every sexual encounter, and by not having sex at all.

Table 4 Knowledge of ways to reduce the chances of getting HIV/AIDS

Background characteristics (Age)	Using condoms	Limiting sex to one uninfected faithful partner	Abstaining from sex
18-25	70.9	86.8	86.2
26-35	71.4	90.6	87
36-45	69.6	88.6	85.8
46-55	66.7	87.9	86.8
56-Above	60.3	88.4	87.1
Marital status			
Never married	70.4	88.2	87.1
Ever had sex	83.3	92	91.6
Never had sex	62.1	85.6	84.2
Currently married	66.6	88.5	86.1
Formerly married	71.3	88.1	87.8

The study revealed that a big percentage who in response to the prompted question, say that people can reduce the risk of getting the Aids virus by using a condom every time they have sex with just one partner who has no other partners.

The results show that knowledge of HIV prevention methods is widespread. More than 4 in 5 respondents (88 percent of women and 90 percent of men) indicate that the chances of getting the AIDS virus can be reduced by limiting sex to one partner who is not infected and who has no other partners. Sixty-eight percent of women and 77 percent of men said that people could reduce their chances of getting the AIDS virus by using condoms every time they have sex. Knowledge of both these means of avoiding HIV transmission is also high, with 63 percent of

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women and 72 percent of men citing both as ways of reducing the risk of getting the AIDS virus. As expected, the proportion of both women and men who know that abstaining from sex reduces the chances of getting the AIDS virus is high—87 percent among women and 85 percent of men. For each of these knowledge indicators, men are slightly more informed than women, especially about condom use.

Respondents in their early 20s are most likely to know the major ways to avoid getting HIV/AIDS, while those in their 40s are the least likely. Similarly, women and men who have never married, but who have been sexually active, are the most likely to know about the major means of avoiding HIV.

4.10.3   Knowledge of Mother-to-Child Transmission

Current strategies in Uganda call for reducing the mother-to-child transmission of HIV. Increasing the level of general knowledge of transmission of the virus from mother to child and of knowledge about the use of antiretroviral drugs is critical to achieving this goal. All Local chair persons, councillors, community leaders and youth representatives interviewed in the study were asked if the virus that causes AIDS can be transmitted from a mother to a child. If the answer was in the affirmative, they were further asked whether the virus could be transmitted during pregnancy, during delivery, and/or during breastfeeding. They were also asked if there are any special drugs that a doctor or nurse can give to a pregnant woman who is infected with the AIDS virus to reduce the risk of transmission to the baby.

Chart 2: Showing How infected Mothers can avoid transmission of HIV to the baby
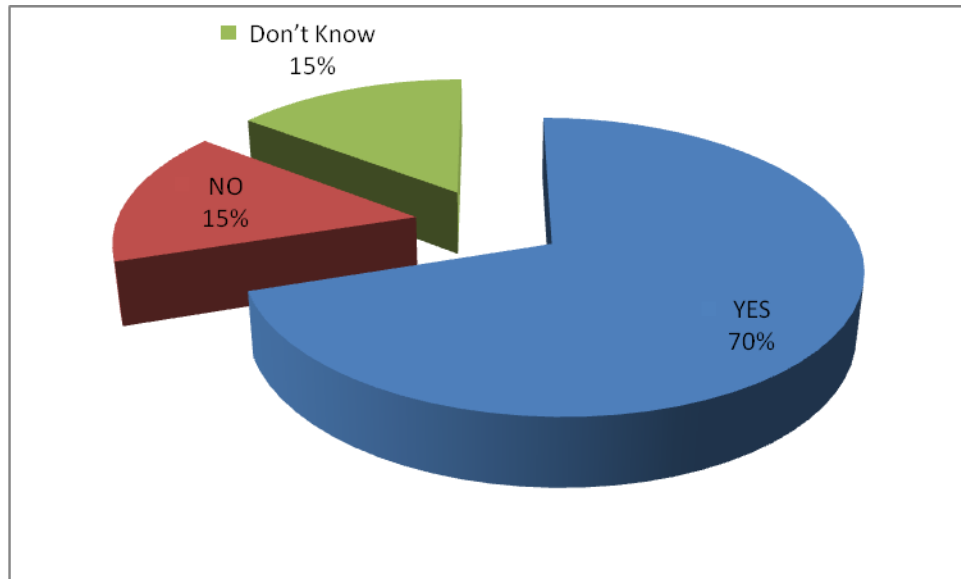
The chart indicates that over 70% are aware that there are possible ways of preventing mother to child transmission. They know at least there are special drugs that can be used to treat the pregnant mothers to safeguard their unborn babies.

Chart 3: Showing methods used to reduce mother to child HIV transmission
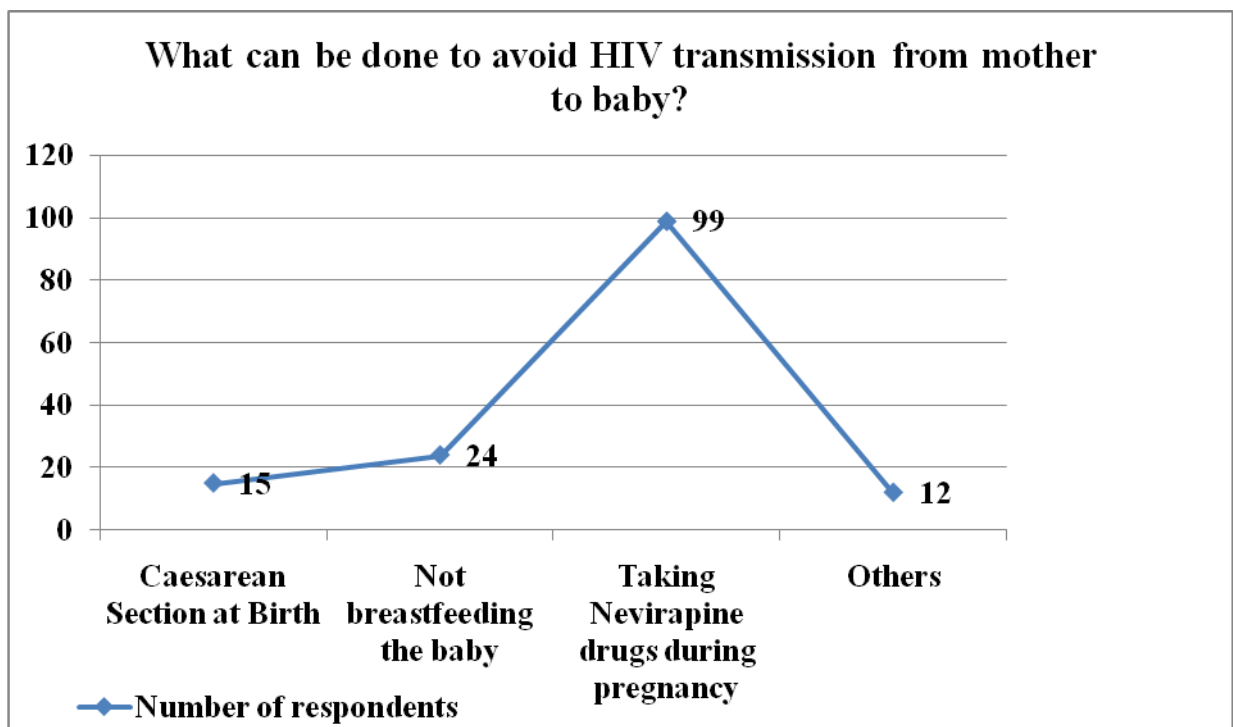
From the chart (3) above over 15 respondents knew that the use of caesarean section at birth was a possible solution to prevent mother to baby transmission, while 24 respondents males and females inclusive thought by not breast feeding the babies, they would be safe from the HIV infection. A very big proportion of over 99 respondents knew about the Nevirapine drugs. They knew that if a pregnant woman takes Nevirapine during pregnancy it would prevent the spread of HIV to her baby.

More than half of them know that HIV can be transmitted from a mother to her child by breastfeeding. Knowledge about antiretroviral drugs is only slightly less widespread, 47% acknowledged that there are special drugs that a doctor or nurse can give to a pregnant woman infected with the AIDS virus to reduce the risk of transmitting the virus to the baby.

In the line with the above the respondents acknowledged that HIV can be transmitted by breastfeeding and there are special drugs that a doctor or nurse can give to a pregnant woman infected with the AIDS virus to reduce the risk of transmission to the baby.

Table 5: Knowledge of ways of preventing HIV from mother to Child

Background characteristics (Age)	Caesarean Section at Birth (%)	Not breastfeeding the baby (%)	Taking Nevirapine drugs during pregnancy (%)	Others (%)
18-25	10.2	22.0	15.5	10.3
26-35	20.3	22.5	20.1	25.0
36-45	32.0	25.2	32.0	32.5
46-55	20.3	19.5	33.3	14.8
56-Above	15.2	11.1	10.5	12.5

The study revealed that a big percentage who in response to the prompted question, say that people can reduce the risk of spreading the HIV to the newly born babies. There are a number of preventive measures suggested.

Knowledge of mother-to-child transmission/prevention and of antiretroviral drugs varies little by age, except that those who are 26 and above – presumably the married ones tend to have more knowledge than those who below 26 years of age about prevention of HIV.

4.10.4   Perceptions about Discordance

Discordance is a situation in which one member of the couple is HIV positive and the other HIV negative. Ignorance about what common discordance is leads couples to neglect taking precaution even in cases in which they know or suspect that one of them is infected, because they feel the situation is hopeless.

Table 6: Perception about Discordance of HIV infection in couples

Belief	Female	Male
Believes if a man has the virus, his sexual partner has virus:		
Always	75.8	73.3
Almost always	8.5	9
Some times	7.4	12.8
Don't know	8.3	4.9
Total	100	100
Believes if a woman has the virus, her sexual partner has the virus:		
Always	76.4	74.2
Almost always	8.3	8.8
Some times	7.5	12.4
Don't know	7.8	4.5
Total	100	100

In the study, respondents were asked two questions: "If a man has the virus that causes AIDS, does his sexual partner always have the AIDS virus, almost always, or only sometimes?" and "If a woman has the virus that causes AIDS, does her sexual partner always have the AIDS virus, almost always, or only sometimes?" Results are shown in Table 6.

The data show that three-quarters of both female and male believe that co-infection is inevitable—if one partner is infected, the other always is too. Eight to 9 percent believe that the partner is almost always infected. Only 7-8 percent of female and 12- 13 percent of male know that if a person is HIV positive, his or her partner is only sometimes infected. Interestingly, there are very few differences in the responses of female and male respondents. Moreover, respondents do not see any difference in the likelihood of HIV transmission from men to women and from women to men.

Knowledge of AIDS is very high and widespread in Uganda. In terms of HIV prevention strategies, women and men are most aware that the chances of getting the AIDS virus can be reduced by limiting sex to one uninfected partner who has no other partners or by abstaining from sexual intercourse. Knowledge of condoms and the role they can play in preventing transmission of the AIDS virus is not as high. Larger proportions of respondents are also aware that the AIDS virus cannot be transmitted by supernatural means or by sharing food. However, many women and men erroneously believe that AIDS can be transmitted by mosquito bites.

> "The evidence, therefore, points to the existence of a range of complementary messages and services delivered by the government and a wide diversity of non-governmental organizations. To be sure, those messages included the importance of both young people delaying sexual initiation and "zero grazing" (monogamy). But contrary to the assertions of social conservatives that the case of Uganda proves that an undiluted "abstinence-only" message is what makes the difference, there is no evidence that abstinence-only educational programs were even a significant factor in Uganda between 1988 and 1995."(SA Cohen,2003)

HIV among adults is mainly transmitted through heterosexual contacts between an infected partner and a non-infected partner. Consequently, the HIV prevention programme has mainly sought to reduce further sexual transmission through three programmatically important ways, namely promotion of sexual abstinence, mutually faithful monogamy among uninfected couples, and condom use by those that cannot abstain. As the landscape of the HIV epidemic changes with time, it is necessary for people to have more comprehensive knowledge of HIV/AIDS. HIV/AIDS combines several individual indicators, for example the researcher observed that it is the matter of respondent's age 25-40 who say that: i) people can reduce the chances of getting the AIDS virus by using a condom every time they have sex, ii) people can reduce the chances of getting the AIDS virus by having sex with just one partner who is not infected and who has no other partners, iii) people cannot get the AIDS virus from mosquito bites, iv) people cannot get the AIDS virus from sharing food with a person who has AIDS, and v) that a healthy-looking person can have the AIDS virus. The proportion of respondents with comprehensive knowledge is highest in Kamwokya I, Kamwokya II and Mengo. Kisenyi I, Kisenyi II and Kagugube parishes, the proportion with comprehensive knowledge is below the national average. Basing on the above, the following key findings were noted as regards knowledge about HIV/AIDS prevention management, Ninety-nine percent of the subjects studied have heard of

AIDS, the radio is by far the most important source of information about HIV/AIDS, awareness of the modes of HIV transmission is high, with almost 90 percent of the respondents knowing that having only one uninfected, faithful partner can reduce the chances of getting AIDS, they acknowledged that a healthy-looking person may be HIV positive and know that HIV cannot be transmitted by sharing food with someone who has AIDS.

CHAPTER FIVE: PRACTICES FOR HIV/AIDS PREVENTION MANAGEMENT

5.1   Introduction

HIV continues to spread. Social-economic, cultural structures and networks influence behaviour that breeds multiple sexual partnerships, commercial sex, improper and or use of epidemic continues to ravage the developing world, it becomes increasingly evident that diverse strategies to confront the wide range and complex social, cultural, environmental and economic context condoms that drive the HIV epidemic. Therefore the main concern of this chapter is to bring up to date practices for HIV/AIDS practices and preventive management.

5.2   National Policy on HIV/AIDS

From the outset of the epidemic, the Uganda Government recognised the gravity of the problem it posed and initiated public health strategies for containment. Recognising that the majority of new infections were transmitted through heterosexual contact, the strategy to contain the spread of the epidemic sought to address sexual behaviour risk factors to avert further HIV transmission by promoting primary and secondary sexual abstinence, mutual faithfulness among married or cohabiting partners, and condom use, especially in higher-risk sexual encounters. This approach to prevention, colloquially known as the 'ABC' (abstinence, being faithful, and condom use) approach has continued to form the backbone of HIV prevention strategy in the country to this day. The ABC strategy has since been expanded to the ABC Plus, to include voluntary counselling and testing (VCT), prevention of mother-to-child transmission of the virus (PMTCT), antiretroviral treatment (ART), and HIV/AIDS care and support services.

In addition to recognising the public health consequences of the problem, the government recognised that its impact transcended the sphere of public health, requiring the involvement of all spheres of public life in the country comprising public, civil society, communities, and individuals. Consequently, the multisectoral approach to HIV prevention and control including care and support services was adopted as early as 1990 and currently forms one of the pillars of the national response. This policy underscores the concerted involvement of all individuals, communities, public and private sectors, including civil society and community-based organisations, in the effort to contain the epidemic. It calls for concerted efforts by all

stakeholders according to their mandates and areas of comparative advantage and capacities. In line with this, a multisectoral coordinating body, the Uganda AIDS Commission, was created by statute of Parliament in 1992 and placed under the office of the President to coordinate the harmonised implementation of the multisectoral approach. Furthermore, the Government recognised the importance of political leadership and commitment at all levels of governance in all efforts to prevent the epidemic and mitigate its impact. Involvement of political leadership is the second pillar in the national response. The government also adopted a policy of openness about the epidemic as one of the pillars of the national response, which is vital to fighting stigma and discrimination. Finally, the Ugandan response received unprecedented support and involvement of development partners at all levels of governance and civil society.

The Uganda government recognises the developmental challenges of the epidemic and has taken concrete steps to address it. HIV control is one of the developmental priorities addressed in the country's Poverty Eradication Action Plan (PEAP) and the National Vision for 2025. The National AIDS Policy, which is currently in draft form, provides for a framework for addressing the multidimensional challenges of the epidemic by a variety of stakeholders in a coordinated way. The policy emphasises the main HIV/AIDS concerns in the development agenda in the country by all sectors and sections of society. It also provides for protection of the rights of vulnerable individuals and populations, and mitigation of the impact of the epidemic at the individual and community levels and also on micro- and macro-economic development. It also provides a framework for strengthening the capacity of institutions and communities to overcome the social and economic challenges of the epidemic. The policy also provides a framework for strengthened monitoring and evaluation of HIV/AIDS programmes, conducting research, and for resource mobilisation. Indeed, this study is an invaluable source of information for the monitoring and evaluation of HIV/AIDS programmes in Uganda upon which leaders should incline to encourage the prevention of the scourge, as the saying goes "prevention is better than cure".

According to the National Policy on HIV, the study observed that, various groups have different roles to play in the implementation of the National policy on HIV/AIDS. These groups have been

categorised as: Heads of Institutions, teachers and educators, community leaders, students and learners**.**

As regards, Heads of Education Institutions, the following are core: University vice chancellors, Head teachers and principals. These are responsible for day-to-day implementation of the policy in Universities, schools, Institutes and colleges. All heads of primary and post-primary and Education Institutions shall ensure that the WHOLE SCHOOL APPROACH MODEL is implemented.

5.2.1 Teachers and Educators at all levels

Teachers and Educators at all levels have the highest interaction with learners and therefore have the greatest opportunity and responsibility to equip learners with age appropriate HIV/AIDS knowledge and skills for preventing HIV infection and mitigating its impact. The policy further suggests that, teachers have the responsibility of enhancing their skills and competencies in HIV/AIDS prevention and mitigation. This is in line with Uganda AIDS Commission (2008) which says:

> All teachers and educators shall respect the rights and uphold the dignity of fellow teachers, learners and other members of the school community living with or affected by HIV/AIDS

The Community leaders have a responsibility to ensure a conducive environment in the communities for preventing HIV/AIDS, ensure that child labour is prohibited and all school age going children including OVCs enrol and stay in school and support school based HIV/AIDS activities including community outreach programs.

5.2.2 Students and Learners

The study observed that, the policy further advocates the following issues, for instance, all students and learners have the responsibility to ensure that they protect themselves and others from HIV infection

- All students and learners living with HIV are expected to live positively, seek and adhere to treatment and care
- All students and learners shall respect the rights and uphold the dignity of teachers and other members of the school community living with or affected by HIV/AIDS

- All students and learners shall actively participate in school/institution based anti AIDS activities that focus on prevention, mitigation and capacity building
- All students leaders shall have the responsibility of HIV/AIDS prevention education and mitigation including fighting stigma and discrimination in their work within learning institutions
- All older students and learners shall be expected to act as positive behavior role models for younger students and learners

Students and learners shall acquire knowledge and skills on HIV/AIDS

Chart 4: Strategies in place to prevent HIV/AIDS Transmission
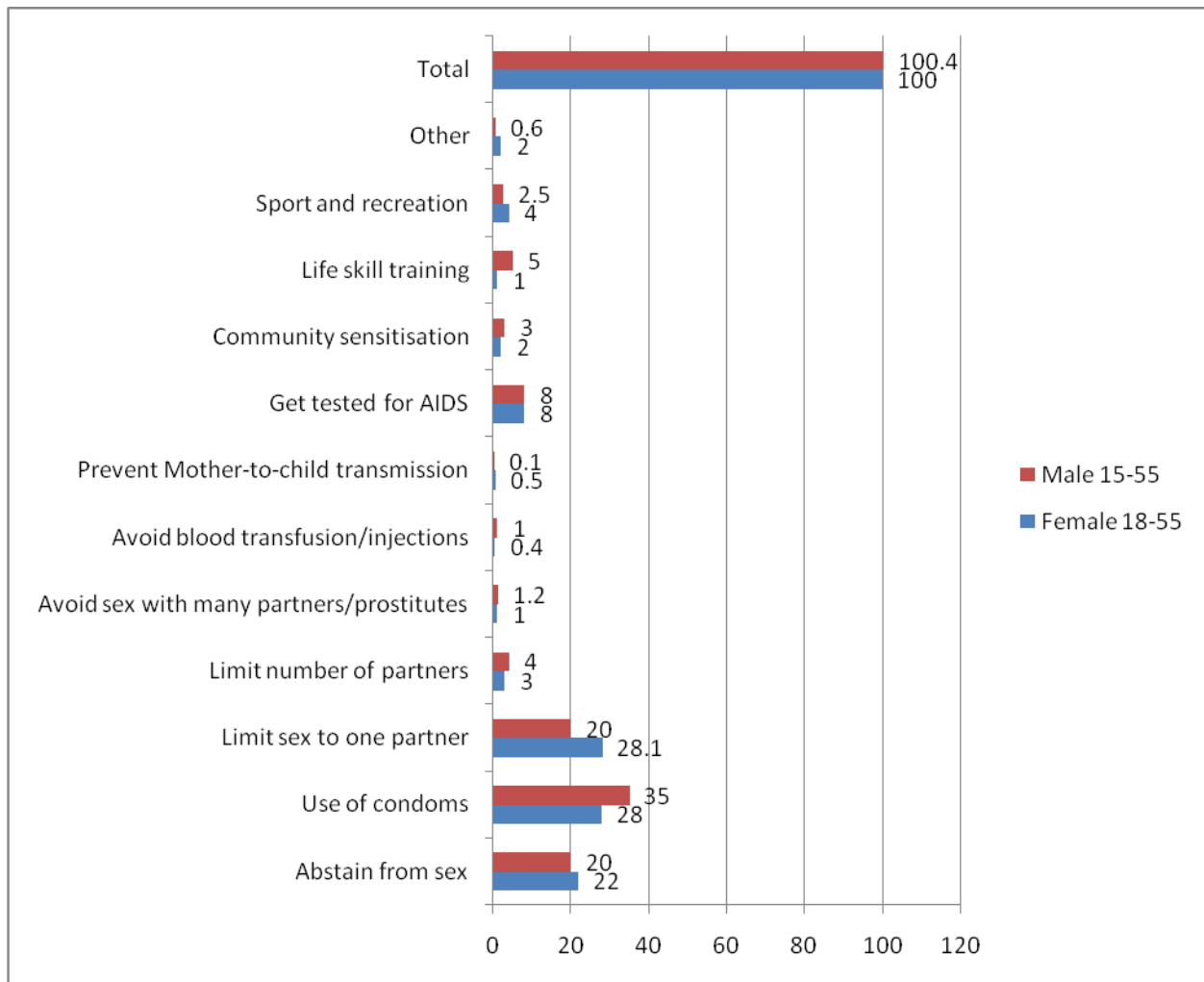
From the chart above we realise that the majority of the respondents are aware of the various ways of preventing HIV, the methods/ ways emphasised range from; abstaining from sex, using condoms, being faithful to one partner, protected blood transfusion, prevention of mother to child transmission, training the society life skills and community sensitisation, engaging in sports and recreation. The blue bars represent the female respondents while the red bars represent the male respondents. The graph clearly shows some variability between the male and female respondents. Most importantly, are the responses on the use of condoms, abstaining from sex and limiting sex to one partner which are far more than the rest of the responses for the other options. This is so due to reputation of the abstinence, Be faithful and Condom use approach discussed in the next section.

5.3　Abstinence, Be faithful and Condom use Approach

The ABC approach to preventing sexual transmission of HIV has been defined and adopted by a variety of organisations, governments and non-governmental organisations ever since the term was first used in 1992. Although it is often associated with Uganda, and is credited with drastically reducing HIV infection in the country in the 1990s, the ABC approach incorporates messages which were used before Uganda's HIV prevention campaigns. Abstinence, a delay of sexual debut, fidelity and a reduction of sexual partners as well as condom use are *behaviours* that play a key role in fighting the HIV/AIDS pandemic. However, there are different strategies aiming to promote healthy behaviour and these different strategies greatly differ in their effectiveness as research shows.

The Uganda HIV prevention programme evolved along the interventions of promoting abstinence, being faithful, and condom use (the "ABC" approach). The ABC approach is particularly pertinent for young adults. Condom use among young adults plays an important role in the prevention of transmission of HIV and other sexually transmitted infections, as well as unwanted pregnancies. Knowledge of a source of condoms helps young adults to obtain and use condoms.

Since the beginning of the response to HIV prevention, it has been known that HIV can be transmitted sexually. Even before the term 'ABC' was conceived, materials provided by WHO, the Global Program on AIDS (later succeeded by UNAIDS) and governments and organisations around the world, contained information on how abstinence, fidelity and condom use could prevent the sexual transmission of HIV. This is in agreement with President Museveni's understanding of ABC as far back in 2002: a 'social weapon' against HIV and AIDS (Uganda Aids Commission, 2008)

Since the late 1980s in Uganda, the government had begun educating the public about sexual transmission but focused on abstinence for youth and 'zero grazing', or partner fidelity. The term 'zero-grazing' comes from the agricultural practice of tying livestock to a post, restricting them to a zero-shaped section of grass. Then in the early 1990s condom promotion in Uganda became more accepted by the government and condom use increased.

Abstinence, a delay of sexual debut, fidelity and a reduction of sexual partners as well as condom use are behaviours that play a key role in fighting the HIV/AIDS pandemic. However, there are different strategies aiming to promote healthy behaviour and these different strategies greatly differ in their effectiveness as research shows.

Over the past years, abstinence-only education programs are increasing in numbers all over the world, driven by enormous US financial support. The 'evidence' that supports the effectiveness of these programs is also increasing usually based on common sense knowledge that abstinence is 100% safe or distorted evidence(SA Cohen, 2003).

Abstinence is 100% effective, if used with perfect consistency (that is 100% of the time). Unfortunately, in the real world, abstinence has a high failure rate: for example, a study presented at the 2003 annual meeting of the American Psychological Society found that over 60% of college students who pledged virginity had broken their vow to remain abstinent until marriage. Another factor contributing to the failure rate is that it is often unclear what 'abstinence' means exactly. For instance: many young people believe they abstain if they refrain from having sexual intercourse, but oral (or even anal) sex is ok, even though these behaviours still put them at risk for contracting HIV.

From the Focus Group Discussion held with youth representative at Kamwokya Christian Caring Community Clinic, it was found that, for a lot of girls and women abstinence is a far away dream: they are forced to have sex as a result of gender inequality, violence or, because of economic hardship, have sex for money. Therefore to decrease their risk of contracting HIV, broad, inclusive, rights-based, non-judgmental outreach using different approaches and methods, including engaging boys and men, is necessary.

In addition, the researcher observed during an interview with Director General for Uganda Aids Commission that:

> Abstinence-only programs often do not give sufficient information about safe sex, condoms or contraceptive use. The evidence whether these programs delay the onset of sexual activity effectively is mixed. However, there is evidence that shows that when young people do have sex, they are less likely to take preventive measures against STIs, HIV or unplanned pregnancies, thereby not providing a solution for these problems but at best postponing them a little.

Even though fidelity during marriage is a behaviour playing a role in preventing HIV, marriage and women's own fidelity are not enough to protect them against HIV infection(SA Cohen, 2003). Men have often contracted the disease during earlier unsafe sexual encounters or have sex with others while being in a stable relationship. Within marriage, woman are not in a position to negotiate condom use or say no to sex and the simple message of 'fidelity' does not offer them any protection. Educating people about condoms and risky sexual behaviour, without judgement of sexual relationships outside marriage, is therefore indispensable in fighting the pandemic.

In ABC strategies, Abstinence and Being faithful are the preferred options. Condom use is promoted for special groups only, such as truck drivers and sex workers. This strategy discourages people to use condoms as they don't want to be seen as such a specific group. As Abstinence-only and AB programmes don't provide a solution for unwanted pregnancies, STIs, and HIV, discouraging condom use is particularly harmful.

'Uganda' is often used as a success-story for abstinence-only education. Uganda's HIV prevalence steadily increased until about 1991, when it peaked at 15%. It then turned sharply downwards through the mid 1990s and reached 5% by 2001(Uganda Aids Commission, 2008). This is supported by a study done by The Alan Guttmacher Institute which shows that during the time period when the HIV prevalence was declining, three key changes in behaviour occurred: fewer Ugandans were having sex at young ages, levels of monogamy increased and condom use rose steeply among unmarried sexually active men and women(The Guttmacher Report, 2003). These behavioural changes were the result of a range of complementary messages and services delivered by the government and a wide diversity of NGOs. Contrary to the assertions of social conservatives that the case of Uganda proves that an undiluted 'abstinence-only' message is what makes the difference, there is no evidence that abstinence-only educational programs were even a significant factor in Uganda between 1988 and 1995.

Condom use has also its challenges as in the interviews it was found out that not all the time the targeted group use them.

Chart 5: condom use
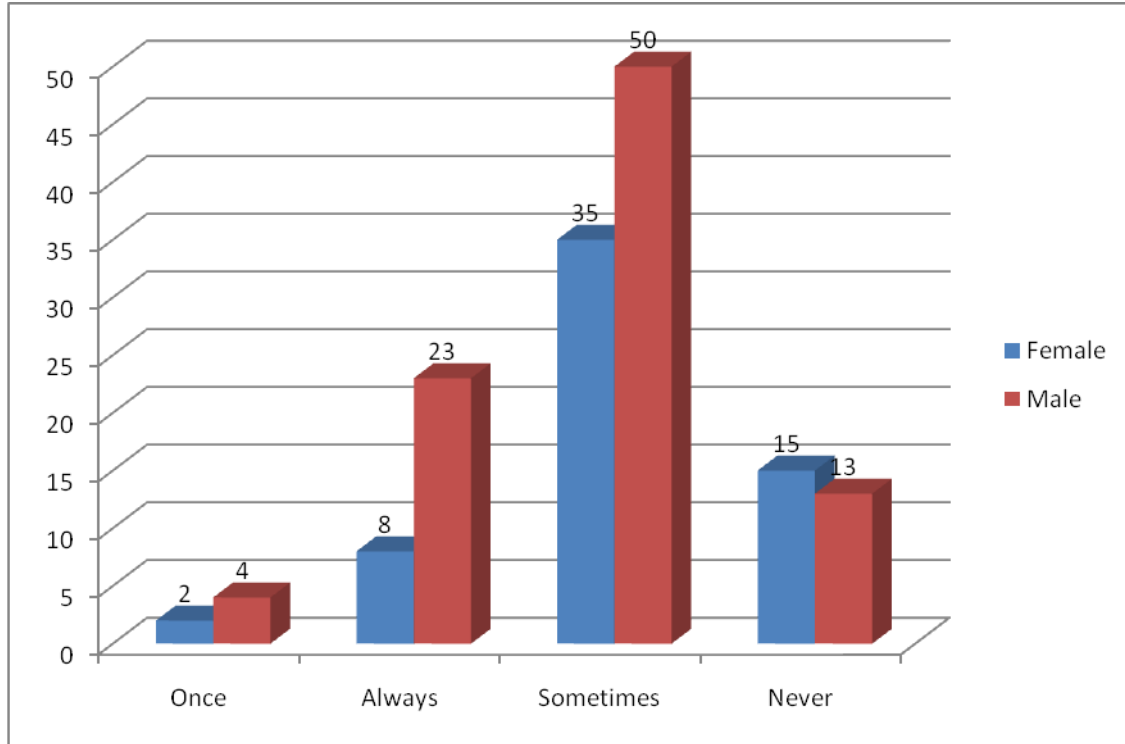
The graph above clearly indicates that in the responses to condom use in the area the majority of the males were using condoms though over 50 out of 90 use condoms sometime implying that at times they have unprotected sex, this is not any better when it comes to the females leaders whom only 35 out of 60 use condoms some times. Although only two female responses and four male leaders confessed to have used a condom once, this is scary since these are leaders who represent a big portion of the informed society. It is also daunting to see that over 28 out of 150 had never used a condom during sex, and of which thirteen were males while over fifteen were female respondents.

5.4 HIV Counselling and Testing

HIV Counselling and Testing (HCT) is the most important service in HIV/AIDS prevention and care strategies. Persons, their spouses and sexual partners are better equipped to make appropriate HIV prevention decisions if they know their HIV status(Uganda Ministry of Health, 2003). Couples about to be married can use HCT to know their HIV status before deciding on marriage. HCT can enable pregnant women to learn their HIV status and seek services to help prevent mother-to-child transmission of HIV. Women of reproductive age who go for counselling before pregnancy are helped make informed decisions about becoming pregnant, based on knowing their HIV status. HCT lets people who are infected learn their HIV status early enough to receive adequate care and support. Early care and psychosocial support may enable them to live a longer and better quality of life with HIV.

Chart 6: Showing what can be done to people with HIV/AIDS to enable them live longer
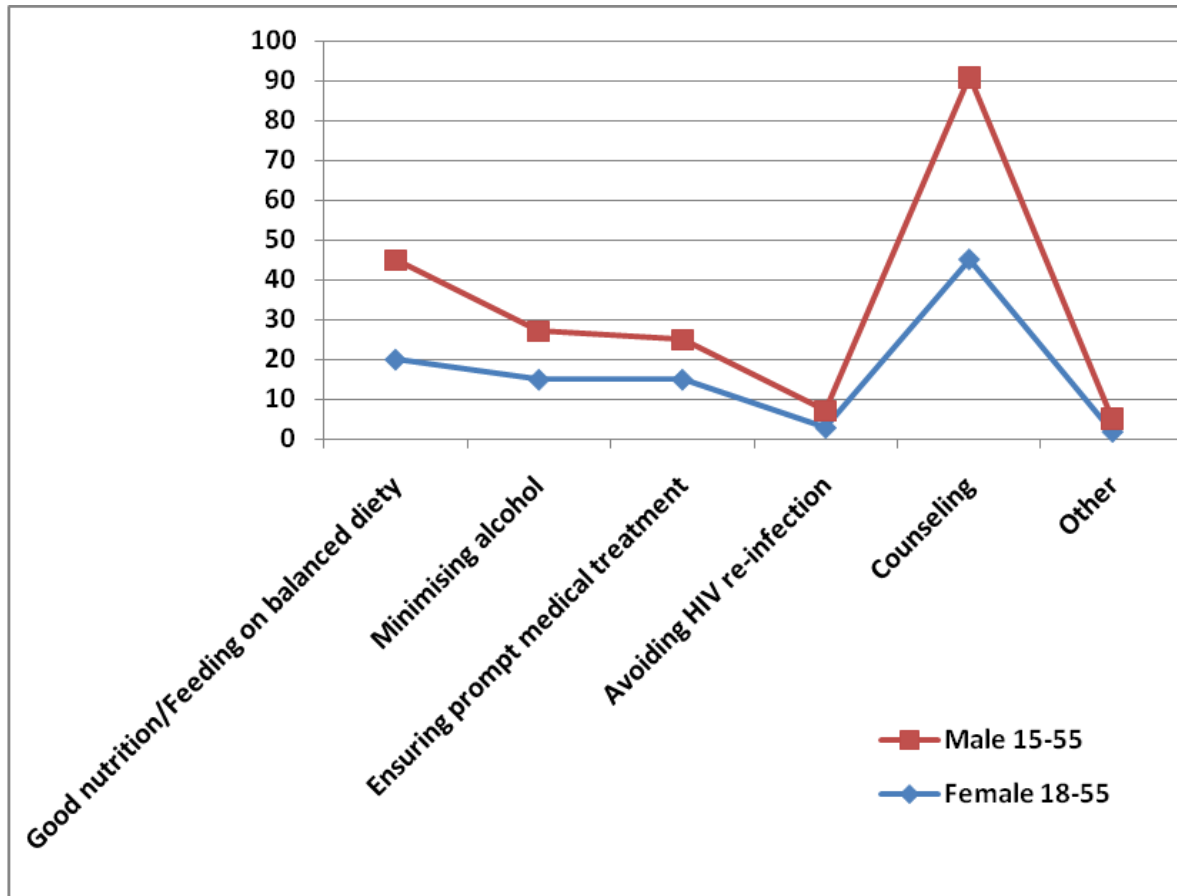
The red lines indicate the trend of male responses while the blue lines show the trend of female responses. Both responses are relatively below 50% on the first four alternatives until the fifth alternative of counselling where both rise such that the blue line approaches the 50% response mark while the red line hits the 90% response mark. The chart above gives a special analysis on the importance of the various way of supporting HIV/AIDS patients. The methods range from providing them with good food, reducing on taking alcohol, getting immediate medical care, avoiding HIV re-infection counselling and others. The most prominent of these is the idea of counselling which has generally many responses from both male and females.

Chart 7: Showing the number of respondents aware of their HIV status
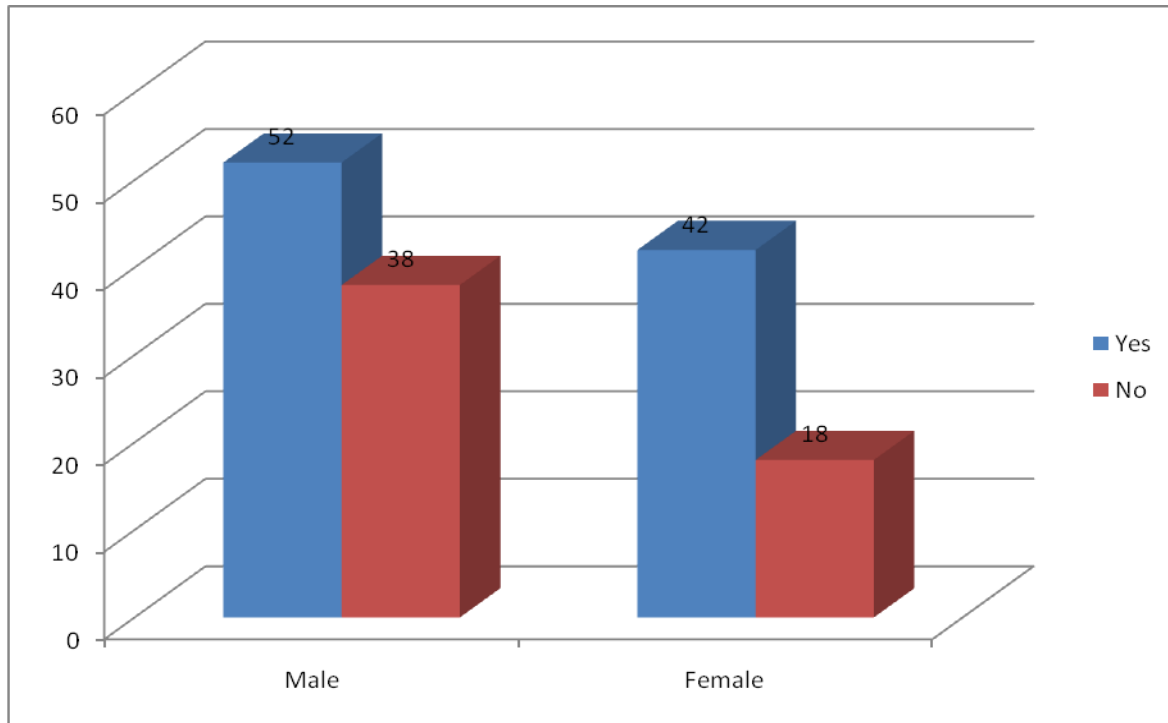
The figure indicates that 94 respondents have tested before and 56 have not tested before. Out of 90 male respondents 52 had tested before while 38 had not and over 42 female respondents had tested compared to the 18 female who had not tested before. However, insight analysis shows that a bigger percentage of females had tested compared to the males which shows that generally females are more vigilant about knowing their HIV status.

Knowledge of an individual's own HIV sero-status can motivate him or her to practice safer sexual behaviour thereafter to avoid transmitting the virus to others. Awareness of HIV status can motivate individuals to further protect themselves against infection or to protect their partners from acquiring the disease. However, the study findings indicate that the vast majority of people from the six parishes which form Kampala Central Division(Uganda Demographic and Health Survey, 2006). Men and women aged 25-29 are in the age group most likely to have been tested for HIV. HIV testing is most common among respondents in urban areas and those in Kampala and Central regions. Higher education level and wealth are associated with a higher likelihood of having received an HIV test. From the interview held with LC III Chairperson, he

asserted that quite a number of people in Kampala Central Division have not tested and therefore do not know their HIV status. To increase the proportion of people who know their HIV status, it is important to know why people do not go for voluntary counselling and testing (VCT). Therefore, the Chair person as a political leader, he was asked why people do not test for HIV. He established a number of reasons why the people he is leading are not seeking voluntary counselling and testing. They include the following: The major reason given is that they do not need to get tested or that they have a low risk of having HIV. The next reason for not getting tested given by him is not knowing where to go and that it costs too much most especially outside government health facilities. In theory, all women should be counselled about HIV during antenatal care (ANC) and offered a test. Treatment exists that can significantly reduce the chance of an infant becoming infected with HIV from an infected mother during childbirth. Even where treatment is not available, new mothers infected with HIV should receive counselling on infant feeding practices best for their baby and on future pregnancy choices.

Many respondents from both the questionnaires and interviews indicated that HCT has played a significant role as regards prevention of HIV/AIDS. Among the various HCT methods identified included: Voluntary counselling and testing (VCT), this HIV testing is provided to individuals who seek the service out of their own will without any coercion. These persons may be referred by a provider, a sexual partner or a friend, or they may have learned of the service from hearsay or public media. In this stare the main point is that, the clients make the conscious decision to seek the service and seek it out without coercion.

Routine Testing and Counselling (RTC), this is within clinical settings. It is facility/hospital based approach aimed at integrating HCT services with existing day to day clinical services. In this model, testing for HIV is carried out routinely in health units/facilities. This increase access to HIV testing, and propels early treatment behaviour among those that test positive.

In line with the above, Dr. Mutaawe, at Kisenyi Health Centre asserts that: it also helps to reduce stigma and discrimination. However the counselling process is modified from that of the traditional VCT. It must be done by skilled personnel as it can scare off communities from seeking health care services from the facilities. Confidentiality as in all medical circumstances and ethics will be ensured. Doctor Mutaawe further argues that, VCT and RTC are both appropriate for the prevention of mother-to-child transmission. Therefore, (PMTCT) VCT and

RCT are provided to the specific target population of pregnant women for the primary purpose of enabling them to make decisions about PMTCT.

Home Based HIV Counselling and Testing (HBHCT) is a community based approach in HIV counselling carried out in the clients' familiar environment in their homes. Counselling and testing are done door to door and results given during the same visit. The home environment can be convenient and conducive for counselling and testing and eases the workload on the existing health infrastructure. Other HCT methods identified by the various respondents interviewed are testing of people seeking employment, HCT for special groups of people and Mandatory HIV Testing in Clinical settings.

5.4.1 Attitudes Relating to HIV/AIDS

This sub heading covers issues related to attitudes towards HIV/AIDS. Specifically, it includes indicators of the level of stigma towards people living with HIV/AIDS, as well as findings related to the ability to negotiate safer sex, and attitudes towards teaching youth about condom use. The following accepting attitudes towards people who are HIV infected were identified; willingness to care for a relative sick with HIV in own home, buy sugar and fresh vegetables from market vendor, and non-disclosure of HIV status by family members. This is in line with Hiv-sero-behaviour survey report 2004-2005 which asserts that:

> If a member of the family got infected with the virus that causes AIDS, it should not necessarily remain a secret.

As regards the attitude towards negotiating safer sex 82% of the respondents feel that a wife is justified in refusing to have sex with the husband if she knows he has a sexually transmitted infection, while others believe that a wife is justified in asking that they use a condom if she knows that her husband has a sexually transmitted infection

5.4.2 HIV/AIDS-Related Stigma

Stigma refers to the fact that, in some communities, people living with HIV/AIDS are viewed as shameful and the disease is perceived to be a result of personal irresponsibility. If not counteracted, such attitudes fuel prejudice against those living with HIV/AIDS, marginalising and excluding individuals. Ultimately such attitudes allow societies to excuse themselves from the responsibility of caring for and looking after those who are infected. More importantly,

stigma leads to secrecy and denial that hinders people from seeking counselling and testing for HIV, as well as care and support services. In Uganda, efforts have been made to reduce fear and discrimination towards those living with HIV/AIDS.

To assess the level of stigma, the study respondents who had heard of AIDS were asked four questions related to their attitudes towards those infected by HIV/AIDS. They were asked if they would be willing to care for a relative sick with AIDS in their own households and if they would be willing to buy sugar, fresh vegetables, or other food from a market vendor who had the AIDS virus.

Chart 8: Showing the respondents who have ever taken care of a person(s) suffering from AIDS
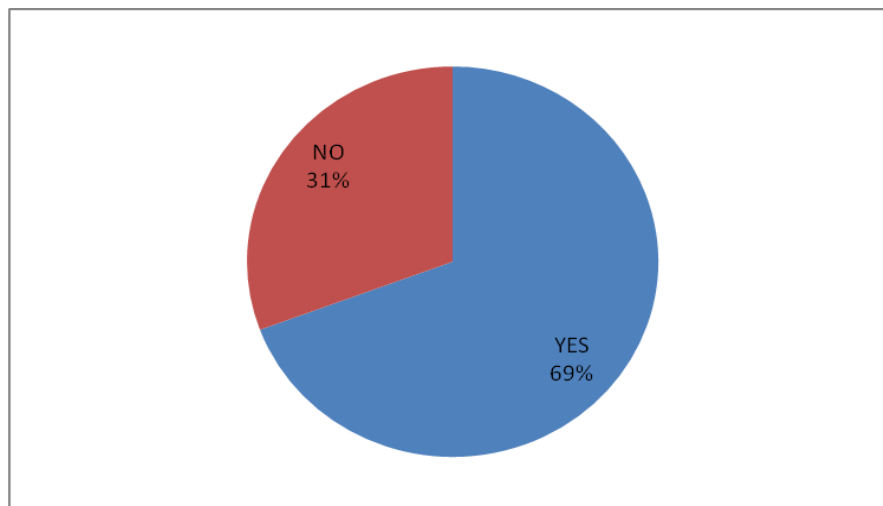
The chart indicates that the majority of the respondents have ever taken care of an AIDS patient are more than willing to give the necessary care to the patients. The responses are very encouraging and appeasing since they show that the leaders have really hands-on knowledge about the HIV/AIDS and can help fight stigma.

Another question assessed whether respondents thought that a female teacher who has the AIDS virus but is not sick should be allowed to continue teaching. A more personal question concerned, if a member of their family got infected with the virus that causes AIDS, whether they would they want it to remain secret or not. The results show that almost nine in ten respondents aged 18-55 say they would be willing to care for a relative who is sick with AIDS in their own household. They also said that if a member of their family got infected with the AIDS virus, they would not necessarily want it to remain a secret. Although Ugandan adults generally

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have accepting attitudes towards those living with HIV/AIDS, a sizeable minority express discriminatory beliefs. Women are slightly less likely than men to express accepting attitudes about people with HIV and there is widespread acceptance of the ability of a woman to negotiate safer sex with her husband either by refusing to have sex or in requesting condom use if she knows he has a sexually transmitted infection (UDHS, 2006). As regards attitude relating to negotiating safer sex, the knowledge about HIV transmission and ways to prevent it are less useful if people feel powerless to negotiate safer sex with their partners.

5.5   Sex Education and Life Skills

Ministry of Health (MOH) Uganda (2003) defines life skills as "a behaviour change or behaviour development approach designed to address a balance of three areas: knowledge, attitude and skills". This is in agreement with Uganda Annual Health Sector Performance (2001) definition which is based on research evidence that suggests that shifts in risk behaviour are unlikely if knowledge, attitudinal and skills based competency are not addressed.

Life skills are essentially those abilities that help promote mental well-being and competence in young people as they face the realities of life. Most development professionals agree that life skills are generally applied in the context of health and social events. They can be utilized in many contexts: prevention of drug use, sexual violence, teenage pregnancy, HIV/AIDS prevention and suicide prevention. The definition extends into consumer education, environmental education, peace education or education for development, livelihood and income generation, among others. In short, life skills empower young people to take positive action to protect themselves and promote health and positive social relationships. According to the Focus Group Discussion held with youth representative, the youth hinged the value of sex education in relation to prevention of HIV/AIDS:

> Sexuality is about all parts of our sexual lives. It is about our bodies, feelings, behaviour and desires. We show our sexuality in the way we communicate, move, dress and behave as sexual beings. Life skills are the skills we need to communicate well, make good decisions, solve problems and act responsibly.

They further asserted that:

> We learn about sexuality through the elders. Now we learn about it at school too because of the problems of HIV and AIDS and early pregnancy. These days, young people get married later and we have to manage our sexual feelings safely before then. HIV is a

serious infection, spread mostly through sexual intercourse. Therefore Young people need to know how to protect themselves from HIV. and have a right to information on sexuality as they grow up, so they can keep safe and happy and protect themselves from sickness.

Research on curbing the spread of HIV/AIDS has indicated that interventions and educational programmes on HIV/AIDS and sexual health appear to have greater impact if they are offered prior to the onset of sexual activity. It has been suggested by various researchers that it may be easier to establish the desired patterns of behaviour from the beginning of sexual involvement, rather than trying to change pre-existing habits. Furthermore, they concluded that the HIV/AIDS and sexual health education programme should be contextualised within a broader life skills programme (African HIV/AIDS Materials Catalogue, Department of Health 1998).

As the primary school years (6 to 13 years of age) are regarded as the most formative years, it is during this phase that young children establish attitudes that are likely to determine their level of responsibility. In view of the lowering of the age of sexual maturation and sexual debut (10 to 14 years of age) on a global scale, and in order to prevent the spread of the HIV epidemic, it is essential to offer young children at primary school level the opportunity to obtain the necessary knowledge, values, attitudes and skills to prevent HIV infection.

UNICEF, UNESCO and WHO list the ten core life skill strategies and techniques as: problem solving, critical thinking, effective communication skills, decision-making, creative thinking, interpersonal relationship skills, self awareness building skills, empathy, and coping with stress and emotions. Self-awareness, self-esteem and self-confidence are essential tools for understanding one's strengths and weaknesses. Consequently, the individual is able to discern available opportunities and prepare to face possible threats. This leads to the development of a social awareness of the concerns of one's family and society. Subsequently, it is possible to identify problems that arise within both the family and society.

With life skills, one is able to explore alternatives, weigh pros and cons and make rational decisions in solving each problem or issue as it arises. It also entails being able to establish productive interpersonal relationships with others. Life skills enable effective communication, for example, being able to differentiate between hearing and listening and ensuring that messages

are transmitted accurately to avoid miscommunication and misinterpretations. Developing life skills helps adolescents translate knowledge, attitudes and values into healthy behaviour, such as acquiring the ability to reduce special health risks and adopt healthy behaviour that improve their lives in general such as, planning ahead, career planning, decision-making, and forming positive relationships.

The adolescents of today grow up surrounded by mixed messages about sex, drug use, alcohol and adolescent pregnancy. On one hand, parents and teachers warn of the dangers of early and promiscuous sex, adolescent pregnancy, STDs/HIV/AIDS, drugs and alcohol, and on the other hand, messages and behaviour from entertainers and peer pressure contradict those messages. Often, they even promote the opposite behaviour. It is through life skills that teenagers can fight these challenges and protect themselves from teenage pregnancy, STDs, HIV/AIDS, drug abuse, sexual violence, and many other health-related problems. Hopefully, developing life skills among adolescents will empower girls to avoid pregnancy until they reach physical and emotional maturity, develop in both boys and girls responsible and safe sexual behaviour, sensitivity and equity in gender relations, prepare boys and young men to be responsible fathers and friends, encourage adults, especially parents, to listen and respond to young people, help young people avoid risks and hardships and involve them in decisions that affect their lives.

Sex education seeks to assist people especially the young in understanding a positive view of sexuality, provide them with information and skills about taking care of their sexual health, and to help them acquire skills to make decisions now and in the future. Dr. Madra Elizabeth Manager of Uganda AIDS Control Programme reports:

> Integrating HIV/AIDS information in school curricular is proving to be an effective way to increase awareness of the disease. Indeed education is working with the teachers and education administrators to create education programmes that teach important life skills, including HIV/AIDS prevention.

A comprehensive sexuality education program includes information as well as an opportunity to explore attitudes and develop skills in such areas as human development, relationships, personal skills, sexual behaviour, sexual health, and society and culture. Sex education enables choice and promotes safe, consensual sexual behaviour. Evidence-based comprehensive sexuality education

can play a crucial role in supporting young people in their (sexual) development, becoming responsible adults and active citizens; it can help decrease vulnerability to SRH problems, including HIV/AIDS; it is crucial for correcting ignorance and misconceptions about sexuality and reproduction. Sexuality education is effective in helping young people to choose for healthy lifestyles: delaying their sexual debut, safer sex and fewer partners. Comprehensive education about sexuality is effective in delaying the onset of sexual intercourse, reducing the number of sexual partners, and increasing contraception and condom use among teens. Unlike what is often thought, comprehensive sexuality education does not increase the number of sexual partners among young people or increase any measure of sexual activity.

Youth receiving comprehensive sexuality education including information, skills and assertiveness to make safe decisions and have them respected, including saying no and delaying sexual intercourse and systematically protecting themselves during intercourse are more likely to delay initiating sex and using protection when they do have sex compared to youth who receive abstinence-only programs. Openness about sexuality is a precondition to create a safe, non-judgmental and respectful environment in which people can enjoy their sexuality. Attention to the positive sides of sexuality, providing insight in one's own sexual development and achieving skills in communicating, are the factors enabling people to negotiate safe and consensual sexual behaviour. It also helps people to make their own choices, either to abstain or enjoy sexuality free of guilt, shame and regret. It contributes to gender equality, decreases stigma and discrimination and decreases sexual violence. A recent review study (2005) on the impact of sex and HIV education programs on sexual behaviours of youth in developing and developed countries showed that:

> All reviewed programs were far more likely to have a positive impact on behaviour than a negative impact on one or more of six aspects of sexual behaviour: 1. initiation of sex; 2. frequency of sex; 3. number of sexual partners; 4. condom use; 5. contraceptive use in general, and 6. sexual risk-taking. Effective education programs commonly created a safe environment for youth, focused on clear goals of preventing HIV/STI and/or pregnancy, focused on specific behaviours leading to these health goals and gave a clear message about those behaviours, addressed psycho-social risk and protective factors affecting those sexual behaviours, included multiple activities to change the targeted risk and protective factors, employed instructionally sound teaching methods that actively involved the participants and helped them personalize the information, employed appropriate activities and messages (for participants' culture, age, sexual experience) and covered topics in a logical sequence. Young people need access to comprehensive and

confidential services that respond to the realities of their lives. And if they do have sex - and eventually most of them will - they need access to the information and means to protect themselves and to enjoy a satisfying sexual life, whenever that will start.

5.6   Moral and Religious Views

Many supporters of abstinence based sex education have a background in or connection to Christian organisations that have strong views about sex and sexuality. Not only do they often believe that sex should only take place in the context of marriage, but some are also opposed to same sex relationships and abortion. As a result of the strong faith basis for their beliefs about sex, supporters of abstinence education see the main objective as being to equip (and encourage) young people to refuse or avoid sex altogether, and they may exclude from their programmes any other information that they believe conflicts with this view. This may result in an abstinence only course failing to include basic information about what activities transmit HIV and how such transmission can be avoided.

The researcher found that even where supporters of abstinence based sex education disavow a strong religious basis for their beliefs about what young people should be taught, they often highlight issues about fidelity to one partner, and reject provision of information about steps young people can take to protect themselves against disease and unintended pregnancy because they argue that to do so sends a mixed message.   In contrast, some leaders suggested comprehensive sex education regard having sex and issues to do with sexuality as matters of personal choice that should not be dictated by religious or political dogmas. Working from an understanding of human rights, which means that people are entitled to access information about matters that affect them and the decisions that they make, they see sex education as being about providing young people with the means by which they can protect themselves against abuse and exploitation as well as unintended pregnancies, sexually transmitted diseases and HIV/AIDS. They argued that without access to information about all aspects of sex and sexuality making these decisions freely is impossible. While they think that it is important that sex education is

sensitive to faith issues, they assert that sex education should not be based on any set of specific religious values.   Uganda is often held up as a model for Africa in the fight against HIV and AIDS. Strong government leadership, broad-based partnerships and effective public education campaigns all contributed to a decline in the number of people living with HIV and AIDS in the 1990s. Although there is a lot to learn from Uganda's comprehensive and timely campaign against the AIDS epidemic, emphasising Uganda's success story must not detract from the huge consequences that AIDS continues to have across the country.

5.7   Advocacy

Advocacy is an organized effort to influence decision making. People who attempt to inform decision makers and to influence their decisions are called advocates. Therefore advocacy is lobbying, campaigning and whatever its name, it means that people are making planned efforts to influence a decision(The Aids Control and Prevention, policy and advocacy in HIV/AIDS Prevention Report, 2006).

As a part of the advocacy efforts, several NGO coalitions and other stakeholders have publicized the results of surveys that show high levels of youth sexual activity and thus strategies. The coalitions expected the data to sensitize government and religious policy makers and parents' groups on the critical AIDS situation. The advocacy message is a brief, clear statement of the problem and a recommendation for its solution. It can be delivered personally in meetings with decision makers, or in the form of posters, banners, fact sheets, newspaper columns, newsletters, or radio and television announcements, etc. Policy makers will act when they recognize the problem and agree with the proposed solution; or when they agree with advocates that a national or organization problem exists requiring their action; or when they are convinced action is to their political or economic advantage. When policy makers are willing to act for these reasons, the work of advocates can guide and convince the policy makers.

However, some policy makers may act for reasons that do not reflect the collective good. For example, they may act to block a rival; or to gain a quick profit or political advantage for themselves or associates; or for ideological reasons. In these cases, advocates will have a more difficult time, unless their messages appeal to the self interest of the policy makers.

HIV/AIDS is a global catastrophe of immense economic and social proportions; today it is the fourth leading cause of death in the world (Nantulya, M. 2002). Therefore advocating for HIV is

necessary due to the prejudices people with HIV face every day. Forty million people are currently infected with the virus and more than 143 million children have lost one or both parents to HIV/AIDS. People living in poverty are particularly vulnerable to HIV/AIDS because illiteracy and underdevelopment are problems most often plaguing those in poverty and are among the principal factors contributing to the spread of the disease.

Community action on HIV is often made difficult by hostile policy environments. There are often severe resource constraints, laws that perpetuate or even exacerbate the marginalisation and stigmatisation of key populations such as sex workers, people who use drugs and men who have sex with men, and lack of accountability and enforcement of laws where they do not exist. Therefore the researcher observed that these factors can be changed through community-led policy action.

CHAPTER SIX: SUMMARY OF THE FINDINGS AND RECOMMENDATIONS

The study set out to investigate the impact of knowledge and practice on HIV/AIDS prevention management among leaders on the social welfare of people with reference to Kampala central division. A number of objectives guided the investigations. The study set out to investigate the fact that leaders are at the fore front of the society therefore they should be knowledgeable in order to lead and improve welfare. Different issues were outlined. Summary of the findings, recommendations are presented in this chapter.

6.1   Summary of the Findings

6.1.1 HIV Counselling and Testing

The study findings show that, HIV Counselling and Testing is the most important service in HIV/AIDS prevention and care strategies. Persons, their spouses and sexual partners are better equipped to make appropriate HIV prevention decisions if they know their HIV status. Couples about to be married can use HCT to know their HIV status before deciding on marriage. HCT can enable pregnant women to learn their HIV status and seek services to help prevent mother-to-child transmission of HIV. Women of reproductive age who go for counselling before pregnancy are helped make informed decisions about becoming pregnant, based on knowing their HIV status. HCT lets people who are infected learn their HIV status early enough to receive adequate care and support. Early care and psychosocial support may enable them to live a longer and better quality of life with HIV.

Knowledge of an individual's own HIV sero-status can motivate him or her to practice safer sexual behaviour thereafter to avoid transmitting the virus to others. Awareness of HIV status can motivate individuals to further protect themselves against infection or to protect their partners from acquiring the disease. To increase the proportion of people who know their HIV status, it is important to know why people do not go for voluntary counselling and testing. Therefore, the L.C Chair persons, community leaders, youth and women representatives, and representatives of people with disability are crucial to champion this cause.

6.1.2 Abstinence, Be faithful and Condom use approach

The Uganda HIV prevention programme evolved along the interventions of promoting abstinence, being faithful, and condom use (the "ABC" approach). The ABC approach is particularly pertinent for young adults. Condom use among young adults plays an important role in the prevention of transmission of HIV and other sexually transmitted infections, as well as unwanted pregnancies. Knowledge of a source of condoms helps young adults to obtain and use condoms.

Since the beginning of the response to HIV prevention, it has been known that HIV can be transmitted sexually. Even before the term 'ABC' was conceived, materials provided by WHO, the Global Program on AIDS (later succeeded by UNAIDS) and governments and organisations around the world, contained information on how abstinence, fidelity and condom use could prevent the sexual transmission of HIV.

6.1.3 Socio-cultural Practices of the Leaders

Culture is critical for the establishment of social order and stability in society. AIDS is a complicated global problem. It is a global health crisis. From the foregoing definition, it is clear that culture influences attitudes and behaviour related to the HIV/AIDS epidemic. There is need for leadership training to avoid sexual recklessness. This is because Leaders are role models to those they are leading thus need to develop a culture of modesty.

African minds are products of unique "cultural edifices" and "cultural streams" that arose from environmental conditioning and long-standing cultural traditions. Within the African cultural stream, are psychological and moral characteristics pertaining to African identity, personality and dignity. African communities are linked by shared values that are fundamental features of African identify and culture. These, for example, include hospitality, friendliness, the consensus and common framework seeking to enforce the principle of human-beingness. They have an emphasis on community rather than on the individual.

Social-culture practices of a leader play a vital role in determining the level of health of the individual, the family and the community. This is particularly relevant in the context of Africa in general and Uganda in particular, where the values of extended family and community significantly influence the behaviour of the individual. The behaviour of the individual in relation to family and community is one major cultural factor that has implications for sexual

behaviour and HIV/AIDS prevention and control efforts. As the impact of HIV/AIDS in Uganda and Africa remains unabated, a culture-centred approach to prevention, care and support is increasingly recognised as a critical strategy.

6.1.4 HIV/AIDS and the Role of Leaders

The rapid spread of HIV/AIDS has created challenges for everyone who is involved in the fight against it. In the study, the researcher observed that, many of the strategies to prevent the spread of the pandemic have focused on promoting condom use, reducing the numbers of sexual partners and treating sexually transmitted diseases. However, by failing to address the social, economic and power relations between men and women, such strategies have not been effective in tackling women's and men's risk of infection, their ability to protect themselves effectively and their respective share of the burdens of the epidemic. The multisectoral approach remains the very core implementation modality and, as such, the leaders serve to guide stakeholders of all kinds on deciding priority interventions in their respective areas of competency and interest. The study recognises the need to strengthen systems for service delivery, i.e., optimising utilisation of the social, community and health infrastructure; streamlining the institutional arrangement at national and local government levels; efficient use of human resources; and enhancing research, monitoring and evaluation. Knowledge of AIDS is very high and widespread in the division. In terms of HIV prevention strategies, women and men are most aware that the chances of getting the AIDS virus can be reduced by limiting sex to one uninfected partner who has no other partners or by abstaining from sexual intercourse.

Knowledge of condom use and the role they can play in preventing transmission of the AIDS virus is not quite as high. It was observed that, 85% of women and 90% of men know that a healthy-looking person can have the AIDS virus. Larger proportions of respondents are also aware that the AIDS virus cannot be transmitted by supernatural means or by sharing food. However, many women and men erroneously believe that AIDS can be transmitted by mosquito bites.

The study further indicated that, 73% of women and 63% of men know that HIV can be transmitted by breastfeeding. A lower proportion of women and about the same proportion of know that the risk of mother-to- child transmission can be reduced through the use of certain

drugs during pregnancy. The study findings indicate that 82% of women know of drugs for people living with AIDS. Among those, few know ARVs by name.

6.1.5 HIV/AIDS and its Gender Implications

In Uganda's culture young girls grow up with the knowledge of the importance of having children. Children are a symbol of wealth, investment and social security in the African context. A woman is therefore expected to bear children and if she does not, then she is not a respectable woman. We need to bear in mind that in Africa, the idea of marriage in our culture was to have children.

The study emphasises that, mainstreaming Gender, Sexual, Reproductive Health and Rights will is crucial and enable strategic positioning to address the phenomena of high discordance rates, the vulnerability of women and the observed increasing new infections within marriage. Deepening the response at Local Government level is expected to translate into improved access and utilisation of services and will result from better and stronger governance and implementation modalities, an enhanced role of the Ministry of Local Government, effective mainstreaming of HIV in all sectors and strategic engagement of Civil Society.

6.1.6 Community Level Interventions on HIV/AIDS

The participatory process through which the National Strategic Plan was developed has renewed Uganda AIDS Commission's commitment, motivation and thinking about the road map to the country's vision of a population free of HIV. As of now the National Strategic Plan is the key tool for coordination and oversight for the national response for the next five years. Therefore partners, community leaders and implementers will, to every extent possible, align their support and interventions to the priorities of the National Strategic Plan and collectively contribute to the achievement of the targets in the most cost-effective way. The gender dimensions of HIV/AIDS are glaringly obvious at the community level. Women bear the major burden of HIV/AIDS because of their traditional roles within the family and the community. Since care giving and domestic chores are still predominantly women's responsibilities, an increase in the prevalence of HIV/AIDS in the society directly and indirectly increases the burden on women. Women's subordinate status, especially in sexual decision-making, is another factor that makes women more vulnerable to HIV/AIDS infection. Coupled with these are negative and harmful socio-cultural beliefs and practices, which vary from community to community.

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Paradoxically, women's emerging and emancipating roles within the family and the community also increases the burden of HIV/AIDS on them. The fact that women are taking on men's traditional role of breadwinning is worsening the situation for women. The combination of productive activities outside the home with domestic work, including care giving to the infected, puts additional strain on women's physical, mental and emotional health. Many women have to divert a significant part of their financial resources into care giving. When the infected woman who heads a household herself becomes ill and unable to earn a living, the situation of the house hold could become hopeless.

6.2   Recommendations

Basing on the findings, the following recommendations have been generated. It is hoped that they can lead to the realisation of the role leadership play in HIV/AIDS prevention management and social welfare among people.

6.2.1   Uganda is at an important crossroad in the history of its AIDS epidemic. After a dramatic reduction in HIV prevalence following an early comprehensive HIV prevention campaign, there are signs that the number of people living with HIV in the country may be rising again. The Ministry of Health has predicted that the current rate of new HIV infections is seriously impeding economic growth and will continue to do so, particularly as HIV and AIDS is affecting people in their most economically productive years. In order to avoid this, leaders at all levels must be involved. Leaders and other stakeholders need to take a serious look at infection trends and behaviour to identify why this rise may be occurring and how to remedy it. Therefore it is recommended that, Uganda clearly needs to revive and adapt its HIV prevention programme, moving away from abstinence-only initiatives to a comprehensive programme that incorporates not only abstinence, fidelity and condom use, but also HIV testing and the prevention of mother-to-child transmission of HIV. In this regard, leaders should be at the fore front.

6.2.2   The Government should devote its efforts to providing the necessary environment for all community leaders and other stakeholders at various levels to participate and contribute to the achievement of the goals of the National Strategic Plan of substantially reducing new infections especially among youth, as goes the kiganda saying "emiti emito gye giggumiza ekibira".

Leaders, married couples and youths are urged to take personal responsibility to avoid risky sexual behaviours that could contribute to an upsurge in new infection and increase the burden of the epidemic. Abstain, Be Faithful and those who cannot practice these two should use condoms. The three arms of Government – the legislature, executive and the judiciary – are called upon to be vigilant in mobilising the community to use HIV and AIDS services. It is the researcher's sincere hope that the renewed commitment can effectively stop the further spread of infection by HIV.

6.2.3   Training of community councillors and grass root leaders, to ensure that communities have the most accurate and current information regarding HIV/AIDS. The information should be geared towards improvement of skills and knowledge of community leaders. They should also be equipped with basic skills that enhance their ability to deliver HIV prevention management services. These may include Home Based HIV Counselling and Testing (HBHCT)

6.2.4   Advocacy, effective interventions will not thrive unless they are supported by a strong policy environment that is led by committed, knowledgeable and informed leaders. Leaders at all levels should help to develop policies to reduce stigma and improve the implementation of prevention and care. UAC, basing on its mandate, is challenging all leadership to re-engage and demonstrate commitment to this reason. All sectors, including the executive, judiciary and legislature; civil society; faith based organisations; the private sector and Decentralised Local Governments as well as individuals and families are called upon to effectively engage their respective "communities" to observe and participate in communal events such as World Aids Day.

Uganda AIDS Commission as a lead coordinating agency working closely with all sectors, districts and NGOs include FBOs therefore calls upon all leaders to cooperate and embrace the initiative and support the theme, "Re-engaging Leadership for Effective HIV Prevention" for a renewed response. The Commission further calls upon everyone to re-arm themselves to exercise and demonstrate effective leadership as a way to make HIV prevention a cornerstone in the struggle to attain zero new infections. This is because leadership worked in 1990s when there was less information, limited capacity and resources. Today we have more leaders, more

resources, up to date information and advanced knowledge about the epidemic. Let all leaders re-engage as leaders using improved technologies and knowledge alongside our traditional skills and values in our various capacities to push the agenda of HIV prevention to attain zero mother-to-child transmission and zero AIDS deaths. *Yes We Can. Obama did.*

6.2.5 World Aids Day should be strengthened and given a deeper meaning. The Parliamentary Committee on AIDS with support from the Parliamentary Commission should organise the Dialogue on the Status of HIV and AIDS. UAC should provide technical input. The Speaker of Parliament should support effective engagement and participation of the MPs. The learned fellows should identify, propose and share some innovative ideas of participating in the event. The Chief Justice' office should be accountable for the event. Permanent Secretaries and sectoral AIDS Focal persons will be accountable for their respective sectoral engagements and action. In this regard, District Chairpersons and Chief Administrative Officers should be responsible for the lower level leadership engagements. People living with HIV and AIDS, working through their networks and associations, should demonstrate visibility and participate in national, district and community based events.

6.2.6 The office of First Lady should work with Women and Girls to recognise their vulnerability and think through strategies to bring about gender equality that works in the context of HIV and AIDS. The office should go ahead with empowering the girls with preventive measures and knowledge that can help them stay safe from the infection. Knowledge of positive living should be spread through the youth and the girls in particular through HIIV/AIDS workshops and seminars.

> **6.2.6.1** Involvement of Men: This has been articulated at a number of forums but no concrete/practical strategies have been made to achieve it. It is important to address the specific challenges and issues that hinder male involvement. There is need to utilise the strategic position of men so as to transform their power and prowess into responsibility for first of all their own lives, and the lives of their families.
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> **6.2.6.2** Dissemination of Accurate Information in time: Men and women need accurate information on such critical issues like MTCT and infant feeding. This will enable

men and women make critical decisions in time, take up their roles and responsibilities more seriously especially in terms of protecting themselves from re-infection and further spread of HIV.

6.2.6.3 Empowerment of Young Girls and Women: Governments should be challenged to put in place policies and laws that address the inherent gender imbalances that deny women the power to make key decisions that affect their lives. This will help reduce women's vulnerability to HIV and STD infection as well as the social injustice they suffer

6.2.6.4 Special attention to the Girl and Boy child: Enactment and reinforcement of Gender sensitive laws that protect and promote equal rights of the Girl child in terms of education so as to prepare her for a better and meaningful future. A future where she can take charge of herself. On the other hand the boy child needs sensitisation and education to acknowledge and appreciate his role and responsibilities in society with a gender sensitive out look.

6.2.6.5 Sensitisation and Advocacy on Gender equality: There is need for communities, governments and the international community to sensitise grass-roots on Gender equality. This will call for a clear understanding of communities; their specific challenges and needs to enable them acknowledge the need for Gender equality

6.2.6.6 All musicians should participate and meet their social responsibility by mobilising communities and all media houses should disseminating information as a social responsibility as well as initiating innovative activities for workers, partners and communities at large

6.2.7 Policy recommendations, to help prevent the spread of HIV/AIDS among women and men in the division and the country, religious institutions in the district adopt and implement the following policies:

a. Affirm the right of women within marriages to be safe and secure in that relationship.

b. Build upon the strength of religious groups in promoting communication within families by offering counselling on inter-personal relations, including sexual relations, and dialogue for couples planning to marry, newly married couples and all married couples.

c.   As a matter of urgency, introduce training on sexual relations and couple communications into the curricula and refresher courses for all clergy.

d. Allocate the necessary resources to support the training of clergy and of their work with community members on couple communication, even if resources must be drawn from other work of the religious groups.

The adoption of these policies will require the careful and thoughtful consideration of each denomination and religious community. Often, such deliberations take many months or years. However, the crisis of HIV/AIDS requires that our religious groups act quickly.

6.2.8 Government and CSOs should promote the development and adoption of new innovations and approaches in prevention in HIV prevention management. Documentation and dissemination of unique best practices is a key avenue. Examples of unique practices include use of sports for HIV awareness

General Conclusion

Basing on the overall findings, it is worth concluding that the AIDS epidemic has affected people in a very devastating way. It has clearly revealed the imbalance of power between men and women. We can not say that we have fared well in our efforts. This is because the epidemic continues to rage on. There is need to utilise the knowledge, diversity of experiences and expertise of leaders to support men and women take up their responsibilities and acquire the power to protect themselves from HIV infection. Each new infection should be a concern of a leader because HIV epidemic is a leadership issue.

The World Aids Day is the most recognised international health day in the world. Therefore it should be a platform and opportunity for leaders to raise awareness on current trends of the epidemic in the world, countries and local governments to the community. It is an aggregated commemoration of those who have passed on and celebrate victories such as increased access to treatment and prevention services. It focuses on the annual struggle to raise awareness about the status of the epidemic, breakthroughs and a beginning of a new campaign that evolves annually.

This study found that literacy of any kind empowers one with analytical qualities, which in turn enable one to acquire the skills to manage human beings, most especially organising them to

develop as Sheikh Rajab Kakooza puts it: kings College Buddo was constructed to train children of chiefs to become leaders.

Children must be educated formally and informally if we are to keep the values of the family institution. Livingstone acted as a role model by inculcating traditional customs and values among his children as well as educating them. This is an encouragement to all parents to do the same. The demands on leadership role are more taxing because leaders of today deal with the literate, urbanised community, the illiterate and the rural community. A contemporary leader, therefore, acts as a link between the two different communities and in turn links both to government. The point is that Livingstone managed to bring all the categories together and linked the church to government which was not the case with his predecessors.

List of Informants

Name	Designation	Gender	Date of interview
Dr. Elizabeth Madra	Manager AIDS Control Programme	Female	28th/08/2011
Were Beatrice	Coordinator National Community of Women living with HIV/AIDS	Female	28th/08/2011
Dr. Mutaawe A	Health Worker	Male	30th /07/2011
Dr. Phiona Kalinda	Clinical Manager at Joint Clinical Rsearch Centre, Kampala	Female	30th /07/2011
Mr. Mugyenyi Peter	Director of the Joint Medical Research Centre, Uganda	Male	30th /07/2011
Theophane Nikyema	Humanitarian Coordinator	Female	30th /07/2011
Bidandi Ssali	Chairperson Peoples' Progressive Party	Male	30th July 2011
Sheik Kakooza Rajab	Director Sharia	Male	25th July 2011
Bishop Eria Paul Luzinda	Retired Bishop of Mukono Diocese	Male	20th July 2011
Kayongo John	Community Leader	Male	1st August 2011
Amooti Godfrey Nyakana	Chairman (LC III)	Male	3rd / 09/2011
Bbosa Juma Serunkuma	Kisenyi II	Male	3rd / 09/2011
Isabirye Al-Hassan	Kagugube	Male	3rd / 09/2011
Kiwanuka Florence	Kisenyi II	Female	3rd / 09/2011
Mutenda John	Vice Chairman/ Secretary for Health	Male	20th /10/2011
Mwesigwa Bahemuka Geofrey	Secretary Works and Physical Planning	Male	20th /10/2011
Olama Resty	Secretary Gender and Social Welfare	Female	20th /10/2011
Kagimu Hamuza	Youth representative	Male	20th /10/2011
Nabisere Asia Rizzo	Deputy speaker	Female	25th /10/2011
Gombya Samuel	Represenative of people with disability	Male	25th /10/2011
Nalubega Afua	Represenative of people with disability	Female	25th /10/2011

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Appendix i

Letter of Introduction

MAKERERE
P.O. Box 7062 Kampala Uganda
Cables: MAKUNIKA

UNIVERSITY
Tel: 256-41-532251/542241
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E-mail rs@arts.mak.ac.ug

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
SCHOOL OF LIBERAL AND PERFORMING ARTS
DEPARTMENT OF RELIGION AND PEACE STUDIES

Dear Sir/ Madam,

TO WHOM IT MAY CONCERN

The bearer of this letter **MULERWA ROBERT**   Master of Arts student on the Leadership and Human Relations Programme in the Department of Religion and Peace Studies, Makerere University. He / She is to carry out research on **THE IMPACT OF KNOWLEDGE AND PRACTICE ON HIV/AIDS PREVENTION MANAGEMENT AMONG LEADERS ON THE SOCIAL WELFARE OF PEOPLE: A CASE STUDY OF KAMPALA CENTRAL DIVISION**

He/She is kindly requesting you to avail him/her with relevant data to his/her dissertation. The purpose of this letter, therefore, is to introduce him /her to you and to thank you in advance for the assistance you will render him or her during this period.

Yours sincerely,

16 NOV 2011

CHAIR

Hajji Kimbi Abdu

Ag,Head of Department

Appendix ii

Letter to Respondents

Department of Religion and Peace
Studies, School of Liberal and
Performing Arts

Dear Respondent,

This is to introduce myself to you as a student of Makerere University. I am out in the field conducting research about, The Impact of knowledge and Practice on HIV/AIDS Prevention Management among Leaders on the Social Welfare of People: A Case Study of Kampala Central Division. The research is a partial requirement of my course for the award of a degree of M A (Leadership and Human Relation Studies). The research will depend upon your cooperation.

I, therefore, appeal for your cooperation in availing me with information pertaining Knowledge and Practice on HIV/AIDS.

As regards this matter, there should not be any suspicion aroused, for no piece of information you give me will be revealed since your name does not appear on this questionnaire.

The information I seek from you is purely for academic purposes and strictly confidential.

Hoping for your cooperation.

Yours Sincerely,

MULERWA ROBERT

M A (Leadership and Human Relation Studies)

INTERVIEW GUIDE

Additional questionnaire/Interview Guide to Priests, teachers and Head teachers

1. Have you heard about HIV/AIDS? What is HIV/AIDS?

2. What are the ways through which HIV/AIDS is spread?

3. What other infections that are linked with HIV/AIDS?

4. What are some of the strategies in place to prevent HIV/AIDS?

6. What can be done to avoid HIV transmission from mother to baby?

7. What can be done to a person done to a person with HIV/AIDS to enable him to live longer?

8. Do you think leaders in Kampala division have been generally active in spearheading the fight against HIV/AIDS in Kampala central?

Appendix iv
QUESTIONNAIRE TO THE TEACHERS, YOUTH AND WOMEN REPRESENATIVES, HEALTHWORKERS, GOVERNMENT OFFICIALS, COUNCILLORS AND RELIGIOUS LEADERS.

<table>
<tr><td colspan="3" align="center">IDENTIFICATION</td></tr>
<tr><td colspan="3">
District…………………………………………………………………………………………
Division………………………………………………………………………………………..
Parish…………………………………………………………………………………………...
Village………………………………………………………………………………………….
Interview Date………………………………………………………………………………….
Name of Interviewer……………………………………………………………………………
Position held by the person interviewed…………………………………………………………

</td></tr>
<tr><td colspan="3" align="center">RESPONDENTS BACKGROUND
(Please circle the correct coding categories)</td></tr>
<tr><td>QN</td><td>Coding Categories</td><td>Comments</td></tr>
<tr><td>101</td><td>How long have you lived in this area
   1. Less than 6 months
   2. 6months- 2 years
   3. 2years- 5years
   4. Over 5 years</td><td></td></tr>
<tr><td>102</td><td>Sex of the respondent
   1. Male
   2. Female</td><td></td></tr>
<tr><td>103</td><td>How old are you?
   1. 15-25years
   2. 26-45years
   3. 36-50 years
   4. Above 50years</td><td></td></tr>
<tr><td>104</td><td>What is the highest level of school you attended
   1. Never attended
   2. Primary
   3. Secondary
   4. Post Secondary</td><td></td></tr>
</table>

105	What is your leadership position? LC i LCii LCiii Youth representative Women representative PWD representative?	
106	What is your marital status? 1. Currently married 2. Formerly married (Widowed, separated, divorced) 3. Single 4. living with a partner	
	KNOWLEDGE AND PRACTICE ON HIV/AIDS	
201	Have you heard about HIV/AIDS? 1. Yes 2. No	
202	What are the ways through which HIV/AIDS is spread? (multiple answers) 1. Sexual intercourse 2. Blood Transfusion 3. Sex with Multiple partners 4. Mother to child transmission 5. Kissing 6. Mosquito bites 7. Sharing Skin piercing instruments 8. Witch craft 9. Other Specify_____	
203	Are there certain infections that are linked with HIV/AIDS? 1. Yes 2. No 3. Don't know	
204	Is it possible for a mother who is breast feeding to pass HIV to her baby? 1. Yes 2. No 3. Don't know	
205	Is it possible to have unprotected sexual intercourse with an infected person and not get HIV? 1. Yes 2. No 3. Don't know	

206	A person can have HIV in his/her body without falling sick? 　　1.　Yes 　　2.　No 　　3.　Don't know	
207	Have you tested for HIV before? 　　1.　Yes 　　2.　No	
208	Have you played sex before? 　　1.　Yes 　　2.　No	
209	How many sexual partners do you have? 　　1.　1 only 　　2.　More than 1 　　3.　Don't have	
210	Do you use condoms during sex? 　　1.　Once 　　2.　Always 　　3.　Sometimes 　　4.　Never	
211	Have you talked to anyone about HIV/AIDS prevention? 　　1.　Yes 　　2.　No	
212	Who have you talked to about HIV/AIDS prevention?(Multiple Answers) 　　1.　Spouse 　　2.　Friends/relatives 　　3.　Community meeting 　　4.　Son/Daughter 　　5.　People in constituency 　　6.　Other 　　　　Specify_____	
213	What strategies do you think should be put in place to prevent HIV spread? 　　1.　Voluntary HIV Counselling and Testing 　　2.　Behaviour Change Communication 　　3.　Life Skills training 　　4.　Livelihood Skills Training 　　5.　PMTCT 　　6.　Community sensitization 　　7.　Sport and recreation 　　8.　STI treatment 　　9.　Other　Specify_____	

	HIV/AIDS MANAGEMENT	
301	Is it possible to cure HIV/AIDS? 　　1. Yes 　　2. No 　　3. Don't know	
302	A person can have HIV in his/her body without falling sick? 　　1. Yes 　　2. No 　　3. Don't know	
303	What infections commonly relate with HIV/AIDS? 　　1. Tuberculosis 　　2. Herpes Simplex 　　3. Malaria 　　4. Crypto coco Meningitis 　　5. STDs 　　6. Cervical Cancer 　　7. Mental illness 　　8. Skin infections 　　9. Other　　Specify_____	
304	Can these infections be treated? 　　1. Yes 　　2. No 　　3. Don't know	
305	If a woman is HIV infected, is there any way to avoid transmission to the baby? 　　1. Yes 　　2. No 　　3. Don't know	
306	What can be done to avoid HIV transmission from mother to baby? 　　1. Caesarean section at birth 　　2. Not breast feeding the baby 　　3. Taking Nevirapine drugs during pregnancy 　　4. Others　Specify_____	
307	Do you know about Anti Retroviral drugs (ARVs)? 　　1. Yes 　　2. No	

308	What can be done to a person with HIV/AIDS to enable them live longer?
	      1. Good nutrition/Feeding on a balanced diet
	      2. Minimizing alcohol/cigarette intake
	      3. Ensuring prompt medical treatment (including ARVs)
	      4. Avoiding HIV re-infection
	      5. Counseling
	      6. Other Specify_____	

309	Have you ever taken care of a person(s) suffering from AIDS?
	      1. Yes
	      2. No	

310	What kind of care did you provide to the suffering person(s)?
	      1. palliative care
	      2. Counseling
	      3. Material and financial support
	      4. Other Specify_____	

311	Do you think leaders in Kampala District have been generally active in spearheading the fight against HIV/AIDS?
	      1. Yes
	      2. No
	      3. Don't know	

312	Are you aware of any services available for HIV/AIDS in Kampala district?
	      1. Yes
	      2. No	

313	If yes what kind of services?
	      1. HIV/AIDS counseling
	      2. HIV testing
	      3. HIV/AIDS Training and education
	      4. IEC material distribution
	      5. Condom distribution
	      6. PMTCT Services
	      7. Treatment for HIV/AIDS
	      8. Nutrition support
	      9. HIV/AIDS Support groups
	      10. Other Specify_____	

314	What strategies do you think should be put in place for HIV/AIDS care and support?
	      1. Stigma reduction
	      2. Formation of Support groups
	      3. Livelihood Skills Training
	      4. Training in and provision of Nutrition
	      5. Prompt treatment (including ART)	

	6. Home based Care 7. Other Specify_____	

315	Have you heard about HIV discordant couples?
	    1. Yes
	    2. No	

316	What are the main source of information about HIV awareness 1 ……………………………………………………………… 2……………………………………………………………….. 3………………………………………………………………. 4………………………………………………………………… 5…………………………………………………………………	