

**THE IMPACT OF HIV AND AIDS CARE AND SUPPORT  
INTERVENTIONS ON HOUSEHOLD WELFARE IN UGANDA:  
A CASE STUDY OF KYANAMUKAAGA AND BUWUNGA SUB-  
COUNTIES, MASAHA DISTRICT**

**BY**

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**DECLARATION**

I hereby declare that my study is original and has not been published and/or submitted for any other degree award to any other University before.

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## **ACRONYMS**

ADP.....	Area Development Programme
AIDS.....	Acquired Immune Deficiency Syndrome
AMREF.....	African Medical and Research Foundation
ARVs.....	Anti Retrovirals
CBOs.....	Community Based Organizations
FAO.....	Food and agriculture organization
FGD.....	Focus group discussion
HDI.....	Human Development Index
HIV .....	Human Immune Deficiency Virus
IPT-G.....	Interpersonal Psycho Therapy for Groups.
LC.....	Local council
MKADP.....	Masaka Kyanamukaaka Area development programme
MOFPED.....	Ministry of Finance, Planning and Economic Development
MRC.....	Medical Research Council
NCHS.....	National council of health services
NGOs.....	Non Governmental Organizations
OVC.....	Orphans and other vulnerable children
PEAP.....	Poverty Eradication Action Plan
PHA.....	People living HIV and AIDS
RATN.....	Regional AIDS Training Network

SSA.....Sub Saharan Africa  
TASO.....The AIDS Support Organization  
TDI.....Transformation Development Indicators  
UAC.....Uganda AIDS Commission  
UN.....United Nations  
UNAIDS.....United Nations Programme on HIV and AIDS  
UNDP.....United Nations Development Programme  
UNICEF.....United Nations Children’s Fund  
US.....United States  
USA.....United States of America  
USAID.....United States Agency for International development  
VCT.....Voluntary Counseling and Testing  
WHO.....World Health organization

## **ABSTRACT**

*The Human immune deficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS) epidemic poses a threat to economic growth in many countries through its effects on household savings and labour productivity. There are a number of interventions targeting people infected and affected by HIV and AIDS to improve their household welfare. However little is known about the impact of these interventions. The study aimed at assessing the impact World Vision Masaka Kyanamukaaka Area Development Programme (World vision MKADP) Human immune deficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS) care and support interventions on household welfare in Kyanamukaaka and Buwunga sub-counties, Masaka district.*

*Both Kyanamukaaka and Buwunga sub-counties were highly affected by the AIDS scourge due to the fact that they boarder with Rakai district where the first HIV and AIDS cases were reported, and the presence of landing sites along Lake Victoria shores which increased the AIDS scourge due to illicit sex among the fishing community. The scourge claimed productive human resource of the sub-counties resulting into orphan headed families, reduced manpower, hence reduced production levels and the resulting scarcity of food.*

*World vision MKADP, a 15 year program started in 1999 and was being implemented in two sub-counties of Kyanamukaaka and Buwunga by providing support to communities in areas of Education, Health, Agriculture, HIV and AIDS, Interpersonal Psychotherapy for Groups (IPT-G), care and support for orphans and other vulnerable children (OVC) among others. The study focused on the impact agriculture support, psychosocial support and education support on improvement of household welfare in Kyanamukaaka and Buwunga sub-counties.*

*The findings of the study showed that World vision MKADP interventions through agriculture project, psychosocial and education support has improved household welfare for people infected and affected by HIV and AIDS in Kyanamukaaka and Buwunga sub-counties. The agriculture project support led to increased productivity hence increased household incomes, food security and improved nutrition. Psychosocial support reduced depression levels among those formerly depressed leading to increased labor productivity. The education support to OVC led to increased school enrollment and education completion. As a result the OVC have got employment and are able to cater for their needs and those of other household members hence improved household welfare.*

*The study recommended that World vision should continue with the agriculture project support through provision of improved crop and animal breeds backed by trainings which have led to increased household incomes, food security and improved nutrition for people infected and affected by HIV and AIDS hence improvement in their household welfare. Other*

*Non governmental organizations (NGOs) and government should adopt it and avoid cash support/benefits which can easily be misallocated.*

*The study further recommended that World vision should continue with assessing the level of depression and where necessary provide psychosocial support before undertaking any developmental interventions since it was discovered from the study that a large percentage of people who were suffering from depression as a result of HIV and AIDS in Kyanamukaaka and Buwunga sub-counties had their productivity affected until World vision MKADP intervened with psychosocial support. Other NGOs and the government should adopt the same practice.*

*Last but not least, Support to OVC to pursue skills training was also recommended since it had a positive impact on increased school enrollment and education completion. Most OVC who completed skills training were employed unlike those who continued with formal education where very few had graduated. World vision MKADP, the government and other NGOs working in Kyanamukaaka and Buwunga sub-counties should put more emphasis on skills training as less costs are involved yet OVC graduate with practical skills.*

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 BACKGROUND**

The Human immune deficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS) epidemic poses a threat to economic growth in many countries through its effects on household savings and labour productivity. AIDS mostly affects adults in their productive years, and the infections resulting from it lead to heavy demand for expensive health care. The macroeconomic impact of AIDS comes partly from the high costs of treatment which, divert resources from productive investments. World Bank simulations on the impact of AIDS indicate a slowing of growth of income per capita by an average of 0.6% point per year in the ten worst affected countries in Sub Saharan Africa (SSA) (World Bank, 1993). Depending on how much medical care a patient gets, in the typical developing country the total cost per adult death ranges from 8 to 400% of annual income per capita (World Bank, 1993).

AIDS also kills many skilled adults adding to its economic impact. An estimated 38.6 million people live with the Human immune deficiency virus (HIV) worldwide, while about 25 million people have died already since the genesis of the pandemic (Simon et al., 2006). The cost of replacing a skilled person is substantial. A study of Thailand estimates that between 2000 and 2010, the cost of replacing long-haul truckers lost to AIDS will be \$8 million, and another study of Tanzania projects the cost of replacing teachers at \$40 million through 2010. The Tanzanian study further shows that the effects of losing an adult persist into the next generation as children are with drawn from school

to help at home. According to the study, School attendance of young people aged 15-20 is reduced by half if the household has lost an adult female member in the previous year (World Bank, 1993).

Empirical evidence to-date reveals a relationship between AIDS and poverty. HIV and AIDS are among the major causes of poverty in Africa. Hence AIDS cannot be described simply as a disease of poverty. It affects the rich and poor, creates poverty, deepens poverty and makes poverty harder to escape from (UNAIDS, 2001). HIV and AIDS are hindering economic and social development in Sub Saharan Africa (Bingu, 2007).

AIDS constitutes one of the most serious crises currently facing human development, and threatens to reverse progress in most severely affected countries for decades (Piot et al., 2001). A study conducted in Uganda, Burkina Faso and Rwanda indicated that HIV and AIDS will not only reverse efforts to reduce poverty, but will increase the percentage of people living in extreme poverty from 45% in 2000 to 51% by 2015 (UNAIDS, 2002).

In Uganda, the AIDS epidemic began to spread during the mid 1970s (World bank, 1995) and was first identified in 1982 in a fishing village on the western shores of Lake Victoria. Since then, the epidemic has had devastating effect on the demographic, economic and governance structures of the economy (Tumushabe, 2006). It is generally argued that HIV and AIDS epidemic are likely to have devastating consequences on the overall economic development of Uganda, and that those consequences are likely to be felt in the future due to the impact of skill losses (Piot, 2005).

Unlike other causes of death, AIDS deaths will continue to rise in the coming years as a result of infection that have already occurred. Infection is high among women and men in their most productive years including those most educated and skilled sectors of the populations as well as women of child bearing age with attendant transmission to children (Piot et al., 2001). AIDS also kills mostly the sexually active population who are most productive economically, leaving children and elderly who are dependants (Berkley et al., 1990). For example, the life expectancy of economically productive Ugandans dropped from 48years in 1990 to 38 years by 1997 (UAC, 2000). At the end of 2001, 600,000 cases (individuals, adults and children) were reported living with HIV and AIDS in Uganda while 84,000 AIDS deaths occurred in the same period (UNAIDS, 2002).

HIV also poses a most serious challenge to the future success in reducing poverty in the country (MOFPED, 1999). HIV and AIDS contributed to national human poverty index which reduced from 39% in 1996 to 34% in 1998, increased from 34% to 37.5% in 2000 due to reduced life expectancy to less than 40 years (UNDP, 2000). Uganda is also among countries with the lowest scores on the Human development index (HDI). The HDI for Uganda is 0.505 giving the country a rank of 154<sup>th</sup> out of 177 countries with data (HDI Report, 2007). The effect of general poverty paired with high rates of HIV infection is dramatic as the epidemic strikes an already vulnerable population. The World Bank points out that because low income households are more adversely affected by an AIDS death than other households, the epidemic will tend to worsen poverty and increase inequality (World Bank, 1999). Poverty in Uganda today affects one third of the population, with 38% estimated below the poverty line. The government of Uganda recognizes HIV and AIDS as a serious

threat to progress in poverty reduction. This is because over 80% of the reported cases are among the people aged 15-45 years, the age group that constitutes the largest part of the labour force (Piot, 2005).

Uganda has gone through 3 main phases of HIV and AIDS epidemic; Rapidly rising prevalence rates from 1980s and peaking around 1992 with antenatal prevalence ranging between 25-30% in major urban areas, nationwide declining prevalence particularly in urban areas from 18% in 1993 to 6.1% in 2000 and stabilization of HIV prevalence between 6%-7% since 2000 (Kindyomunda). Also estimates by the United states (US) census Bureau/Joint united Nations programme on HIV and AIDS (UNAIDS) regarding prevalence are that national HIV prevalence peaked sometime around 15 percent in 1991 and had fallen to 5 percent as of 2001.

Now considered to be one of the Worlds's earliest and best success stories in overcoming HIV, Uganda has experienced substantial declines in prevalence, and evidently incidence, during at least the last decade, especially among the young cohorts (USAID, 2002). The confirmation of the declining HIV prevalence from mid 1990s to 2000 when the epidemic was rapidly growing in different parts of the world show cased Uganda as a global champion in response against HIV and AIDS and a source of learning for many countries especially in developing world. This decline of HIV and AIDS prevalence in Uganda also presents an interesting case study for future control mechanisms (UN, 2001).

The decline in HIV and AIDS prevalence in Uganda is attributed partly to Multi-sectoral approach and involvement of various partners including civil society, Non governmental Organizations (NGOs), media, religious leaders, youth groups, traditional leaders, people living with HIV and AIDS (PHA), high political commitment spearheaded by the president of Uganda, openness in society in discussing matters of sexuality and reproductive health, psycho-social learning skills especially by adolescents and strong institutional framework (UN, 2001), international and local donors (AMREF & UAC, 2001). For example by 1997, over 1200 agencies were implementing HIV and AIDS related activities in the country (UAC, 2002). These organizations have increased HIV and AIDS awareness and have also provided PHA with counseling, food, shelter, clothing, school fees, basic training and income generating schemes (Tumushabe, 2006). The government position on control of the epidemic and favorable policy environment on HIV and AIDS has made it conducive for other stakeholders to respond to the challenge presented by the epidemic. Partner organizations and institutions are encouraged to identify and focus on areas where they can create most impact (Kamya, 2003).

The partners have also utilized the National HIV and AIDS strategic framework in their interventions for example a World vision Uganda HIV and AIDS strategic plan (2001-2005) was developed in the context of the national strategic framework for HIV and AIDS activities in Uganda. The strategy is a framework, which Area development programmes, projects and the national office base their plans in responding to HIV and AIDS in the areas of prevention, care and advocacy with a focus on World vision HIV and AIDS hope initiative goals (Kamatsiko & Kakande, 2004).

Masaka and Rakai in south-western Uganda were the two districts where the first people with HIV were diagnosed. Both districts have experienced the worst effects of AIDS such as social and infrastructure destruction; death of parents, youth and children; increasing number of orphans and over-stretched extended families. The most affected age group (15-49 years) has a very crucial role to play in the families and communities at large. They are heads of households, providers of labor force and leaders in society (Kamatsiko & Kakande, 2004). Studies show that the death of the able-bodied people led to reduced manpower at household and community level hence reduced production levels and the resulting scarcity of food (Wasike, 2004). Masaka district which was one time referred to as the food basket for the country in the 60s and 70s has been hard hit by AIDS which has adversely affected the productive capacity of people. The prevailing abject poverty in the district is linked to AIDS which has claimed the most productive age group 15-49 years resulting into inadequate food reserves, lack of access to credit and low nutrition (World vision MKADP, 2005) (Bamulangaki, 2006) in agreement. As such HIV and AIDS have touched the very aspect of national development (Kamatsiko & Kakande, 2004). As stated by a number of commentators, AIDS is therefore a development problem and not just a health issue (Loevinsohn & Gillespie, 2003).

Kyanamukaaka and Buwunga Sub-counties in Masaka district were not spared from the epidemic. The sub-counties were highly affected by the AIDS scourge due to the fact that they boarder with Rakai district where the first HIV and AIDS cases were reported and the presence of landing sites along lake Victoria shores like Ddimu, Namirembe, Kalokoso and Malembo due to illicit sex in the

fishing community. It is estimated that 16% of the youth between 16 and 20 years in Kyanamukaaka Sub-county are infected with HIV and AIDS. The scourge has also claimed household heads resulting into orphan headed families (Ssempijja, 2008).

Poverty seems to be the central problem affecting people's lives. The average household income among these community members ( in Kyanamukaaka and Buwunga) is about \$70 to \$100 per annum, which cannot effectively meet family obligations yet family sizes are fairly large with an average of 6 members (Mugabi, 1999). This has been made worse by having orphan, elderly and widow headed households where the heads are either very young or old, or do not have access to production resources, or are not in position to produce due to depression resulting into poor household welfare. For example in a research conducted by World vision Uganda and John Hopkins University, depression levels were found to be 21% due to HIV and AIDS pandemic. Study participants described depression as characterized by lack of hope, thoughts of suicide, reckless behavior, including disregard of ones own health. Those suffering from depression found it 20 times more difficult to complete given tasks than those who were not (Male, 2007).

In response to HIV and AIDS, a number of NGOs have come up to assist the affected persons/communities in Kyanamukaaka and Buwunga sub-counties. One such NGO is World vision Masaka Kyanamukaaka Area Development Programme (MKADP) which is the case study of the research. World vision MKADP is a 15 year program supported by World Vision Uganda. It started in 1999 and is being implemented in Kyanamukaaka and Buwunga sub counties. World vision

MKADP is supporting communities in areas of Education, Health, Agriculture, Leadership development, HIV and AIDS, Interpersonal Psychotherapy for Groups (IPT-G), Water and Sanitation, orphans and other vulnerable children (OVC) care and support, gender, disaster preparedness and Child Sponsorship Services (Calibre consult, 2007).

## **1.2 STATEMENT OF THE PROBLEM**

The HIV and AIDS scourge in Kyanamukaaka and Buwunga sub-counties led to loss of productive human resource resulting into orphan headed households, reduced manpower at household and community level and hence the reduced production levels, resulting into scarcity of food. This has been made worse by having orphan, elderly and widow headed households where the household heads are either very young or old, or do not have access to production resources, or are not in position to produce due to depression.

There are a number of interventions targeting people infected and affected by HIV and AIDS to improve their household welfare. However little is known about the impact of these interventions. Therefore the study seeks to find out the impact of HIV and AIDS care and support interventions by World vision Masaka Kyanamukaaka Area Development Programme (MKADP) on household welfare for people infected and affected by HIV and AIDS in Kyanamukaaka and Buwunga sub-counties.

### **1.3 RESEARCH OBJECTIVES**

#### **GENERAL OBJECTIVE**

The study sought to assess the impact of World Vision Masaka Kyanamukaaka Area Development Programme (MKADP) Human immune deficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS) care and support interventions on household welfare in Kyanamukaaka and Buwunga sub-counties.

#### **SPECIFIC OBJECTIVES**

- i. Establish the impact of Agriculture project support on incomes, food security and nutrition of households for people infected and affected by HIV and AIDS.
- ii. Establish the impact of psychosocial support on labor productivity of households for people infected and affected by HIV and AIDS.
- iii. Establish the impact of Education support to orphans and other vulnerable children on their school enrollment and education completion.

### **1.4 RESEARCH QUESTIONS**

- i. Has the Agriculture project support led to increased incomes, food security and improved nutrition for households of people infected and affected by HIV and AIDS?
- ii. Has psychosocial support increased labor productivity for households of people infected and affected by HIV and AIDS?
- iii. Has the Education support to orphans and other vulnerable children led to their increased enrollment and education completion?

## **1.5 SIGNIFICANCE OF THE STUDY**

Understanding the impact of Human immune deficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS) care and support interventions by World Vision Masaka Kyanamukaaka (MKADP) on household welfare is important because these interventions were in response to effects of HIV and AIDS on household welfare in Kyanamukaaka and Buwunga sub-counties. These effects included loss of able bodied people who were productive resulting into reduced production hence reduced household incomes, food insecurity, malnutrition, orphan headed households (Wasike, 2004) and increased depression levels (Male, 2007).

## **1.6 SCOPE OF THE STUDY**

The study was conducted in Kyanamukaaka and Buwunga sub-counties. The sub-counties had a total population of 83,738 with 45,199 and 38,539 people in Kyanamukaaka and Buwunga respectively (UBOS, 2002). The study focused on the impact of HIV and AIDS care and support interventions by World Vision MKADP on the welfare of households for people infected and affected by HIV and AIDS. The infected include people living with HIV and AIDS (PHA) while the affected group includes those who lost their loved ones due to HIV and AIDS like OVC, widows and widowers.

The study mainly used secondary data from three surveys. These were end of phase 1 evaluation for World vision MKADP by Wasike (2004), end of phase 11 evaluation for World vision MKADP by Calibre consult (2007), and Transformation development indicator (TDI) survey by World vision MKADP (2007). The purpose of the end of phase evaluations of 2004 and 2007 and the TDI survey

of 2007 was to inform the stakeholders (the district, Sub-counties, World Vision and the entire community of Kyanamukaaka ADP) about the impact of World vision interventions on the beneficiary communities.

During the study, other World vision MKADP reports were consulted and key informant interviews conducted to supplement data collected from the reviews.

### **1.7 PROGRAMME BENEFICIARIES**

The primary programme beneficiaries are OVC of Kyanamukaaka and Buwunga sub-counties, their guardians, community leaders and farmers. Women and girl child are targeted as a special interest group. People with disabilities are also given special attention in distribution of programme benefits (World vision MKADP, 2005). Widows, widowers, PHA and youth also benefit. In the case of children, the programme addresses issues related to registered children and OVC with a focus on male and female both in and out of school. Secondary beneficiaries are men and women considered key partners for sustainability (Calibre consult, 2007).

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 INTRODUCTION**

This chapter presents a review of literature on the effects of Human immune deficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS) on household welfare. It also highlights a number of interventions from different settings to address these effects. The theoretical review presented in section 2.1 highlights studies by other researchers on the role of Non Governmental organization (NGOs) in providing HIV and AIDS care and support interventions to improve welfare for people infected and affected by HIV and AIDS. The empirical review on the impact of HIV and AIDS from different countries is presented in section 2.2. Section 2.3 highlights the HIV and AIDS care and support interventions by World vision Masaka Kyanamukaaka Area development programme (World vision MKADP) in Kyanamukaaka and Buwunga sub-counties.

#### **2.1 THEORETICAL REVIEW**

According to Frik & Hennie (2000) if a government is not able to provide all the services required in the field of welfare, development, local government and economic growth, it should utilize NGOs to fulfill these functions. Likewise in Uganda, there is inadequate capacity of state institutions to provide extensive welfare services (Dounahue, 1998). Since there is inadequate capacity by state institutions in Uganda to provide all HIV and AIDS care and support interventions, the government of Uganda has utilized a multisectoral approach so as to improve the welfare of people infected and affected by HIV and AIDS.

The multi-sectoral approach in response to the impact of HIV and AIDS epidemic has emphasized the role of civil society in controlling the HIV and AIDS spread, and mitigating associated effects. NGOs have modeled a number of approaches to mitigate the challenges that AIDS has inflicted on society and to tackle its long-term challenges (UNAIDS, 2006). NGOs possess institutional mechanisms that help mobilize people into solidarity groups, which are capable of mitigating HIV and AIDS challenges (Jamil & Muriisa, 2004).

Like other NGOs, World vision MKADP has had HIV and AIDS interventions. A theoretical framework which describes responses/ interventions by World vision MKADP and desired effects on the welfare of people infected and affected by HIV and AIDS is described below.

### **2.1.1 THEORETICAL FRAMEWORK**

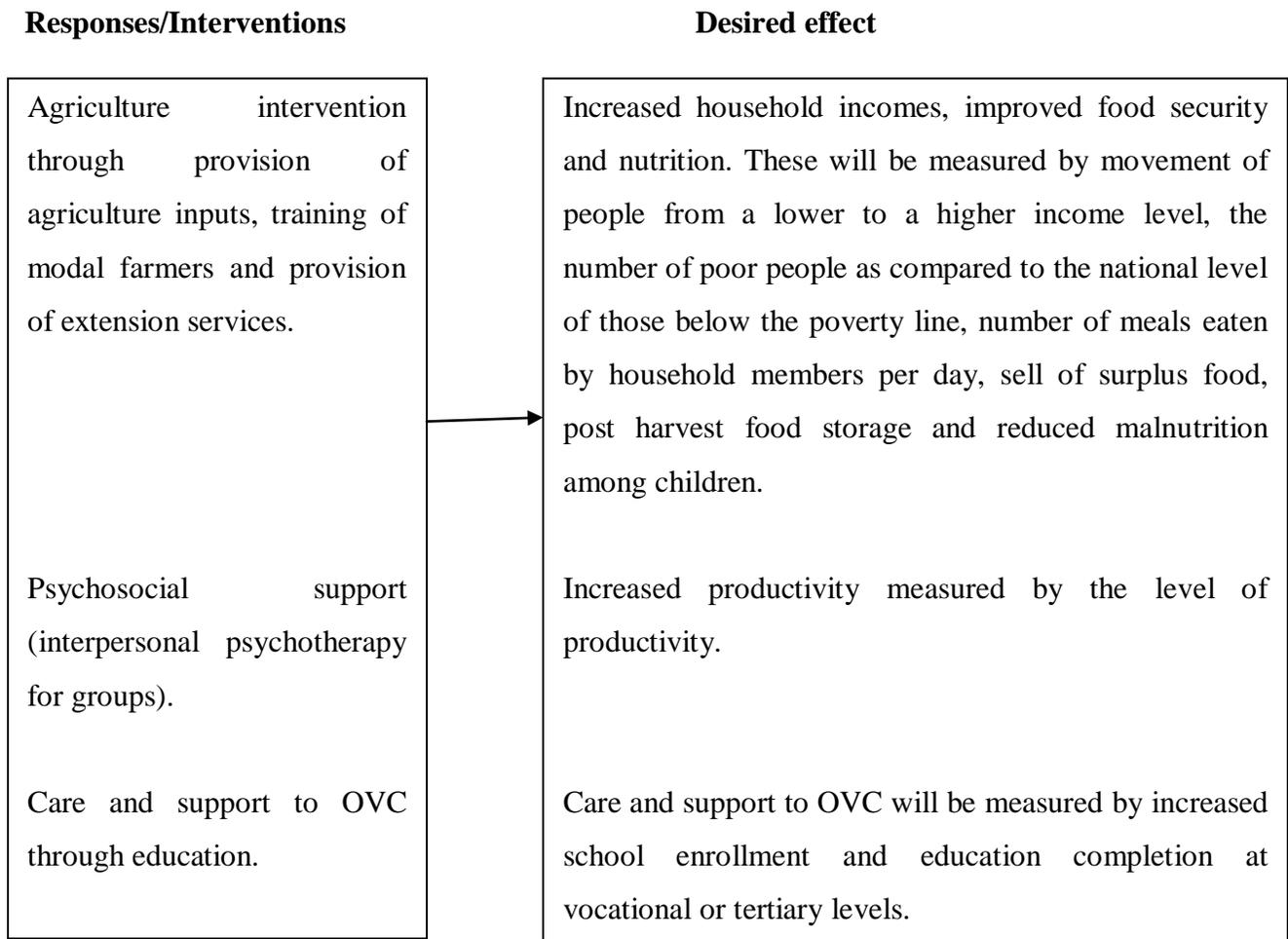
According to the theoretical framework, the responses/interventions should lead to desired effects.

Agriculture intervention through provision of agriculture inputs, training of model farmers and provision of extension services should lead to increased out put and in turn increase household incomes, food security and improve nutrition.

Psychosocial support should lead to increased productivity for people formerly depressed due to HIV and AIDS.

Education support to OVC should lead to increased school enrollment and education completion by OVC at vocational and tertiary levels.

### 2.1.2 THEORETICAL FRAMEWORK SUMMARISED



Source (by author)

## **2.2 SUMMARY OF ISSUES COVERED**

### **2.2.1 EFFECTS OF HIV AND AIDS ON HOUSEHOLD WELFARE**

The illness and death of individuals affects the various institutions/communities to which they belong. The household is one such institution and possibly the worst affected by the HIV and AIDS epidemic. The characteristics of the virus, its concentration in certain age groups, the mode of transmission and progression, and the stigma attached to HIV and AIDS can seriously affect the economic welfare of a household. HIV and AIDS also tend to drive the household into a process from which it may be difficult to break away. The process may be illustrated by dividing it into three phases of household impact: the illness, death and long term consequences (Loewenson & Whiteside, 1997).

In responding to effects of the epidemic, households developed coping mechanisms. The impacts of the first stage of coping mechanisms are reversible in the sense that the reallocation of economic resources and labour has only a temporary consequence. The second stage is irreversible as assets of the family and household may be converted into cash to meet the changed requirements. In this stage children could easily get deprived of education and care. The third stage the household depends on charity or eventually breaks up (Isaksen et al., 2000).

There is also loss of members, grief, impoverishment, forced migration, lack of income for health care and education, inability to provide parental care, decrease in middle generation in households

leaving the very old and young, stress, dissolution, and demoralization (Hunter & Williamson, 2000).

#### **2.2.1.1 EFFECTS OF HIV AND AIDS ON HOUSEHOLD INCOME**

Foster identified 3 stages of illness and death from AIDS. These were: Illness, the period following immediately after death and the long term aftermath (Foster, 1996).

Illness, where the concentration of HIV infection in the productive age group has significant implications for the productive capacity and income of affected households, the period following immediately after death where survivors contended not only with the emotional loss, but also with medical and funeral expenses, and the loss of income and services that a prime age adult typically provided and the longer term aftermath with long term impacts like orphaning. The impact of HIV and AIDS illness at household level is serious. Household income falls while costs increase (Foster, 1996).

HIV and AIDS affect the availability of disposable income. During episodes of illness, household financial resources are diverted to pay for medical treatment and eventually to meet funeral costs. Loss of income, additional care related expenses, reduced ability to work and mounting medical fees and funeral expenses collectively push affected households deeper into poverty (UNAIDS, 2006). A study of Uganda has shown that the burden of socio economic impact of HIV and AIDS is disproportionately affecting rural women. More households were found to be headed by AIDS

widows than widowers. Widows lost access to land, labour, inputs, credit and support services. HIV and AIDS stigmatization compounded their situation further (Bailer, 1997).

Also the growing number of orphans was likely to alter and affect households' economic strategies, in particular their decisions on consumption and investment (Dounahue, 1998).

#### **2.2.1.2 EFFECTS OF HIV AND AIDS ON AGRICULTURE PRODUCTION**

Agriculture is the dominant sector in Uganda's economy (FAO, 2003), and is a primary livelihood base for many people who in Uganda live with, or are affected by HIV. Access to food and livelihood security is often fundamental to people's choices. Similarly, the consequences of AIDS-linked illness and death, which is seen through households, extended families, communities and beyond, are shaped by features of agricultural and livelihood systems (Loevinsohn & Gillespie, 2003).

In agriculture, bulk of production is concentrated exclusively on small holder farms and tends to be labour intensive. At farm level, AIDS affects labour quantity and quality. AIDS affects availability of disposable income used to purchase agriculture inputs, occasional extra labour or complementary inputs. So subsistence production is preferred. Compositions of crops are altered and area under cultivation reduced (World Bank, 1995). Therefore the AIDS epidemic has had major effects on food security in high prevalence countries (UNAIDS, 2008).

HIV and AIDS are estimated to reduce gross domestic production (GDP) by 2% in several affected countries like Uganda annually. Agricultural production has been shown to decrease by 37-61% in such countries. It has also been observed that in some parts of Uganda HIV and AIDS have led to a shift from high to low labour-intensive farming systems and a decline in production of cash crops (UAC, 2000). A major cause for declining yields/productivity for both food and cash crops is household members' illness and death and survivors inability to practice recommended agronomic activities (FAO, 2003). Affected families reduce the cultivation of labour intensive crops and shift to low labour input food crops including vegetables. For example among the affected families, banana cultivation reduced by 36%, coffee by 29%, millet by 30%, beans by 23%, maize by 23% while sorghum and pumpkin increased by 11% and 15% respectively (FAO, 2003). Non affected families decreased cultivation of food crops like peas by 76%, millet by 30%, pumpkins by 58%, sorghum by 26% while increasing cultivation of cash crops like maize by 47%, ground nuts by 16% and coffee by 4% (FAO, 2003).

HIV and AIDS have also resulted into changed areas of land cropped, type of crops grown, and farming practices used. In case of child headed households, or when widow headed household heads fall sick, older children have to look after their siblings and at the same time carry out a wide range of agricultural activities. Orphans cannot not sustain agricultural production at the same level as their parents did because they lack the requisite knowledge, skills and experience hence compromising the quantity and quality of agricultural production (FAO, 2003).

AIDS also impacts communities by altering values. Many people who have been affected or infected by HIV and AIDS develop a short term outlook. In terms of economic activities they often prefer to invest in petty trading, rather than agricultural enterprises whose returns take long to accrue. From the perspective of a poor household, even growing annual crops can be risky. Also the children left behind when their parents die may not have acquired enough skills to perform key agriculture and economic activities. This increases livelihood insecurity (Loevinsohn & Gillespie, 2003).

#### **2.2.1.3 EFFECTS OF HIV AND AIDS ON NUTRITION**

Evidence suggests that HIV and AIDS disproportionately affect agriculture relative to other sectors (IFAD, 2001). This is not because rates of HIV are higher among workers in the agricultural sector than elsewhere, but because the structure of agriculture sector especially small holder sub sector is much less able to absorb the impact of human resource losses associated with the epidemic. More over this impact on agriculture is likely to be far reaching as over 70% of the population depend on the sector for livelihood. In agrarian societies, the HIV and AIDS epidemic intensifies existing labour bottle necks and increases malnutrition (Waal & Tumushabe, 2003). For example farming systems are already un able to provide sufficient protein and or energy requirements thus susceptible to increased malnutrition (World Bank, 1995).

Children and adults in AIDS afflicted households were found to be less well nourished, more likely to be sick and to die from all causes. There was reduction in household quantity and quality/variety of food leading to both adult and child malnutrition. Evidence from south and eastern Africa showed

that households affected by HIV and AIDS ate fewer meals, consumed poorer foods and invested less in health of surviving members (Waal & Tumushabe, 2003). In Uganda, 23% of Children (0-5 years) were under weight for age in 2004 making Uganda the 41<sup>st</sup> in rank (HDI Report, 2007). This could have been attributed to the HIV and AIDS epidemic.

#### **2.2.1.4 EFFECTS OF HIV AND AIDS ON FOOD SECURITY**

HIV poses a potentially major threat to food security and nutrition mainly by diminishing availability of food due to falling production, loss of family labour, land, livestock and other assets, and reducing access to food as households have less money. Research carried out in Uganda in 1990s showed that food insecurity and malnutrition ranked foremost among the immediate problems faced by female headed AIDS affected households (UNAIDS, 2006).

In general households have lost self sufficiency. This is attributed to the reduced availability of produce that results from less land being cropped and the larger household sizes. Fostering orphans appear to constrain many households' ability to meet their own food requirements. Death in a household also puts an added stress on food availability. Mourning lasts for an average of two to three days during which time much food is consumed and many expenses incurred while farming activities are suspended (FAO, 2003).

The declining productivity of HIV positive individuals is primarily and initially felt within the family. Household labour quantity and quality are reduced initially in terms of productivity when an

HIV infected person is ill and later supply of household labour falls with death of the person (Desmond & Karen, etal).

The employed people living with HIV and AIDS (PHA) are not able to work for long or they put in less effort to prolong their life. Household members also spend up to 50% more on funerals than on medical care (UNAIDS, 2002). The inability to work and the eventual death of household members reduces the amount of labour for subsistence agriculture, cash income generating activities and general wage labour hence limiting resources of the household (Isaksen et al., 2000).

Household members devote productive time caring for the sick persons, traditional mourning customs which last as long as 40 days for some family members which adversely affect labour availability (Bailer, 1997). The quantity of labour is affected as members of afflicted households spend time looking after the sick and burying the dead and less time in agricultural pursuits. Other members of society are also affected for time spent at funerals and visiting the sick. Traditionally, funerals ceremonies last 4-7 days, with more celebrations after one month or 40 days or a year (Loevinsohn & Gillespie, 2003). In Uganda some traditions require that the dead be buried at a specific place (usually the ancestral grounds) irrespective of where one dies. A minimum of 4days are spent on mourning and if the deceased was the head of the family it takes 7days. The amount of time spent on funerals has a devastating impact on work and output since majority of the affected adults are the work force. The impact is observed in reduced out put, deepening poverty, increased economic dependence and food insecurity (Dounahue, 1998).

Disruption of family as an economic unit undermines household food security, thus reduced productive capacity, purchasing power and food availability per householder (World Bank, 1995). Surviving household members are under increased pressure to seek agricultural wage labour or pursue non agricultural income generating activities that yield a quick return. In either case labour available for on farm work is further reduced and less available at critical moments in the season. Affected households are also forced to reduce their reliance on labour or input intensive crop or livestock enterprises, and focused on activities that are of reduced scale and with fewer risks, but that also have lower output or provide less income (Loevinsohn & Gillespie, 2003).

### **2.2.2 PSYCHOSOCIAL IMPACT OF HIV AND AIDS**

The AIDS epidemic has had adverse psychological and economic consequences leading to changes in family structure (Ankrah, 1993). The psychological impact of illness and death of an individual leads to depression and a lack of motivation to work hard among other family members (Waal & Tumushabe, 2003). The continuing discrimination and stigmatization of people living with HIV and AIDS (PLHA) even when a lot of sensitization has been made, makes people living with HIV and AIDS experience trauma, distress, stress and depression (UAC & Uganda HIV/AIDS partnership, 2004).

### **2.2.3 EFFECTS OF HIV AND AIDS ON CHILDREN**

In sub Saharan Africa nearly 12 million children under 18 years have lost one or both parents to HIV (UNICEF, UNAIDS & WHO, 2008). According to Uganda AIDS commission (UAC), Uganda has the highest number of orphans in the Sub-Saharan Africa. It is estimated that 1.1 million orphans below the age of 15 lost one or both parents due to HIV and AIDS thus creating disadvantaged persons who are less likely to get fed, go to school or receive health care, all factors that characterize poverty. Uganda's orphan crisis will continue to strain society's resources for many decades (UNAIDS, 2002). The growing number of orphans is likely to alter and affect households' economic strategies, in particular their decisions on consumption and investment (Deininger, Crommelynck & Kempaka (2005).

AIDS is the leading cause of death among children under five years old significantly increasing mortality rate of this age group (UNAIDS, 2006). HIV also lowered life expectancy and reversed gains in child survival in East and Central Africa (Nicoll et al., 1999). Child headed households already exist in most districts particularly in Rakai and Masaka, and are expected to increase in Uganda if the epidemic is not effectively contained (MOFPED, 1995).

The toll of HIV and AIDS on households can be very severe. In many cases presence of AIDS means that the household will dissolve as parents die and children are sent to relatives for care and upbringing (UNAIDS, 2006). Much of the burden of caring for children orphaned as a result of HIV

falls on the elderly especially grand mothers who step in when one or both parents die (UNICEF, 2007). In addition to trauma of losing one or both parents, being orphaned as a result of HIV increases vulnerability in many ways. Loss of a parent leads to a significant decline in the standard of living and increases the likelihood of exploitation. Where both parents die, children become heads of households assuming enormous burdens at an early stage (WHO, 2004). One of the most obvious impacts of the epidemic is increase in the work performed by children sometimes as young as five years old. The workload of children starts when parents become sick and increases when children become orphaned. The workload of orphans may be greater than that of non orphans who live in the same household (Foster, G. & Williamson J. 2000).

Children in sub Saharan Africa are probably the most vulnerable group and suffer hard from the HIV and AIDS epidemic when left as orphans (Isaksen et al., 2000). A wide variety of other problems affect orphans including increased food insecurity, stigma, discrimination, reduced access to education and economic opportunities (Desmond et al., 2000). Vulnerability of children increases long before the death of a parent or guardian. Children watch a parent deteriorate and eventually die (Wagt et., al). Children experience orphan hood at critical ages when parental guidance and socialization is needed most. There is Lack of quality care giving, education, nutrition and socialization of children whose parents are bedridden or have died (UNAIDS, 2006). They often face loss of family and identity, increased malnutrition and reduced opportunity for education (Wagt et., al) (Isaksen et al., 2000 in agreement). Without adequate care and support, many are exposed to exploitative child labour and abuse and face increased vulnerability to HIV infection (Wagt et., al).

Education is critical to children's future potential and sense of self esteem, and to the generational transmission of knowledge and values within societies (WHO, 2004). Decline in school enrolment is one of the most visible effects of the epidemic. Contributing factors include removal of children from school to care for parents and family members, inability to afford school fees and other expenses (UNAIDS, 2006). In a household survey of 56 countries, orphans who had lost both parents were on average, 12% less likely to attend school than non orphans (WHO, 2004). 71% of children 15-19 years of age whose parents had died had their schooling interrupted while only 29% had their schooling uninterrupted. 25% lost school time and 45% dropped out of school (Sengendo & Nambi, 1997). Child education was disrupted when a parent became ill. Children reported a decline in school attendance and school performance by 26% and 25% respectively when parents became ill (Gilborn et al., 2001).

### **2.3 WORLD VISION MKADP HIV AND AIDS CARE AND SUPPORT INTERVENTIONS IN KYANAMUKAACA AND BUWUNGA SUB-COUNTIES.**

World vision MKADP covers two sub-counties of Kyanamukaaka and Buwunga with a total population of about 83,738 with 41,706 Female and 41,935 Male (UBOS, 2002). Close to 50% of the population are female and 50% children below 18 years. This is the group, which does the cultivation, while the male, elderly and very young children are like dependants. 89% of the community of Kyanamukaaka ADP is involved in agriculture, 7% business, 2% salary, and 2% other

as source of income while 61% have agriculture, 34% animal husbandry and 5% business as their main source of livelihood (Wasike, 2004).

World vision MKADP interventions cover some areas which were first hit by HIV and AIDS and yet people did not know the genesis of the disease. The AIDS scourge left so many widows and orphans who needed support hence the HIV and AIDS interventions by the programme. The death of able-bodied people led to reduced manpower at household and community level leading to reduced production levels and the resultant scarcity of food. The World vision MKADP agricultural component was a timely intervention to train the old folk and children in improved methods of production and thereafter gave them superior breeds of livestock and varieties of crops (Calibre consult, 2007).

World vision MKADP also provided income generating activities, payment of school fees for orphans and other vulnerable children, psychosocial support and food supplements among others (Calibre consult, 2007).

### **2.3.1 AGRICULTURE INTERVENTIONS**

Households are supported to rear improved breeds of livestock to ensure safe food stuff through out the year, surplus food stuffs are sold to earn cash income, ensure balanced diet and stable families. The strategies used to achieve this are provision of hybrid seeds and other planting materials, adopting improved farming practices, providing exotic animal breeds and providing extension

service to farmers (Mugabi, 1999). The objective of the agriculture interventions was to improve food security and household incomes for 3000 families by 2008 through training of 100 farmers in 100 villages, supporting the trained farmers with improved seeds and farm inputs (Sajjabi, 2006).

In an effort to enhance attainment of self sufficiency in food production and increase household incomes, World vision MKADP provided training to 327 contact farmers with skills in modern production practices and organic farming. The community members also had access to improved crop varieties and livestock breeds (Calibre consult, 2007). Various inputs like; 250 Goats were procured and given out to children of IPT-G clients (Sajjabi, 2005), 5 churches were given 8 pigs each, beans and maize seeds to use the proceeds to care for OVC, 18,000 improved banana suckers, 100 sacks of mosaic resistant cassava cuttings, 200 bags of vitamin A orange-fleshed sweet potato vines, 20,000 coronal coffee seedlings, 800 Kgs of beans and 500 Kgs of improved maize seeds, 136 goats, 230 pig lets were procured and given out to model farmers for multiplication as income generating activities (Sajjabi, 2006). A 50 revolving heifer scheme where the beneficiaries pass on the off springs to others, 600 improved banana plantation sites at modal farmers places and 10 bull centres were put in place for improving local cattle, 23 he goat centres to improve the quality of local goats were put in place, 1000 local goats, 1000 pigs given to improve nutrition and income, and 3800 registered children and their families received income generating activities (Sajjabi, 2007).

### **2.3.2 PSYCHOSOCIAL INTERVENTIONS**

Since its induction in 1999, World vision MKADP started with development activities. The community was supported through provision of beddings, construction of houses, provision of goats, cows and scholastic materials. However, during follow up of activities, the community facilitators realized that people were not caring for the items offered by World vision MKADP. The animals were dying, parents were not taking children to school and gardens were abandoned (Male, 2007). A research by World vision Uganda and John Hopkins University in 2000 showed high prevalence levels of depression (21%) as a result of HIV and AIDS epidemic. Study participants described depression characterized by lack of hope, thoughts of suicide, and reckless behavior, including disregard of ones own health. Those suffering from depression were unable to function normally, they found it 20 times more difficult to complete given tasks than those not suffering from depression in the study. The interpersonal psychotherapy for groups (IPT-G) approach was then introduced in World vision MKADP to deal with HIV and AIDS related depression (Male, 2007). Those who had received the intervention showed dramatically reduced symptoms of depression and dramatically improved function. As a result of the above, interpersonal psychotherapy for groups (IPT-G) was introduced in 2002 as a treatment for depression and was later integrated into the ADP in 2004 (Male, 2007).

Over 1000 people benefited from IPT-G both directly and indirectly. Those people that went through IPT-G have helped other community members through counseling and have been able to treat their family members much better than before joining the therapy. 26 Volunteers were trained in the IPT-

G model (12 Females and 14 Males). 50 people have accessed IPT-G under the Community led model through volunteers while the rest 950 accessed IPT-G through staff. Many people who were not able to work before they joined the group have regained their functionality and are now able to work and care for their families. Those that had lost hope have regained their hope and people living with HIV and AIDS through the IPT-G model have been guided to testing centers and are accessing ARVS. 30 IPT-G have been equipped with income generating activities in form of pigs, goats, and bananas now that they are more functional. 250 Goats were also procured and given out to children of IPT-G clients (Sajjabi, 2005)

### **2.3.3 EDUCATION SUPPORT TO OVC**

The objective of the education support was to promote Skills development among the orphan youth through equipping them with life sustaining artisan skills, provision of tool kits and payment of Fees (Mugabi, 1999). To achieve this, World vision MKADP provided educational support to orphans and other vulnerable children to pursue primary and post primary education. The scope of educational support by World vision MKADP was through provision of uniforms, exercise books, pens and pencils, school fees subsidy and support for school meals. Priority was given to registered children although OVC were also supported. The programme was supporting a total of 867 children in secondary and tertiary school and about 6000 needy primary going children are supported with exercise books and uniforms (Wasike, 2004).

51 OVC were facilitated to pursue skills training in carpentry and joinery, brick laying and concrete practice, motor vehicle mechanics and hairdressing. Some were helped to complete their secondary education (Sajjabi, 2006).

## **2.4 CONCLUSION**

HIV and AIDS have had an effect on household incomes by affecting the availability of disposable income. This is because during episodes of illness, household financial resources are diverted to pay for medical treatment and eventually to meet funeral costs. Loss of income, additional care related expenses, reduced ability to work and mounting medical fees and funeral expenses collectively push affected households deeper in into poverty.

HIV and AIDS have also affected the agriculture production. Agriculture is the dominant sector in Uganda's economy, and is a primary livelihood base for many people who in Uganda live with, or are affected by HIV and AIDS yet bulk of production is concentrated exclusively on small holder farms and tends to be labor intensive. At farm level, AIDS affects labour quantity and quality hence reduced production and the resultant scarcity of food, adult and child malnutrition.

AIDS illness and death affects psychosocial well being of an individual leading to depression and a lack of motivation to work hard among other family members hence reduced household labour productivity for households of people infected and affected by HIV and AIDS.

HIV and AIDS further leads to orphanage thus creating disadvantaged persons, who are less likely to get fed, go to school or receive health care, all factors that characterise poverty.

In Uganda, there has been a multi-sectoral approach in response to the impact of HIV and AIDS epidemic in controlling its spread, and mitigating associated effects. This has been by the government, civil society organizations and groups of people living with HIV and AIDS.

World vision Masaka Kyanamukaaka area development programme one of such organizations which was the case of the study has carried out agriculture, psychosocial and education support interventions to improve welfare of households for people infected and affected by HIV and AIDS in Kyanamukaaka and Buwunga sub-counties, Masaka district.

## **CHAPTER 3**

### **METHODOLOGY**

#### **3.0 INTRODUCTION**

This chapter presents in section 3.1 the research designs used, section 3.2 the sample and sampling techniques, section 3.3 the type of data collected as per research objectives and section 3.4 data analysis techniques used. Section 3.5 presents the conclusion of the chapter.

#### **3.1 RESEARCH DESIGN**

Quantitative and qualitative study designs were used. Mainly document review was done and was supplemented by primary data on the impact of World vision Masaka Kyanamukaaka Area development programme (MKADP) Human immune deficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS) care and support interventions on household welfare in Kyanamukaaka and Buwunga sub-counties.

#### **3.2 THE SAMPLE AND SAMPLING TECHNIQUES**

This work was mainly based on three reviews. These were World vision MKADP end of phase one evaluation survey by Wasike, 2004, World vision MKADP end of phase two evaluation survey by Calibre consult, 2007, and TDI 2004 and 2007 surveys by World vision MKADP. The purpose of the above reviews was to inform stakeholders on whether the programme interventions had improved welfare of the beneficiaries. In addition to this, World vision MKADP; psychosocial

project semi annual report 2004, annual report 2006, biannual report 2007, psychosocial annual report 2007 and IPT-G update 2008 were used in the analysis.

During the 2004 (end of phase one) evaluation survey for World vision MKADP, 9 out of 17 parishes from Kyanamukaaka and Buwunga sub-counties were selected. 15 villages were randomly selected from the 9 parishes and they were considered as primary sampling units. Data was collected using household interviews conducted in 450 households, focus group discussions held with registered children and Women groups and key informant interviews held with people knowledgeable about the issue under investigation (Wasike 2004).

For the 2007 (end of phase two) evaluation for World vision MKADP, cross-sectional survey research design applying quantitative and qualitative methods was used. Purposive and simple random sampling techniques were used to ensure reasonable geographical spread of respondents. Information was collected through discussions with implementers, review of documents and administration of semi-structured and household survey questionnaires. A total of 648 respondents were involved. These included World Vision staff, the district and sub-county leaders, civil society and targeted beneficiaries who were purposively selected. Instruments used included the survey questionnaire (responded to by 480 households), the progress indicators checklist, World Vision interview guide, evaluation questions guide, focus group discussion guide, school and health facility assessment tools. The review process involved scrutinizing specific issues to be addressed, number of beneficiaries targeted, planned interventions for ensuring development at both community and

household level for improving welfare of children and their families with strengthened community development efforts to mitigate adverse effects of HIV, AIDS and poverty (Calibre consult, 2007).

Even though the number of households which were sampled in the first evaluation were different from those sampled in the second phase evaluation, the samples were drawn from the same area whereby the initial conditions before World vision MKADP interventions remained the same. In the first evaluation, 450 households were sampled whereas in the second phase evaluation, 480 households were sampled.

For the Transformation development indicator (TDI) survey of World vision MKADP, 900 households within the program area were selected. 30 households per village from 30 villages were visited (TDI, 2007).

To supplement the secondary data collected from reviews and reports, individual interviews were conducted for 10 key informants. The key informants were: Three World vision staff, three community committee members, two psychosocial volunteers and two politicians one from Kyanamukaaka and one from Buwunga sub-counties. These were purposively selected because of their knowledge of the issues under investigation.

### **3.3 DATA TYPE**

Quantitative and qualitative data was collected. Secondary quantitative and qualitative data was collected while only qualitative data was collected from interviews with key informants. Information was collected as per research objectives.

To address objective one which is the impact of agriculture project interventions on incomes, nutrition and food security for households of people infected and affected by HIV and AIDS, data was collected on: Impact on incomes which was measured by movement of households from a lower to a higher income level and the number of poor people as compared to the national figure, impact on nutrition which was measured by reduction in the number of malnourished children and by the number of meals eaten by households per day, and impact on food security which was measured by sell of surplus food and post harvest food storage.

For objective two, data on the impact of psychosocial support on labor productivity of households for people infected and affected by HIV and AIDS was collected and this was measured by the level of labor productivity.

Lastly for objective three, data on the impact of education support to orphans and other vulnerable children (OVC) was collected. This was measured by; school enrollment and education completion at vocational or tertiary level.

### **3.4 DATA ANALYSIS**

Quantitative data was analyzed using excel spread sheets and presented in form of results. Numbers, percentages and figures illustrate results on the impact of World vision MKADP HIV and AIDS care and support interventions on household welfare for people infected and affected by HIV and AIDS in Kyanamukaaka and Buwunga sub-counties. Qualitative data from key informant interviews was organized, sorted and results were presented as per study objectives in qualitative form.

### **3.5 CONCLUSION**

The study employed qualitative and quantitative designs. Mainly document review was carried out, and was supplemented by primary data from key informants who were purposively selected. Information was collected on the impact of agriculture project interventions on incomes, nutrition and food security for households of people infected and affected by HIV and AIDS, impact of psychosocial support on labour productivity of households for people infected and affected by HIV and AIDS and impact of education support to orphans and other vulnerable children. Data was organised, sorted and analysed using excel spread sheets and presented in form of results.

## **CHAPTER 4**

### **RESULTS AND DISCUSSION**

#### **4.0 INTRODUCTION**

This chapter presents results of the study and their discussion. Generally, it was established from the study that assistance by World vision Masaka Kyanamukaaka area development programme (World vision MKADP) to households in Kyanamukaaka and Buwunga sub-counties led to improved welfare for people infected and affected by Human immune deficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS).

Section 4.1 presents results as per objective one; the impact of agriculture project support on household incomes, food security and nutrition for households of people infected and affected by HIV and AIDS. Section 4.2 presents results as per objective two; the impact of psychosocial support on labour productivity for households of people infected and affected by HIV and AIDS. Section 4.3 presents results as per objective three; impact of education support on school enrolment and education completion by orphans and other vulnerable children. Section 4.4 presents a conclusion of the chapter.

#### **4.1 RESULTS AS PER OBJECTIVE ONE:**

##### **4.1.1 IMPACT OF AGRICULTURE PROJECT SUPPORT ON HOUSEHOLD INCOMES**

The agricultural package by World vision MKADP consisting of extension services and farm tools enhanced the capacity of families to mitigate the social and economic impacts of HIV and AIDS such as large numbers of orphans, depleted incomes and insufficient food. World vision MKADP assisted to raise agricultural production and incomes by training modal farmers, making available improved varieties of planting materials and better breeds of livestock for multiplication. Most households reported increase in their household income resulting from World vision MKADP activities like training in improved methods of production, provision of improved animal breeds and planting materials such as mosaic and drought tolerant cassava cuttings, banana stems, sweet potato vines, beans and maize (Calibre consult, 2007).

Results of interviews with key informants did not differ from the above. They revealed that agriculture inputs to households in Kyanamukaaka and Buwunga sub-counties by World vision MKADP which were in form of animals like diary cows, bulls, local cows, improved pigs, improved goats, rabbits, poultry and crops like banana suckers, cassava cuttings, fruit trees, clonal coffee, vanilla plus training of modal farmers helped improve household incomes.

The training of modal farmers in basic agricultural principles and practices left the communities with vast numbers of change agents. Of those who had received agriculture training from World vision MKADP, 21 % acquired skills in modern farming methods, 4% in use of improved seeds and other

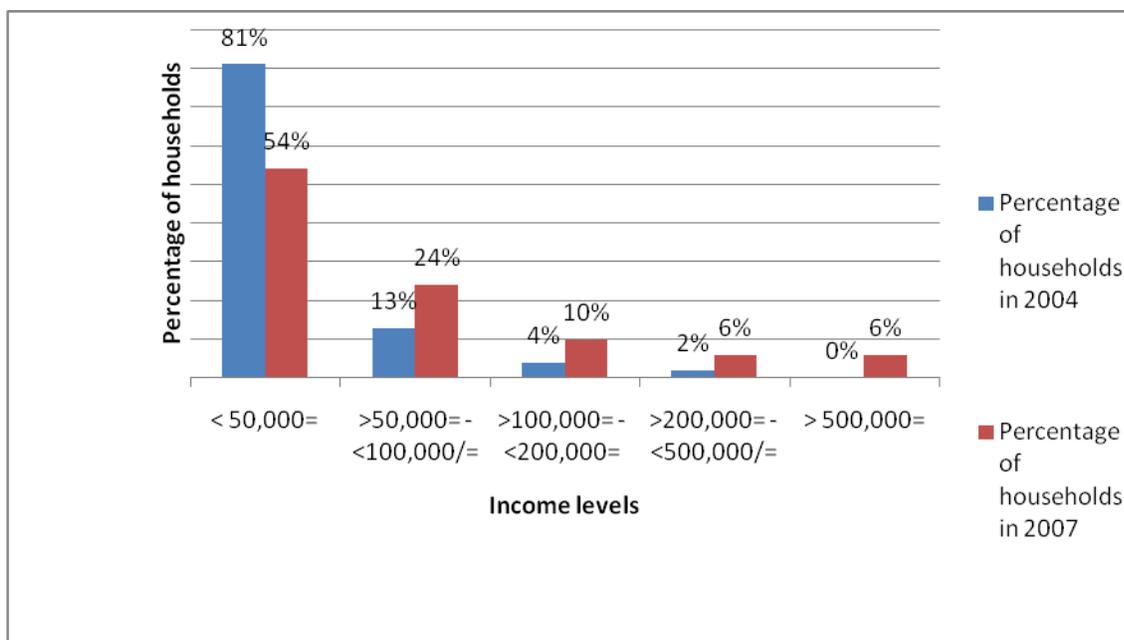
planting materials. Most of the trained farmers had increased agriculture production, increasingly realized larger incomes, which enabled them to provide better education for their children and improved welfare of their families (Calibre consult, 2007). The agriculture intervention led to improved income as people were selling bananas from the stocks given to them (Sajjabi, 2007).

Also the training of model farmers led to the establishment of backyard gardens for vegetables and fruit trees. 88% of the households had planted fruit trees (avocados, mangoes, papaws and oranges) in their gardens. 49% of the households benefited from improved household incomes through sale of fruits (Calibre consult, 2007).

Further still the study established that, statistics of average monthly household income in the last harvest season were found to be as follows: 81% of the households had an average income of less than 50,000/=, 13% had an average income ranging between 50,000 and 100,000/=, 4% of households had their average incomes ranging between 100,000= and 200,000/=, while 2% had their average incomes ranging between 200,000= and 500,000=. However there was an increase in households incomes where the percentage that earned less than 50,000= reduced to 54%, while 24% earned between 50,000= and 100,000=, 10% between 100,000= and 200,000=, 6% between 200,000= and 500,000= and 6% earned above 500,000= (Figure 4.1). This increment in household incomes could have been attributed to World vision MKADP agriculture support since most of the households depended on agriculture as their main source of income. 25% of the above households reported that increase in their household income was a result of World vision MKADP activities

like training in improved methods of production, provision of improved animal breeds and planting materials such as mosaic and drought tolerant cassava cuttings, banana stems, sweet potato vines, beans and maize (Calibre consult, 2007).

**FIGURE 4.1: AVERAGE MONTHLY HOUSEHOLD INCOME IN KYANAMUKAANKA AND BUWUNGA SUB-COUNTIES IN 2004 AND 2007.**



Source: Wasike, 2004 & Calibre consult 2007

Results from individual interviews conducted with key informants did not differ from those discussed above. They showed that most households that benefited from agriculture support had their incomes increased. This was through sell of food and animals (clonal coffee, diary cows, and pigs). Others had their income increased as a result of increased output and they would say

*“Nakungudde World vision”* a Luganda phrase meaning, *i have harvested World vision* (improved seeds were provided by World vision MKADP and household members were able to plant and harvest on a larger scale). Some of the household members had their incomes raised from casual employment on farms and plantations for those who benefited from agriculture support by World vision MKADP. Key informants reported that the increased incomes had enabled households provide other basic necessities which implied improved household welfare for people infected and affected by HIV and AIDS. However still in an interview with key informants, they reported that few people who did not have their incomes increased included the elderly, the sick and the mentally disturbed.

Results of the transformation development indicator survey also revealed that in Kyanamukaaka and Buwunga sub-counties, 29.6% of the population were very poor, 33.1% poor, 25% middle while 11.9% were rich (TDI report, 2007). Though these results were not very far from the national figures where 31% of the Uganda population were living below the poverty line (UNDP, 2007), the proportion of the very poor (those living below the poverty line) in Kyanamukaaka and Buwunga sub-counties were less than the national average figure by 1.4% implying reduced poverty in the area as a result of increased incomes of households. This increased income for households could be attributed to agriculture project support by World vision MKADP.

#### **4.1.2 IMPACT OF AGRICULTURE PROJECT SUPPORT ON HOUSEHOLD FOOD SECURITY**

The study further revealed during the end of phase two evaluation for World vision MKADP that extension services backed with training in agriculture led to increased agriculture production which resulted into food security of households for people infected and affected by HIV and AIDS (Calibre consult, 2007).

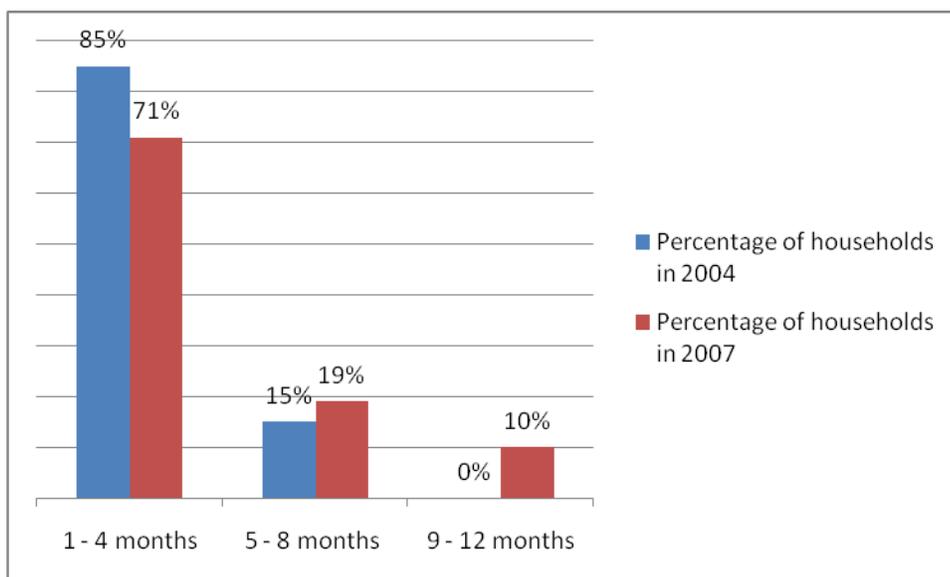
Results from end of phase one and two evaluation surveys for World vision MKADP further established that 61% of the households sold some of the food balance after consumption for income while others stored the food balance and consumed it later. 85% of the households consumed the food balance in four months in 2004 compared to 71% in 2007, 15% and 19% consumed the food balance within a period between five and eight months in 2004 and 2007 respectively. There were no households consuming food balances beyond eight months in 2004 but in 2007, 10% of the households consumed the food balance up to 12 months (figure 4.2). Also 56% of the households who planted fruit trees admitted benefiting as a food security measure during times of food scarcity. The planted fruit trees increased the diversity of food options and improved family welfare (Calibre consult, 2007).

Sell of surplus food and storage implied that World vision MKADP interventions had assisted farmers to raise agricultural production thereby reducing their dependency on food from markets,

shops, friends, and donation from non governmental organization (NGOs) or government during periods of acute food scarcity (Calibre consult, 2007).

The above results did not differ so much from those of individual interviews with key informants where it was established that most households stored food. One of the key informants who was an executive member of the community committee in World vision had this to say, “*Nakati tulina abalina Kassoli awumbye*” a Luganda phrase meaning that even now we have people whose maize got stale in store. An indication that people had enough to eat and even stored some which has reached an extent of getting stale before consumption.

**FIGURE 4.2: POST HARVEST FOOD STORAGE BY HOUSEHOLDS IN KYANAMUKAANKA AND BUWUNGA SUB-COUNTIES IN 2004 AND 2007.**



Source: Wasike, 2004 & Calibre cosult 2007

#### **4.1.3 IMPACT OF AGRICULTURE PROJECT SUPPORT ON HOUSEHOLD NUTRITION**

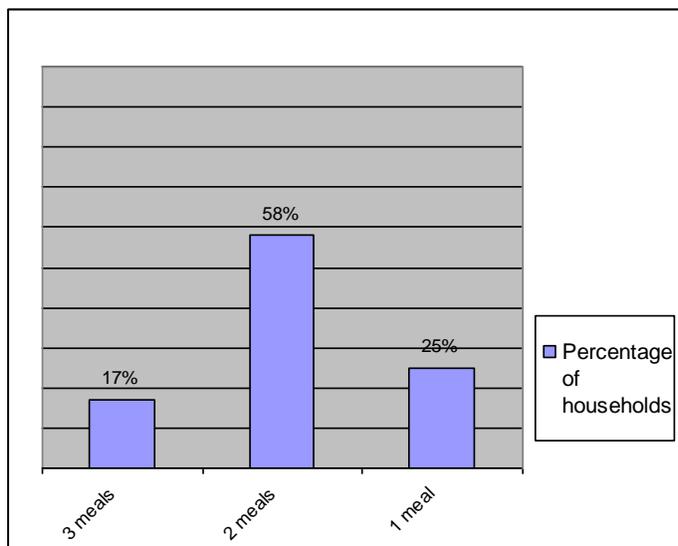
In the study it was further established that the agriculture intervention also led to improved household nutrition especially among children as a result of the stocks given to the families (Sajjabi, 2007). There was a reduction of children aged 6-59 months who severely or moderately malnourished in the programme area from 47.7% (TDI report, 2004) to 31.6% of children aged 6-59 months who were either severely or moderately malnourished (TDI report, 2007). Hence the results shown an improvement in nutrition which could be attributed to World vision MKADP agriculture intervention.

The community diversification of agricultural activities enabled most households improve their nutrition and the amount of food consumed. This was through use of improved skills of agricultural production like good soil and water conservation practices, timely planting, pest and disease control, increased acreage under production, access to use of improved and high yielding varieties of crops and breeds of livestock backed by agricultural extension services, improved storage because of World vision MKADP agriculture project support. Through encouragement by World vision MKADP, 49% of the households that grew fruit trees benefited through nutrition and health improvement (Calibre consult, 2007).

Generally, household nutrition improved for most of the households that benefited from the agriculture intervention (Figure 4.3). Most of the households (75%) ate at least two meals per day (Calibre consult, 2007).

Results of interviews with key informants were not different from the above. They also revealed that there was improved nutrition among most households that received agriculture support. It was further established that the few households that ate one meal either did not benefit from the agriculture project support by World vision MKADP or benefited but did not take good care and use of the inputs and skills acquired.

**FIGURE 4.3 : NUMBER OF MEALS PER DAY FOR HOUSEHOLDS IN KYANAMUKAANKA AND BUWUNGA SUB-COUNTIES.**



Source: Calibre Consult, 2007.

## **4.2 RESULTS AS PER OBJECTIVE 2:**

### **4.2.1 IMPACT OF PSYCHOSOCIAL SUPPORT ON WELFARE OF HOUSEHOLDS FOR PEOPLE INFECTED AND AFFECTED BY HIV AND AIDS.**

A study by World vision Uganda and John Hopkins University in 2000 found depression level at 21% as a result of HIV and AIDS epidemic (Male, 2007). Results from individual interviews also revealed that many people were depressed before psychosocial support. Those who were not depressed had turned to God.

Psychosocial support beneficiaries got skills which enabled them to deal with life threatening situations and they started growing pineapples, cassava, maize, beans and sweet potatoes, rearing animals and making hand crafts. A post assessment exercise was carried out for 123 (Interpersonal psychotherapy for groups) IPT-G clients and it was found out that 91% of them had regained hope and function ability (Munanira, 2004). Other 30 IPT-G with 250 people were trained in modern farming methods and 20 (67%) of these groups were facilitated with income generating activities which included goats and pigs. They regained their function ability (Sajjabi, 2006) hence their increased labour productivity.

Results of the study during individual interviews with key informants further established that psychosocial support through IPT-G, Counseling, and agriculture inputs was given to those formerly

depressed. 850 people benefited directly from IPT-G. Most of the people, who benefited from IPT-G, had their labor productivity increased.

### **4.3 RESULTS AS PER OBJECTIVE 3:**

#### **4.3.1 IMPACT OF EDUCATION SUPPORT TO ORPHANS AND OTHER VULNERABLE CHILDREN (OVC)**

With many children who were dropping out of school due to varying reasons, World vision MKADP provided them support in formal education and skills training. Thus there was reduced drop out rates because the threat of the sending away children for fees and other scholastic materials was non-existent. Close to 3800 children were provided with scholastic materials like books, pens, school uniforms, and some of their tuition taken care of by World vision MKADP (Calibre consult, 2007).

This education support increased school enrolment thus enabling some children to pursue their education up to university and other tertiary institutions (Calibre consult, 2007). Two of the OVC who were facilitated to go through formal education completed professional Bachelor of education and nursing respectively; they were employed and were taking care of their siblings (Sajjabi, 2007). Twenty nine OVC were supported to acquire vocational skills in tailoring, motor vehicle repair, carpentry and joinery, bricklaying plus concrete practice and hair dressing. Post training support in form of tools was availed to the graduates. This provided economic empowerment to these youths who were either self employed or working some where else hence improving their household welfare (Calibre consult, 2007). Some of the former OVC who were supported by World vision

MKADP to complete skills training became trainers. Through this they earned a living and were able to cater for the rest of the household member's needs (Sajjabi, 2006), hence improved household welfare as a result of World vision MKADP education support to OVC.

The results of individual interviews with key informants did not differ from those of previous reviews. It was established that education support to OVC was in form of School fees support, Scholastic materials including tool kits, exercise books, pens, school uniforms, text books, furniture, class room construction and support of trainings for school management committees. This support increased school enrollment and through this, some OVC completed skills training in carpentry, tailoring and cosmetology and were employed. Few from formal education had completed university and were also employed. However it was noted during an interview with the program Coordinator of World vision MKADP, that performance was better for OVC in skills training. Those in formal education had other problems other than school fees like looking for food which limited their time for revision.

#### **4.4 CONCLUSION**

From the study it was established that World vision Masaka Kyanamukaaka area development programme HIV and AIDS care and support interventions led improved household welfare for people infected and affected by HIV and AIDS. The agriculture project support through training farmers in improved methods of farming, provision of agriculture extension services and inputs led to increased agricultural production which in turn led to increased household incomes, food security

and improved nutrition. The psychosocial project support through interpersonal psycho therapy for groups also led to reduced depression levels which increased labor productivity for those formerly depressed. Education support to orphans and other vulnerable children in form of school fees support, start up tools and provision of scholastic materials led to increased school enrollment and education completion by these children.

## **CHAPTER 5**

### **CONCLUSION OF THE STUDY**

#### **5.0 INTRODUCTION**

This chapter presents the summary of results in section 5.1, recommendations of the study in section 5.2, and limitations of the study in section 5.3. The study sought to establish the impact of Human immune deficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS) care and support interventions by World vision Masaka Kyanamukaaka area development programme (MKADP) on household welfare. The interventions were in response to effects of HIV and AIDS on household welfare for people infected and affected by HIV and AIDS which included: loss of able-bodied and productive people resulting into reduced production hence reduced household incomes, food insecurity, orphan headed households and increased depression levels.

#### **5.1 SUMMARY OF RESULTS**

The interventions undertaken included agriculture project support, psychosocial project support interventions and education support to orphans and other vulnerable children.

Through agriculture project support in an effort to enhance attainment of self sufficiency in food production and increase household incomes, World vision MKADP provided training of contact farmers with skills in modern production practices and organic farming. This was backed by agriculture extension services and provision of improved crop varieties and livestock breeds.

Psychosocial project support interventions through interpersonal psychotherapy for groups was initiated after a research by World vision Uganda and John Hopkins University, 2000 showed high prevalence levels of depression (21%) as a result of HIV and AIDS epidemic. From the study, those suffering from depression were unable to function normally, they found it 20 times more difficult to complete given tasks than those not suffering from depression in the study.

Education support was also provided to orphans and vulnerable children (OVC) to pursue primary and post primary education. The scope of educational support by World vision MKADP was through provision of school fees, start up tools and scholastic materials.

During the study, quantitative and qualitative study designs were used. Mainly document review was done and was supplemented by primary data on the impact of World vision MKADP HIV and AIDS care and support interventions on household welfare in Kyanamukaaka and Buwunga sub-counties.

Results as per objective one; Impact of Agriculture project support on household incomes, food security and nutrition for households of people infected and affected by HIV and AIDS shown that agriculture support led to increased agriculture production, which in turn increased household income through sale of agriculture output and employment on farms. However, though incomes for most households increased, the few who never benefited from the agriculture support and those who did not take good care of inputs did not have their incomes increased. There was also increased household food security as households were able to sell surplus food and also store some which even

took them to the next harvest period. In some households however it was reported that surplus food was not well stored and thus ended up getting stale. Household nutrition also improved as members had more meals per day and there was reduced malnutrition among children.

Results as per objective Two: Impact of Psychosocial project support labor productivity for households of people infected and affected by HIV and AIDS shown that psychosocial support led to decreased depression which increased function ability of those formerly depressed hence increased labor productivity.

Results as per objective Three: Impact of Education project support on school enrollment and education completion for orphans and other vulnerable children (OVC) shown that Education support to OVC led to increased school enrollment for those who had dropped out of school. There was also increased education completion by OVC in both formal and informal education.

Therefore, World vision MKADP interventions through agriculture project support, psychosocial support and support to OVC to acquire education improved household welfare. However, it was also found that though World vision MKADP interventions took the largest percentage, there were other organizations that provided care and support interventions to households for people infected and affected by HIV and AIDS which could have also contributed to improvement of household welfare. During interviews with key informants, they mentioned MADDO, Kitovu mobile, TASO, Micro enterprise development network (MEDNET), GOAL, Molly and Paul foundation, VI, Uganda virus

research institute, Rakai project and MRC as other NGOs providing support in Kyanamukaaka and Buwunga sub-counties.

An executive member of the community committee for World vision however had this to say during an interview, “*World vision ebadde ekyakutte nnyo akati*” (Luganda) meaning World vision’s contribution was much ahead compared to that of other NGOs in the area. One of the political leaders was also in agreement of the above and said other organizations had contributed but not as much as World vision. He said may be this could be attributed to World vision’s long span in the area. World vision intervened more in care for people infected and affected by HIV and AIDS while other NGOs mostly dealt with HIV and AIDS awareness plus Voluntary counseling and testing (VCT).

## **5.2 RECCOMENDATIONS OF THE STUDY**

World vision should continue with the agriculture project support through provision of improved crop and animal breeds backed by trainings which have led to increased household incomes, food security and improved nutrition for people infected and affected by HIV and AIDS hence improvement in their household welfare. Other Non governmental organizations (NGOs) and government should adopt it and avoid cash support/benefits which can easily be misallocated.

World vision should continue with assessing the level of depression and where necessary provide psychosocial support before undertaking any developmental interventions since it was discovered

from the study that a large percentage of people who were suffering from depression as a result of HIV and AIDS in Kyanamukaaka and Buwunga sub-counties had their productivity affected until World vision MKADP intervened with psychosocial support. Other NGOs and the government should adopt the same practice.

Support to OVC to pursue skills training has had a positive impact on increased school enrollment and education completion. Most OVC who completed skills training are employed unlike those who continued with formal education, very few have graduated. World vision MKADP, the government and other NGOs working in Kyanamukaaka and Buwunga sub-counties should put more emphasis on skills training as less costs are involved yet OVC graduate with practical skills to enable them lead a better life.

### **5.3 LIMITATIONS OF THE STUDY**

The study did not compare the impact of World vision Masaka Kyanamukaaka area development programme (MKADP) HIV and AIDS interventions on household welfare in beneficiary and non beneficiary households. This could have answered the question of whether the improvement of Household welfare in terms of increase in household incomes, food security, improved nutrition, increased labor productivity and increased school enrollment and education completion by orphans and other vulnerable children could have been attributed to World vision MKADP interventions only. This to a small extent affected conclusion of the study results.

Data collection instruments for the end of phase evaluation surveys for World vision MKADP were different. The end of phase one evaluation used three instruments; household questionnaires, focus group discussion guide and interview guide for key informants. The end of phase two evaluation used a wide range of instruments namely; household questionnaires, progress indicator check list, interview guide for key informants, evaluation questions guide, focus group discussion guide, school and health facility assessment tool. As a result, information generated from the two surveys may not be directly compared because the end of phase two evaluation was in depth and could have generated more information than end of phase one evaluation. This had a limited effect on study results since the two evaluation surveys were carried out in the same areas where initial conditions were the same.

From the reviews which were carried out, little was documented on psychosocial support and the impact on labor productivity which could have limited the findings of the research objective. The project could have had a greater impact on improvement of household welfare for people infected and affected by HIV and AIDS than what was reported. However this did not affect the study results since it was established that psychosocial project led to increased labour productivity but could have enhanced them the more.

There was little data on education completion by OVC especially at tertiary level. This could have been due to gaps in monitoring and documentation and could have limited study results as well. The education support to OVC could have had a greater impact on school enrollment and education

completion for OVC than the study could establish. This still did not affect so much study results but could have enhanced them.

### **5.3.1 AREAS OF FURTHER INQUIRY.**

Basing on limited availability of secondary data about the impact of psychosocial support on labour productivity for households of people infected and affected by HIV and AIDS and the impact of education support to school enrollment and education completion by orphans and other vulnerable children, Other researchers intending to do a similar studies should mainly base them on primary data and supplement that with secondary data.

The author also suggests that other researchers should compare the impact of HIV and AIDS care and support interventions on household welfare in Kyanamukaaka and Buwunga sub-counties by looking at households that have benefited from HIV and AIDS interventions by world vision (MKADP) and those who have not. This will answer the question of whether the improvement of Household welfare in terms of increase in household incomes, food security, improved nutrition, increased labour productivity and increased school enrollment and education completion by orphans and other vulnerable children could have been attributed to only World vision MKADP interventions in Kyanamukaaka and Buwunga sub-counties.

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## **APPENDICES**

### **A. RESEARCH INSTRUMENT (GUIDE QUESTIONS FOR INDIVIDUAL INTERVIEWS)**

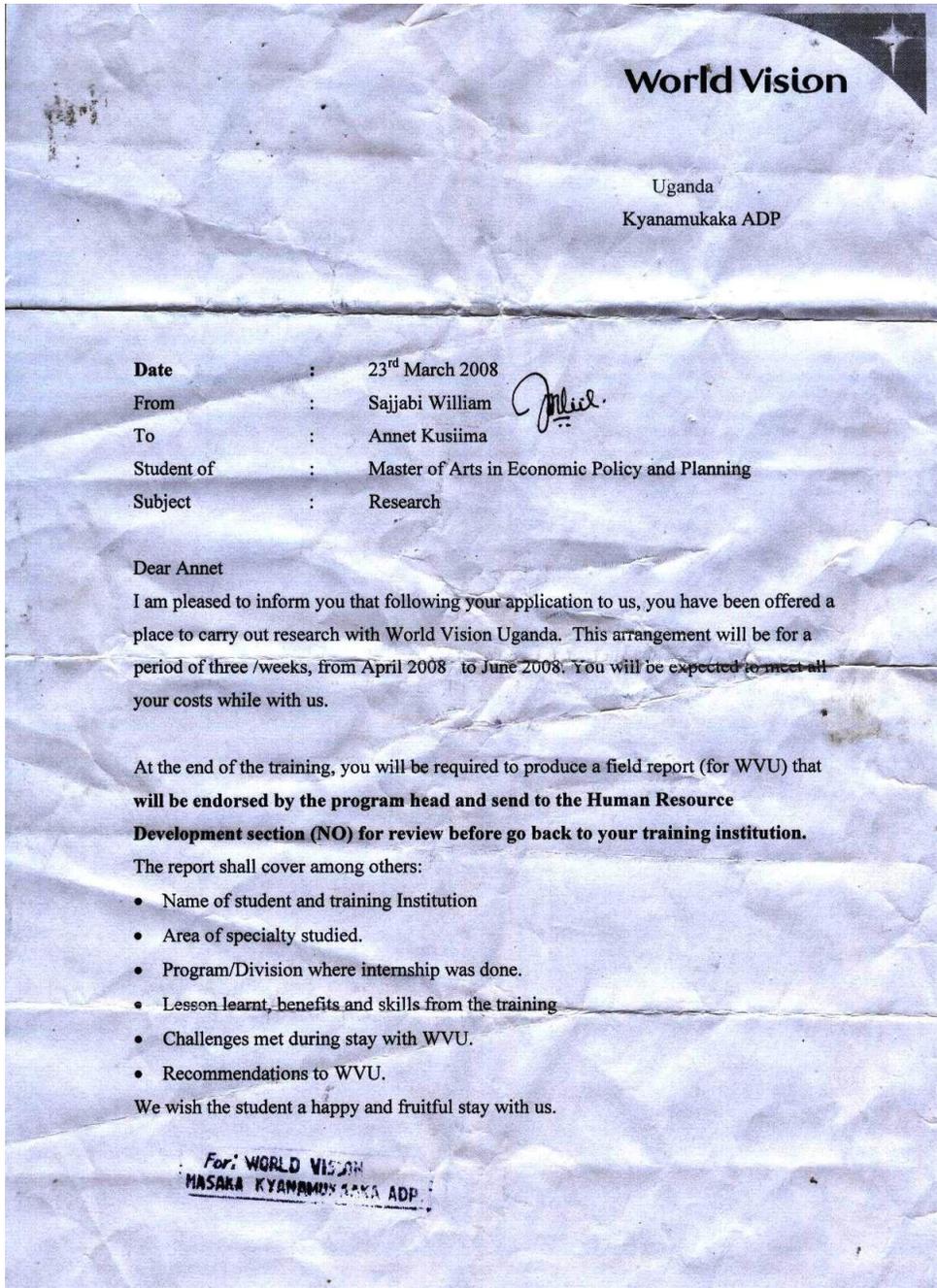
1. How many households are in Kyanamukaaka and Buwunga sub-counties?
2. What kind of care and support is given by World vision to these households?
3. What kind of agriculture support has WVMKADP given to households for people infected and affected by HIV and AIDS in your area of operation?
4. How many households do you think have benefited?
5. What has been the impact of this Agriculture project on incomes, nutrition and food security for households of people infected and affected by HIV and AIDS?
6. What are the sources of incomes for households in Kyanamukaaka and Buwunga?
7. What is the average income for households in Kyanamukaaka and Buwunga?
8. How much do you think was household incomes before the agriculture intervention?
9. How many people do you think were depressed before psychosocial project by World vision?  
Or how many households do you think had at least one depressed person before the psychosocial project was started?
10. What kind of psychosocial support is given to households for people infected and affected by HIV and AIDS?
11. What has been the impact of psychosocial support on productivity of households for people infected and affected by HIV and AIDS? How many people do you think have had improved productivity as a result of this psychosocial support?
12. How many OVC are in Kyanamukaaka and Buwunga?

13. How many OVC do you think have received care and support from World vision? What kind of support has been offered?
14. What has been the impact of education support to OVC on improvement in welfare of households for people infected and affected by HIV and AIDS?
15. Who are the beneficiaries of the above and how are they selected?
16. What other organizations are provide HIV and AIDS care and support in Kyanamukaaka and Buwunga?

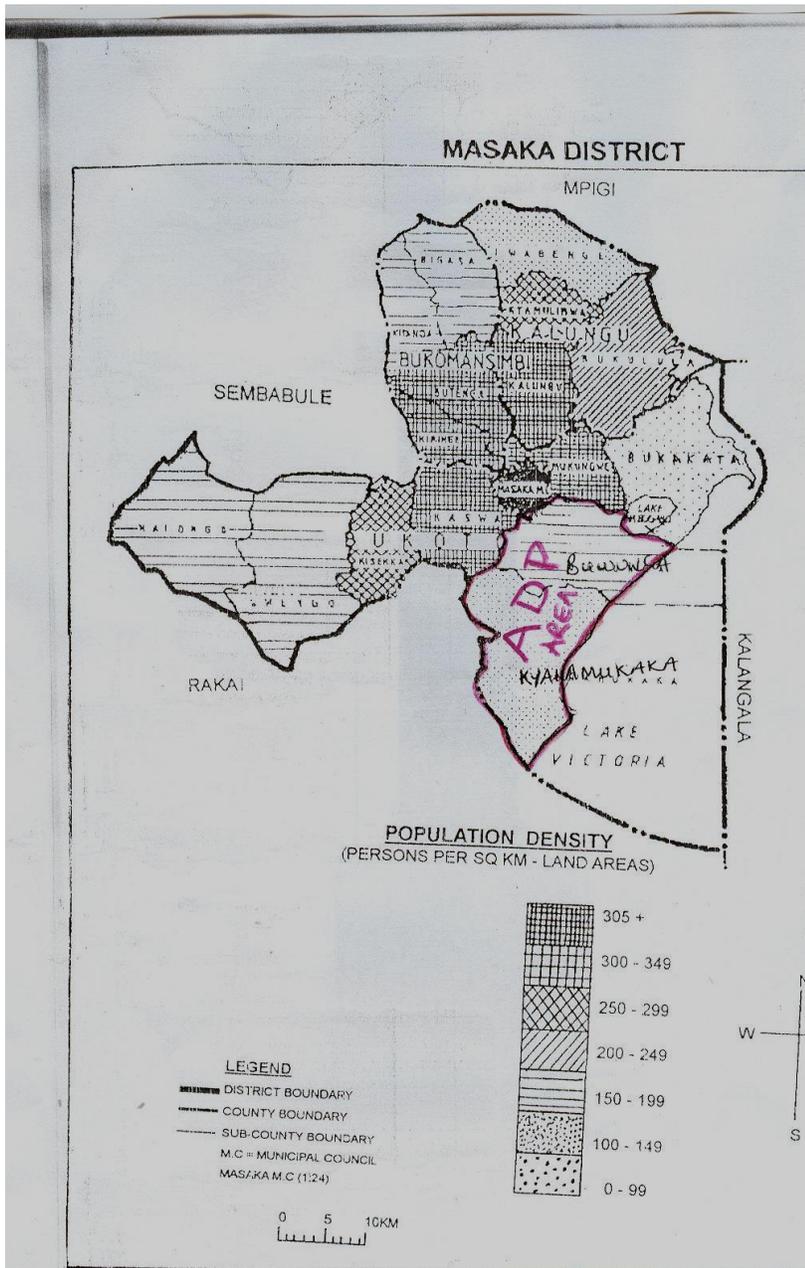
## **B. PERSONEL MET**

1. Mr. Sajjabi William Programme coordinator World vision MKADP
2. Mr. Kibuuka John Psychosocial Facilitator World vision MKADP
3. Mr. Kasendwa Nathan Child Sponsorship Assistant World vision MKADP
4. Mr. Miggade Paul LC 3 Chair person Kyanamukaaka sub county
5. Mr. Wasswa Batte LC 3 Chair person Buwunga sub county
6. Nnalongo Kizito ADP chair person community committee
7. Mrs. Lugemwa Pauline chairperson Kyanamukaaka sub-county committee
8. Mrs. Kasendwa Prossy Executive member ADP committee
9. Ms. Najjuma Teddy Psychosocial volunteer
10. Ms. Namyalo Teddy Psychosocial volunteer

## C. RESEARCH APPROVAL LETTER



**D. MAP OF WORLD VISION MASAKA KYANAMUKA KA AREA DEVELOPMENT PROGRAMME AREA OF OPERATION**



## **E. AREAS VISITED**

1. World vision MKADP office
2. Kyanamukaaka sub county office
3. Buwunga sub county office
4. Kitofali village, Kyantale parish, Kyanamukaaka sub county
5. Buyinja village, Buyinja parish Kyanamukaaka sub county
6. Kitwe village, Buwunga parish, Buwunga sub county
7. Zzimwe village, Zzimwe parish, Kyanamukaaka sub county
8. Kyajjundu village, Kyantale parish, Kyanamukaaka sub county