March 2004

Combating the HIV/AIDS pandemic

An analysis of why Uganda has been relatively successful in fighting HIV/AIDS

Kathrine Tveit

Cand. Polit Degree Thesis

University of Oslo, Department of Political Science

Spring 2004

Table of contents

TABLE OF CONTENTS 2

Acknowledgements 4

Map of the Republic of Uganda 5

I African health challenges and the Ugandan Success 6

1.1 Introduction and focus of the thesis 6
1.2 Uganda and HIV/AIDS in a regional perspective 8
1.3 Focus, theoretical approach and questions to be addressed 13
1.4 Methodological Approach and sources of Information 19

2 Ugandan background 27

2.1 Introduction and political background 27
2.2 Social and economic conditions 28
2.3 Uganda Today 30
2.4 Conclusion 36

3 Theoretical Approach 37

3.1 Introduction 37
3.2 Theory on implementation of public programmes 38
3.3 Development theories 44
3.4 Theory on implementation of health programmes 52
3.5 Conclusion 59

4 HIV/AIDS programmes in Uganda 60

4.1 Introduction and the National Policy on HIV/AIDS 60
4.2 Government programmes 61
4.3 Civil society programmes 67
4.4 Resources 70
4.5 Conclusion 75

5 Explaining the Ugandan success! 76

5.1 Political will and commitment 77
5.2 Support of government officials 79
5.3 Resource allocation 82
5.4 Involvement and support of civil society 84
5.5 Decentralisation 87
5.6 Analysis and discussion of findings 89
5.7 Analysis and theoretical implications 99

6 Summary and Conclusion 116

Appendix I Abbreviations 120

Appendix II Resource allocations from donors, year 2001 121

Appendix III Interview Material 122

Appendix IV Bibliography 124

Acknowledgements

The idea for this master thesis came to me as I read about the HIV/AIDS pandemic, and discovered an African country where there is light despite human tragedy. By focusing on Uganda I wanted to bring some hope into the debate on how to fight the HIV/AIDS. Too many people have died of AIDS, and too many have been affected by this horrible disease. Therefore, I dedicate this master thesis to all those worldwide who have died of AIDS, and all those who have lost their loves ones due to this deadly disease.

Writing this thesis has been a very interesting process which has made me travel from Oslo to Geneva, Uganda and Uppsala. I would like to thank my supervisor Liv Tørres for all the great feedback and encouragements. Thanks to UNAIDS, Geneva and particularly the people at the Africa Desk. The internship in your department taught me so much, and it was a delight to see how engaged you are to fight HIV/AIDS. I also wish to thank researchers at the Nordic Africa Institute for interesting discussions. Furthermore, I would like to express gratitude to all the people I met during my stay in Uganda. They welcomed me to their country and helped me to understand how Ugandans have fought and continue to fight HIV/AIDS. I would like to thank UNAIDS in Kampala, Uganda and especially Lillian Mutesi for helping me to get in touch with people engaged in AIDS work. Special thanks go to Angela, and to all my friends working at the restaurant “La Fontaine”. I would also like to thank those who have contributed financially to my fieldtrip to Uganda: The Department of Political Science at the University of Oslo, Glaxo SmithKline and Bristol-Myers Squibb.

Finally, I wish to express gratitude to my family for believing in me and supporting me all the way. Thanks also to good friends for all encouragements. A special thanks to Bård. I am extremely grateful for your love, humor and patience.

Oslo, March 2004
Kathrine Tveit

Map of the Republic of Uganda

I African health challenges and the Ugandan Success

1.1 Introduction and focus of the thesis

> *The challenge of AIDS is a metaphor for the challenges of the 21st century in a world of high interdependence - a challenge, which threatens our humanity and security* (Clinton: 5/ 11/03[1]).

Terrorism is currently considered to be the greatest threat to development and international security. At the same time, millions have died worldwide by HIV/AIDS in the past decade. While initially being regarded first and foremost as a health issue, the pandemic is increasingly threatening living standards for the individual, growth and development for the countries concerned and stability and security for the world at large. According to statistics from UNAIDS (2003) an estimated number of 40 million people are infected with the HIV virus worldwide. 95 percent of those infected live in developing countries with insufficient health systems and few resources for prevention and care (Harboe 2000). The African continent is most heavily affected by the pandemic, reinforcing problems of poverty and low growth in many countries. In sub-Saharan Africa around 25-28.2 million people are infected with the HIV virus, and the disease is considered to be the most frequent cause of death (UNAIDS 2002; 2003). With medical solutions and answers still awaiting, improved knowledge about health and government programmes to ease the burdens is critical.

Uganda is the country most often regarded to be "a success story" in the fight against HIV/AIDS, having managed to turn the trend and reduce a high number of infected. The first estimates in 1990 suggested that Uganda was one of the countries most heavily affected by the disease with 14 percent of the adult population (19 to 49 years old) infected with the HIV-virus (UNAIDS 2000). By 2002 the prevalence rate had fallen to around 5 percent (UNDP 2003: 260).[2] While there are several reasons to

[1] From the seminar: "Meetings the Challenges of HIV/AIDS in an interdependent World", 5th November, 2003, University of Oslo.

[2] "By 1992, HIV prevalence rates in women receiving antenatal services had climbed to 30 percent in urban areas and 3 percent in rural" (Okware et al. 2001). However, in 1993, the first positive signs emerged with declining HIV prevalence rates at six large surveillance sites in Kampala and other urban areas (Kaleeba et al. 2000).

regard AIDS statistics with caution (see 1.4), the decrease in prevalence trend is clear[3] and an apparent fall in incidence rate (reflected by the prevalence rate among 15-24 year olds) increases the probability of real changes[4]. Uganda has managed, where other neighbouring countries struggle an uphill battle. Uganda's success in reducing the number of newly infected comes in spite of major poverty problems, socio-economic challenges and limited resources compared to many other countries on the African continent. So what may explain Uganda's success? The focus of this master thesis is on health and public policies in developing countries with specific attention to the politics of combating HIV/AIDS.

Classic theories of public policy implementation have focussed on the importance of the public sector, centralisation and the role of the state. Others have argued for more decentralised programmes, and the involvement of civil society actors. Yet, these theoretical perspectives have in common that they have been born and bred in Western settings. How adaptable or relevant are they to non-Western settings? To what extent can they explain the apparent success of public policies in Uganda? We will look at the following questions in order to understand the progress in the fight against HIV/AIDS in Uganda:

- What characterises the Ugandan HIV/AIDS programmes?
- How can we explain the relative success of Uganda in fighting HIV/AIDS?
- To what extent do existing Western implementation theories need to be supplemented in order to grasp the challenges of health and service delivery in developing countries?

The reason for the reduction in number of infected with HIV in Uganda is most probably a change in people's sexual behaviour, as this is the most common way to attract the disease. The efforts made by the government to reduce the impact of the epidemic is assumed to have influenced people's sexual behaviour and on reducing the number of people infected with the HIV/AIDS virus. Hence, we will first and foremost

---

[3] The number of newly infected (15-19 years old) has decreased most drastically from 21 percent in 1993 to 7.1 percent in year 2000 (STD/AIDS Control programme 2001: 05). In the capital of Kampala the share of HIV-contaminated has fallen from around 29.4 percent in 1992 to around 8.3 percent in 2002 (STD/AIDS Control Programme 2003: 12).

[4] See section 1.4-p.19 for more information on "incidence vs. prevalence rates".

look at the preventive policies and measures put in place by the Ugandan government and their partners in order to reduce the spread of the epidemic rather than the policies and programmes put in place to help those already affected. The overall aim of the thesis is to contribute to political knowledge and theory building on public policy implementation in developing countries, and more specifically to a better understanding of health programmes and HIV/AIDS programmes.

1.2 Uganda and HIV/AIDS in a regional perspective

The World Bank emphasises structural conditions such as education and income growth to be important factors in deciding the country's health: "Since overall economic growth- particularly poverty-reducing growth- and education are central to good health, governments need to pursue sound macroeconomic policies that emphasize reduction of poverty" (WB 1993: 06). These structural conditions will be important for influencing people's behaviour and for improvements of their health.

Compared to other countries in sub-Saharan Africa, Uganda scores relatively low on central social and economic indicators[5]. Uganda is among the poorest countries in the world, ranging as number 147 of the 175 countries on the Human Development Index (HDI) with a GDP per capita (PPP $) of 1490. Nevertheless, other countries have a much higher percentage of their population infected with the HIV virus compared to Uganda. Uganda has an HIV prevalence rate of 5 percent, and as such is the country with the lowest percentage of their adult population infected followed by Tanzania (7.8 percent). Countries like South Africa and Namibia, ranked as number 111 and 124 on the human development indicator list (HDI), have a considerably higher HIV-prevalence rate than Uganda. South Africa has the fastest growing epidemic with about 20 percent, i.e. 4, 7 million, of the adult population infected. In Zimbabwe an estimated percentage of approximately 34 percent of the adult population is infected, in Swaziland about 33 percent, Lesotho 31 percent, Namibia 23 percent, Zambia 22 percent, Kenya 15 percent, Malawi 15 percent and Mozambique 13 percent. Surprisingly, a country like Botswana, which has a GDP almost seven times higher than Uganda, has a prevalence rate as high as 38.8 percent.

---

[5] See table 1, page 4.

All of the countries represented in the table have a higher level of literacy than Uganda except for Mozambique. Thus, one could expect the people's ability to acquire information about the HIV/AIDS epidemic in Uganda to be lower. According to the WB; "People who have had more schooling seek and utilize health information more effectively than those with little or no schooling" (WB 1993: 08). Simultaneously a life expectancy in Uganda of 44, 7 years is somewhat higher than most other Southern African countries represented in the table (besides South Africa, Namibia and Botswana and Kenya). Hence, although social and economic indicators have improved in Uganda since the mid 80s[6], factors such as economic growth and literacy cannot in themselves explain the relatively low percentage of the Ugandan population infected with HIV.

Table 1 Social and Economic indicators in Uganda and selected Southern African countries (UNDP 2003)

Country	HDI	HDI Rank	Real GDP Per capita (PPP US$) 2001	Real GDP per capita (PPP USD) minus HDI rank[7]	Life expectancy at birth	Adult Literacy Rate 2000 Percent	People Living w/HIV/AIDS (15-49 yrs.) Percent
South Africa	0,684	111	11,290	- 64	50,9	85,6	20,1
Namibia	0,627	124	6,431	- 59	47,4	82,7	22,5
Botswana	0,614	125	7,820	- 65	44,7	78,2	38,8
Swaziland	0,547	133	4,330	- 34	38,2	80,3	33,4
Lesotho	0,551	137	2,420	- 13	38,6	83,9	31,0
Zimbabwe	0,496	145	2,280	- 18	35,4	89,4	33,7
Kenya	0,489	146	980	14	46,4	83,3	15,0
Uganda	**0,489**	**147**	**1,490**	**1**	**44,7**	**68**	**5,0**
Tanzania	0,400	151	520	14	44,0	76,0	7,8
Malawi	0,387	162	570	11	38,5	78,4	15,0
Zambia	0,386	163	780	7	33,4	79,0	21,5
Mozambique	0,356	170	1,140	- 15	39,2	45,0	13,0

Uganda's political history

As several theories address the need for political commitment and decentralisation in order to succeed in implementation of public programmes, it is essential to look into

[6] In 1990, Uganda had a HDI of 0.194, a GDP of 524 (dollars), an adult literacy rate of 48.3 percent of the population and a life expectancy of 52 years (UNDP 1993)

[7] A positive figure shows that the HDI rank is better than the real GDP per capita (PPP USD) rank, a negative the opposite (UNDP 2003).

the political history of Uganda. The country's political background is not a favourable one in comparison to other countries in the region. At the time of independence Uganda was a prosperous country rich on natural resources, a well developed infrastructure and a favourable climate (Mugaju 1996: 06). However, for twenty years Uganda has suffered devastating consequences of seven different regimes, with no limit to their exercise of power, ignored the rule of law and left people powerless without a sense of personal security (Hyden 1998). Several dictators have fought wars and led genocides, leaving the country in economic ruins. The terror regimes of Obote and Amin ruined the country's resources, infrastructure and people's lives. Thus, at the time when Museveni became the president of Uganda in January 1986 "Uganda itself was a country with one of the greatest single resources of political instability, social dislocation and economic disruption in the Great Lakes region of sub-Saharan Africa" (Twaddle/Hansen 1998).

Today the political system in Uganda is not a multi-party democracy as some of the other Southern African countries, but rather a zero-party system. The constitution of 1995 requires suspension of all political parties under the regime of the National Resistance Movement (NRM). NRM is according to Museveni an organisation and not a party representing *all* Ugandans, under the President's authority (Human Rights Watch 1999). Museveni announced the importance of political stability when he seized power in 1986 as a former guerrilla leader fighting the previous regime. He promised that a no-party system would only be a "system of transition" until economic stability and establishment of a middle class would lead to a multiparty democratic system (Human Rights Watch 1999). Today, President Museveni is honoured for having brought great changes to the country: economic growth, peace and democratic transitions. Uganda has followed a liberalisation of the economy according to the World Bank's policy, and is often referred to as a success story also in the economic area as well as in the fighting of the HIV/AIDS epidemic. In practice however, the system is often criticised for lack of democracy and for resembling a one-party system. According to Mamdani (Human Rights Watch 1999) the only difference between a one party state and the Ugandan Movement System is that they call themselves a political *system* and not a party, even though they are organized as one.

Another important characteristic of the political system in Uganda is the election of representatives to five different levels of government (Councils), a system intended to introduce democracy to people. The decentralization policy in Uganda is based on a hierarchy of councils and committees including the village (LCI), parish (LC II), subcounty (LC II), county (LC IV) and district level (LC V). These political structures were legalised by the 1993 Resistance Council Statute, which was in turn enshrined in the Uganda Constitution of 1995, with amendments made the Local Government Act, 1997 (Makerere Institute for Social Research, 2000: 02 in Golola: 2001). Despite intentions of introducing democracy, the NRM is criticised for controlling the Local Councils and the NGOs and to ensure own power. According to Mamdani the Local Councils are partisan and the higher up in the bodies, the less democratic they appear (Human Rights Watch 1999). Today Uganda is also known for its corrupted regime and for having a large record of human rights abuses (Ofcansky 1996: 59).

History, impact and progress of the HIV/AIDS epidemic in Uganda

The first cases of the HIV/AIDS epidemic in Uganda were reported in the Rakai district in 1982 (Okware et al. 2001). Currently about 5 percent of the adult population is infected with the virus (UNAIDS 2003). In urban areas there is a higher HIV prevalence than in rural (6.1 vs. 4.2 percent) and more women than men are infected with the HIV virus (STD/AIDS Control Programme 2001). In Uganda the HIV virus is in 75 to 80 percent of new cases transmitted through hetero-sexual intercourse while spread of the virus from mother to child is the second most important source of contamination (around 25 percent) (STD/AIDS Control Programme 1997). "The HIV/AIDS epidemic has had far reaching consequences for individuals, families, communities and the country as a whole" (UAC 2000: 13). The epidemic was in 2001 assumed to have taken the lives of 838,000 Ugandans (STD/AIDS Control Programme 2001: 14). The epidemic has affected an already overstretched health sector- as the demand for palliative care is large and the access is limited (Ibid, p.15). The extended family structure of Uganda has been challenged by HIV/AIDS as the most productive

age groups pass away, and the old are left to take care of the many orphans (Lyons 1998)[8].

In addition to the decline in prevalence rates, various studies report of high levels of awareness about HIV/AIDS among Ugandans. In the 1995 Uganda Demographic and Health Survey (p.147), 92 percent of women and 96 percent of men reported knowing about AIDS. In the following survey (2000-2001) this percentage had increased to 99.7 of women and 100 percent of men[9]. However, knowledge of ways to avoid contracting the virus is lower: 78 percent of women and 90 percent of men (Uganda Demographic and Health Survey 1995: 158). Level of education is positively associated with the level of knowledge of ways of avoiding HIV/AIDS and the level of awareness is higher among people in their twenties and thirties (Ibid). Several researchers assert a change in sexual behaviour in addition to increase in awareness and decline in prevalence rates. A study conducted by the Ugandan AIDS Control Program (ACP) was published in the international journal *AIDS* in 1997. This report compared sexual behaviour between 1989 and 1995 in two major urban districts (Kaleeba et al. 2000: 5). The study revealed behavioural changes among the young Ugandan population consistent of factors like: a two year delay in first sexual intercourse among youths aged 15-24, real increases in condom use and 9 percent decrease in casual sex among male youths 15-24 (Asuumwe-Okiror et al. 1997). Simultaneously, in the same area under the same period, there was an overall decline in the rates of HIV seroprevalence among pregnant women attending antenatal clinics (Ibid). “It can be hypothesized that the observed declining trends in HIV correspond to a change in sexual behaviour and condom use, especially among youths” (Ibid).[10]

Later studies confirm the progress in fighting HIV/AIDS in Uganda also in rural areas. The first general population study was published in year 2000 covering a seven year period in a rural area of Masaka. This was “the first study of this kind showing overall long term significant reduction in HIV prevalence and parallel evidence of sexual

[8] In the year 2001 alone, 880 000 children became orphaned by AIDS (UNAIDS 2002).

[9] However, knowledge of AIDS does not necessarily mean that people act according to their knowledge, thus we have to also look at if they have actually changed their sexual behaviours. One should be careful to analyse these results due to the insecurity on surveys on knowledge and attitudes in developing countries.

[10] For further discussion on the progress of Uganda, see section 1.5.

behavioural change" (Kamali et al. 2000). According to Rwomushana (1999) evidence of decrease in new infections is clearest among the youth and is associated with delay of sex till marriage. A population based KABP survey from four rural districts also shows an almost universal level of awareness as well as an increase in age at sexual debut of 16 years and an increase in condom-use especially with non-regular partners (STD/AIDS Control Programme 2001). However, the observed changes in sexual behaviours in this survey do not match the high level of awareness among Ugandans (Ibid). A study conducted in 2000 by Ntozi et al. from three different districts in Uganda also confirms an almost universal knowledge and a positive relationship between awareness and changes in sexual behaviour (Ntozi et al. 2000). In this study (…) "more than one third of the respondents used condoms, six times more than observed in the 1996 Uganda Demographic and Health Survey (Ibid)[11]. The last surveillance report reveals that 38 percent of women and 59 percent of men reported using a condom last time they had sex with a non-cohabiting partner, figures increasing with their level of education (STD/AIDS Control Programme 2003: 34).

1.3 Focus, theoretical approach and questions to be addressed

Researchers point to the fact that the government of Uganda has shown an early political will and initiative to combat the disease of HIV/AIDS in the country. "Uganda's was the first government on the continent to recognize the danger of HIV to national development" (UNAIDS 2000). Museveni has been acknowledged by the UN for his personal fight against the disease. There might however be other explanations on the reduction of the disease acting in relation to or outside of the government's HIV/AIDS politics. With reference mostly to theory on public administration and implementation of development and health programmes this thesis will look closely on the necessary factors for succeeding in implementing HIV/AIDS prevention campaigns.

This study will look closer at the initiation and implementation of various HIV/AIDS programmes in Uganda. The intention is not to measure the effect of the different

[11] Also according to a UNAIDS study (1998) there was an increase in condom use between 1987 and 1996 from 3 percent to 25 percent.

programmes, but to examine the general response to the epidemic, and to look at the cooperation between the various actors initiating and implementing the programmes. By exploring the interplay between different actors in the process of combating the HIV/AIDS epidemic, the thesis will seek to explain the positive changes observed in Uganda when it comes to high level of awareness of the disease, changes in sexual behaviour and reduction of the HIV-prevalence rate. The study will look into a selection of factors to examine how they have contributed to the relative success in Uganda. Hence, the dissertation will not attempt to find the whole solution to the successful HIV/AIDS programs, but will seek to understand some of the dynamics having contributed to the positive developments in Uganda. In order to examine the factors, which can contribute to explain the relative success of the HIV/AIDS programmes in Uganda, we have to look thoroughly into theoretical approaches from different areas in political science. Thereby we will select *some* of these factors that we wish to examine.

Theoretical perspectives

The classic implementation theories in public policy and administration have not been extensively employed in developing countries, and especially in seeking to understand programmes directed towards reducing HIV-prevalence. Yet, the "bottom-up" and the "top-down" approaches distinguish themselves in their emphasis on different actors, as well as in their different points of departure. The **"top-down" or "decision-oriented" approach** represented by Pressman/ Wildavsky, Mazmanian/ Sabatier and Van Meter/ Van Horn starts off from a policy made decision and examines if the implementers have followed their goals and decisions. If this is the case, the programmes have a higher possibility of being successful (Kaufman: Chpt.10, in Sabatier 1986a). Adherents of this approach emphasise the formal decision-makers (politicians at central level), the central bureaucrats as the most important actors and point to their degree of control over the "lower-level"-as essential for successful programs. This "top-down" approach finds control and a centralised, bureaucratic and formal implementation process as an advantage. Adherents prefer centralisation over decentralisation in order to assure enough control over the implementation process.

They claim decentralised programmes will have a small impact on their target groups (Van Meter/ Van Horn 1975).

On the other hand, the **"bottom-up" or "process-oriented" approach** looks into the informal networks and control mechanisms and supports a more decentralised implementation of programmes. The "bottom-up" approach focuses on the networks being created and the actors' goals, strategies, activities and contacts (Banik/ Kjellberg: 2000: 153). Adherents of this approach like Elmore, McLaughlin and Porter/ Hjern look into the policy problem, rather than the policy decision and focus on the importance of "street-level bureaucrats" (Banik/Kjellberg 2000: 153). These informal actors like private organisations are emotionally and geographically closer to people, thus having a better opportunity than the bureaucratic, formal actors to influence their behaviours. The "bottom-up approach" supports a decentralised system of governance as decisions are brought closer to people, leading to a higher possibility of a successful outcome (Ibid).

Other theoretical contributions have looked more at *the implementation of specific development programmes* in developing countries. Researchers are stressing the necessity of political will, support and commitment in order for programmes to have successful outcomes. In addition these researchers put greater emphasis on the need for mobilisation of resources compared to classic implementation theories. They see political commitment and resources as two highly interrelated factors. For instance Rondinelli/Montgommery (1991) emphasise political support to be essential in order to mobilise resources for programmes in developing countries. Another important factor stressed by development theories is the involvement of the private sector. Thus, Turner and Hulme perceive inclusion of private organisations as a way to reduce the pressure on the public sector in delivery of services, attracting more resources to the programmes (Turner/Hulme 1997: 88). They claim decentralisation is positive if it leads to more involvement of civil society and brings decisions closer to people (Materu et al. 2000; Turner/ Hulme: 1997: 114). Grindle and Cleaves (1980) (….) stress the importance of looking into the context- the type of political regimes in which programmes are being implemented. Thus, whether or not e.g. political and

bureaucratic support is efficient depends on the kind of political system in the country. They claim real political support to a programme is more often the case in open democratic societies. Involvement of civil society is a positive factor if the interest groups are representing people and not protecting the existing regime. They also find regimes like open democracies to be more pluralistic, i.e. involving autonomous private organisations in their programmes (Cleaves 1980). Development theorists claim that even though the private sector could play an important role, the bureaucrats should be supportive of the programmes and responsive to people's needs (Grindle 1980; Rondinelli/ Montgommery 1991).

Several reports published by the World Bank focus on the *implementation of health programmes* and how to improve people's health both in Africa and in general (WB 1993; 1994). The WB considers political leadership: political will and political commitment as a precondition for successful health programmes to be initiated and carried out. The Bank claims real political commitment will lead to more financial resources from donors and thereby enhance the possibility of success (WB 1994: 155). Support by government officials will also be an important trait to secure resources (WB 1993: 128). However, the WB considers civil society to be more efficient actors than the government and its officials[12] as their involvement will improve efficiency of health programmes (WB 1994: 09). The Bank supports decentralisation, and by involving civil society at local level and thus building capacities, health programmes are more responsive to local needs (WB 1993: 128). WB also finds a decentralised system to be more capable of channelling resources than a centralised system and coordination between various actors as more efficient. According to the WB both donors and government should increase their financial expenditures to health programmes, and economic growth should be one of the targets (WB 1993: 168). In addition, governments should play an important role in more efficient and transparent channelling of donor resources (WB 1994: 43, 155).

[12] The WB as well as WHO emphasise the possibility that government officials are corrupt and incompetent and thus are not as efficient and responsive to people's needs as the civil society organisations (WB 1993: 59; WHO 2000: 63, 120).

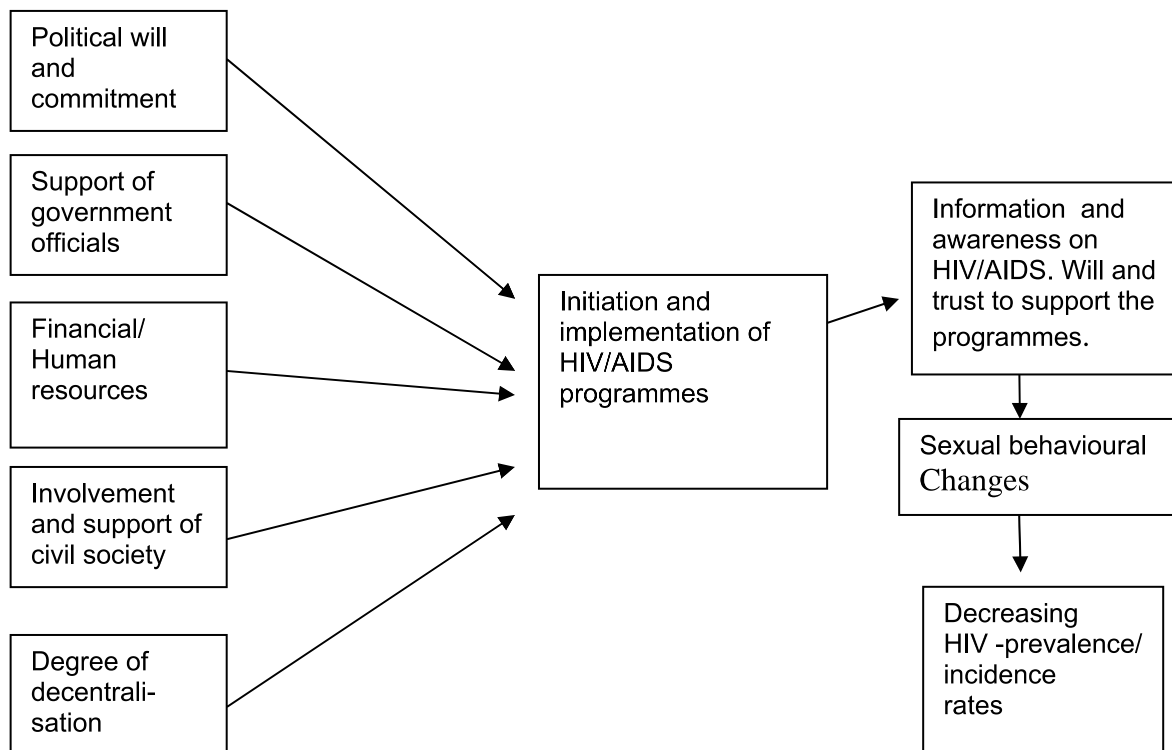
Also WHO (2000: 64) claims decentralisation leads to more flexibility and responsiveness among local implementers, but there is also a danger of fragmentation of health services (WHO 2000: 69). The organisation supports the involvement of civil society in health service delivery, but considers the ultimate responsibility of health services should lay within the government. WHO expresses a need for coordination and regulation of the activities of the NGOs as well as for sharing of information between government officials and civil society (WHO 2000: 128).

These theoretical contributions will be combined and employed as a tool for the present analysis seeking to develop a better understanding of the Ugandan HIV/AIDS programmes. While analysing the question of the HIV/AIDS epidemic, it is important to keep in mind that these programmes are seeking to change people's sexual behaviours. Thus, the issue is more sensitive and personal than most issues (tax reforms, prevention of malaria etc), and the results of the interventions are more difficult to measure. Hence, the analytical approach may carry certain weaknesses. Moreover, the study provides an interesting opportunity to evaluate and supplement theories employed in other areas of public sector research and implementation theory.

Research questions

Based on the issues raised by the theoretical perspectives above, questions arise as to centralisation versus decentralisation; public versus private responsibilities, and civil society involvement in the health programmes in Uganda. With the overall aim to describe and explain HIV/AIDS programmes delivery in Uganda, we will look closer at the more operationalised issues: *political will and commitment, support of government officials, resource allocation, involvement and support of civil society* in programme or decision-making *and local control over the programmes (decentralisation).* As these factors will operate in tandem and interlink, it is an overall aim of this study to discuss whether some characteristics of the Ugandan programmes seem more important than others. The following figure outlines the focus of this study and the possible relationship between the factors examined and the relative success of fighting HIV/AIDS in Uganda.

Figure 1 Contemporary mind map on the influence of the different factors explaining the relative success of fighting HIV/AIDS in Uganda



To what extent, and how, may these factors have influenced the relative success of the HIV/AIDS programmes in Uganda? On the basis of interviews with a substantial number of respondents involved at various levels in the HIV programmes in Uganda (see section 1.4), we address the factors mentioned above through the following questions:

Political will and commitment: Do politicians express support to the HIV/AIDS programmes? Is the issue of HIV/AIDS expressed in various documents by politicians: in speeches, policies, meetings, laws etc? To what degree and how have politicians been involved in channelling information about the epidemic to the people? Do they hinder HIV/AIDS interventions to be carried out? How large amount of the HIV/AIDS resources have been spent by the government? What loans have been granted from international donors to the Government of Uganda to fight the HIV/AIDS epidemic? To what degree have politicians created an enabling environment for other actors involved in fighting the epidemic such as civil society and international organisations?

Support of the government officials: Do they express support to the HIV/AIDS programmes? To what degree and how have bureaucrats initiated and implemented HIV/AIDS programmes? How extensively are they involved in channelling of resources? Do they channel resources efficiently to actors? Do they support and cooperate with civil society and donors? Do they hinder HIV/AIDS interventions from being carried out?

Involvement and support of civil society[13]*:* How do the civil society organisations spread information to people about the disease? Do their programmes/ activities support and compliment government programmes? To what extent do they cooperate with the government? How are CSOs[14] included in public programmes, in decision-making and implementation? To what extent and how is civil society controlled by the government in their HIV/AIDS activities?

Human and financial resources*:* How much money has been spent on HIV/AIDS activities? Where has the money come from? How much has been given to HIV/AIDS activities from international donors and through what channels? How much and to whom has government given financial resources? What activities and what actors have attracted most financial resources? How have human resources been mobilised and through what actors? Are financial/ human resources adequate or are there great gaps between needs and resources?

Degree of decentralisation*:* How much has been and is decided by central government and how much by local governments? Who has implemented and implements HIV/AIDS programmes in Uganda? At what levels of government do initiatives to various programmes come from? How much control, supervision does central government have over local governments? How do districts mobilise and channel resources?

1.4 Methodological Approach and sources of Information

This is a case study as I want to find out *why* Uganda has been relatively successful in fighting the epidemic, through which factors one can explain the phenomenon. In addition, the thesis focuses on *how* the selected factors are influencing the HIV/AIDS programmes. According to Yin (1993: 01) a case-study is "(…) the preferred strategy when "how" or "why" questions are being posed. The object of this study seems to fit in Yin's preconditions of case-studies: A case study is an empirical inquiry that: "investigates a contemporary phenomenon within its real-life context especially when the boundaries between the phenomenon and context are not clearly evident!" In principle, a comparative case-study of two countries: one with success and another without could have been interesting and probably more informative than a singe case. However, as a topic for a master-thesis a comparative study would be too extensive and resource demanding.

With the intention to acquiring more information on how HIV/AIDS programmes in Uganda have been initiated and implemented the thesis will combine *national* and *district* level data and analyses. Through a combination of a district and a national study: one can look into the national overall response and further examine the local dynamics of the HIV/AIDS programmes. Data from these two levels will be collected,

[13] In this thesis civil society is regarded as both NGOs (non-governmental organisations), CBOs (community based organisations), FBOs (faith-based organisations) and partly INGOs (international non-governmental organisations).

[14] NGOs, CBOs, FBOs and ASOs

compared and combined. Comparisons of two districts could be interesting. However, difficult in obtaining data about HIV prevalence rates, made this approach beyond the scope of this thesis[15]. The chosen research strategy will expectantly increase the availability of additional data, which may lead to more in depth conclusions about the necessary factors, and lessen the possibility of reliability/validity errors.

The district of Masaka's response to the HIV/AIDS epidemic will be examined in this thesis. There are numerous reasons for choosing Masaka district. It was the second district, after Rakai, which was struck by the HIV/AIDS disease and response programmes were put in place early. Various types of evidence suggest that Masaka has experienced progress in fighting the HIV/AIDS epidemic. A cohort study collected by the Medical Research Council suggests that in a sub-county of Masaka the HIV-prevalence in the adult population declined from a peak of 8.2 percent in 1989 to 6.9 percent in 1998. The reduction was found in seroprevalence among young men and women, but not among older women (Kamali et al. 2000). The study suggests behavioural changes to be the reason to these changes. Among young men aged 13-19 years there was a trend towards an increase in reported age of sexual debut and women report marrying later (Ibid).

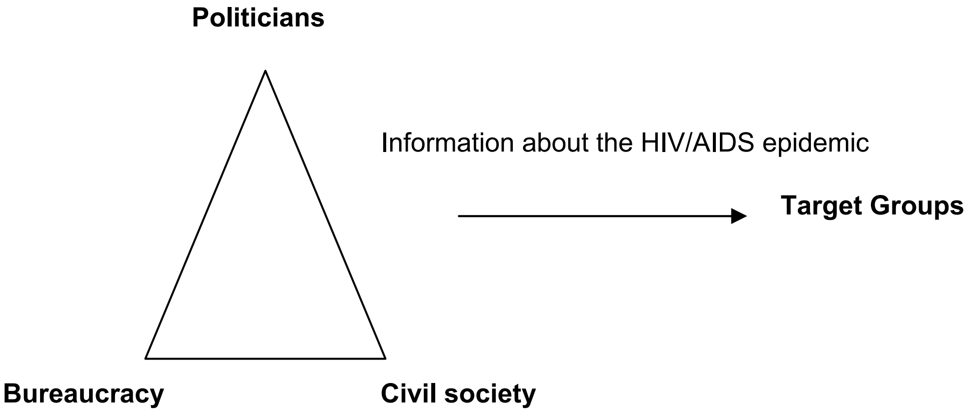
In addition to the observed changes, Masaka is a district with more accessible information than many other districts in Uganda. Several research projects have been initiated, and the district has numerous organisations involved in fighting the HIV/AIDS epidemic. However, we should keep in mind that Masaka district might be an example of a "good-case scenario" where more interventions have taken place than in many other districts. However, in order to understand which factors have contributed to the progress in Uganda, Masaka could at least serve as an example.

Several actors have been involved in initiating and implementing HIV/AIDS programmes in Uganda with politicians, government officials, civil society and donors/ international organisations as the most important. The focus of this dissertation

[15] I considered comparing areas districts with "success" versus districts with more of a failure rate in fighting the HIV/AIDS epidemic. However, lack of information that may be "broken down" into district level, made such a strategy more difficult. On the basis of existing statistics, it is difficult to find areas where there has been an increase instead of a decrease in prevalence levels. There is also limited information in those districts where fewer interventions have been initiated/ implemented.

will lay on the national actors involved in fighting the epidemic, as well as actors operating at district level in Masaka. Even though external donors and international organisations apparently have been important actors I will not regard this as a separate variable but primarily analyse its role through national programmes and actors. However, the international community will be included when analysing resource allocation. Cooperation between the various actors will be an essential part of my analysis, and the effect of different factors/ variables will be examined through the effect they have on the cooperation between various actors.

Figure 2 Collaboration between the internal actors in HIV/AIDS programme



Data collection and sources of information

On the basis of limited resources, the information required for my research questions, could be best achieved through the use of qualitative material, through interviews and documents. No surveys or quantitative measures are available about people's approach to, or expectations and delivery from, government programmes. Furthermore, the information we need is in depth information about the phenomenon and not information about expansion or numbers, qualitative measures will be employed (Thagaard 1998:16). The research will collect evidence from numerous sources as the studies of implementation of programmes should do (Yin 1982).

One of the most important sources of information in case-studies is the interview (Yin 1994: 84). However, as interviews represent subjective material and could be biased, poor and inaccurate, they will be supplemented by other sources of information (Ibid:

85). Thus, the *primary* sources of information will be collected through interviews and secondary data from various documents. Figures on HIV/AIDS spending, although not extensively employed, will be used as information to see resource use as well as to get information about the various contributors. By an integration of different types of empirical material, the reliability of the research will hopefully increase.

In order to get as much balanced information as possible; to assure reliability a certain number of informants have been interviewed and documents have been collected from different sources. As the three main actors within this area are bureaucrats, civil society and politicians, they are all aims of the interviews and the collection of the written material. However, politicians have been difficult to get hold of and therefore only interviews of two politicians in Masaka are included. In addition some interviews of academics who have analysed the problem will be included although they have not been directly involved in program implementation. Moreover, documents and interviews from international organisations and donors were collected as another means of getting more information on HIV/AIDS programmes, the interplay between actors and resource allocation. Various informants: government officials, donors, academics, politicians and civil society probably have different ways of looking at the HIV/AIDS programmes and have different interests in the HIV/AIDS programmes. Thus, when analysing the material provided by the different actors we should take into consideration that they may overemphasise their own role and underestimate the roles of others. In addition, there is a possibility that there might be a certain lack of trust between civil society and the government.

Various documents were examined to supplement the information from the interviews: Documentations on the action of the government and others in reducing the HIV-prevalence: the different National Strategic Frameworks for combating HIV/AIDS; Government agencies plans for HIV/AIDS activities in their sector; Documentations on financial and human resources (education/qualified health personnel etc.); Information about the programmes of the civil society organisations (their own reports, leaflets, etc.); Reports on how information is passed from one actor to the other: the cooperative mechanisms between them (NSP, guidelines etc); Inventory of Agencies

(1997; 2001): studies of all agencies involved in HIV/AIDS activities and Documents from various donors: (UNICEF, UNDP, World Bank etc.) on available financial resources.

Interviews[16]

An important source of information for this research will be semi-structured interviews. The interviews are structured as they pose certain questions, but there is also the possibility of posing more questions when this is needed or to skip some questions if they are already answered. The questions will be open and without standard answers to obtain as much information as possible from the respondents. Too structured interviews would not be appropriate as “the implementation proves represents a complex interaction, over time, among a distinctive set of key actors and events at any given site” (Yin 1982).

The first questions posed are very general questions about the reasons for the observed progress in Uganda to get as much information as possible about the reasons for success. Information on their influence/ contribution is also important. Other questions are being posed to get more information on the different factors examined. Potential problems may rise from the fact that HIV/AIDS and sexual behaviour is a sensitive issue. Nevertheless, as the focus will be put on what the respondents observe and experience through their work and in general in Uganda and not their own sexual practices, problems of sensitivity are probably avoided.

Critics of the Ugandan success-story

We have witnessed in the previous sections various evidence of progress in Uganda’s fight against AIDS. Thus, I will argue that the country has been at least relatively successful in their efforts. Nevertheless, some researchers have posed the question of whether the reduction of the HIV/AIDS epidemic in Uganda is only a natural course of the epidemic and not a result of the prevention programmes. Thus, Epstein (2001) opens up the possibility of the HIV-virus spreading in two periods in Uganda as several other epidemics have shown ups and downs during their course. The rapid

[16] Go to Appendix IV for further information on how the interviews have been carried out.

spread of the HIV/AIDS epidemic during the civil war in the 80s mainly happened through rapes and as a result of large migration waves, which again resulted in a huge prevalence rate a few years later (beginning of the 90s). A decrease in HIV prevalence could therefore be a result of death for people being infected through the "first wave" (Ibid).

On the contrary UNAIDS (1998) also sees the reduction of the HIV-prevalence and incidence to be (…) "more than expected from the natural history of the epidemic and probably result from a behavioural change". Kamali et al. (2000: 434) emphasise that the migration effect can not explaining the observed decline in prevalence. In addition to focus on real changes in seropositives we must look at the incidence: how many *new* people are infected with the virus. Prevalence in the young age groups (age 15-19) is closest to the incidence rate since infections have occurred recently and mortality is high and relatively stable (Fylkesnes et al. 2001). A study by Killian et al. (1999) points at the decrease in HIV prevalence to be larger than what is possible for an uninfluenced epidemic indicating changes in behaviours to be responsible also among the youngest age groups.

The perhaps most critical article to the "Ugandan success story" was written by Justin Parkhurst and printed in *Lancet,* 2002. According to Parkhurst (2002) the assertion that HIV prevalence rate has fallen from 30 to 5 percent is mistaken as this is the only case in a few of the antennal urban sites, and there has been an overrepresentation of urban sites, especially in the early years. Parkhurst claims fall in prevalence rate is commonly regarded as fall in incidence rate[17]. However, this is a misinterpretation of data as a fall in prevalence rate will only reflect reduced incidence rates around seven years earlier. According to Parkhurst (2002) fall in prevalence rate in Uganda has been reported since 1993, which would result from falling incidence rates for 1985 when the country was in civil war and no prevention programmes had been initiated.

[17] Incidence rate: the number of **new** people infected with HIV-1 virus,

Prevalence rate: the number of people infected with HIV-1 virus throughout the whole population

In contrast with Parkhurst's assertions UNAIDS (2000) operates with a general peak on a 14 percent HIV prevalence rate from the early 1990s[18]. Rural areas were also looked at separately, and overall declines have also been observed here. In addition, most reports observed a certain decline from 1993. Interestingly in 1986 the NRM introduced the first prevention programmes. Thus, apparently there is a seven-year delay between the start of the response and the beginning of fall in prevalence rates. Parkhurst's scepticism to the prevalence rates does not seem to undermine the validity of this thesis. In fact, even the author himself claims there is growing evidence today that also the incidence has declined based on the fall of prevalence-rate among the *youngest* age group. The author even claims "other African countries have not seen similar declines in prevalence, suggesting that Uganda alone must have acted in a way that changed the course of its HIV/AIDS epidemic" (Parkhurst 2002). He believes other countries have several policy lessons to learn from Uganda (Ibid).

Nevertheless, I share Parkhurst's reservations about the exaggeration of the "Ugandan success-story". Uganda could be referred to as a country with observed progress rather than "a success story". Eight percent of the population in Uganda or 720 000 people are still infected with the HIV-virus and many people have died (UNAIDS 2002). However, there seems to be common agreement on the progress in Uganda in fighting HIV/AIDS which we can not find elsewhere in Africa. There is also reason to believe that programmes have been somewhat successful as a reduction in HIV/AIDS-incidence/ prevalence has coincided with high level of awareness among people with changes in sexual behaviour. However, to what extent the behavioural changes are a direct result of different programmes are open to question (UNAIDS 1998).

In addition, a final note of warning concerns the reliability of the statistics. Statistics and health and welfare data in developing countries generally struggle with inaccuracies as they are only estimates and often depend on people's own perceptions. People might for instance exaggerate or underestimate their sexual activities. AIDS statistics also suffer from serious underreporting (STD/AIDS Control Programme 2003). On that basis, causal explanations of health patterns and public policy have

[18] Even though a 30 percent prevalence rate was observed in certain urban areas in Uganda.

clear deficiencies, which will be taken into consideration when analysing data from Uganda's HIV/AIDS programmes. In order to control the amount of progress in Uganda and in Masaka, the respondents will also answer to whether or not they have observed any real changes in prevalence rates, awareness and sexual behaviours and cause of such changes as well as present limitations.

Despite these possible weaknesses, there are certain tendencies which can be observed through the examination of the figures on which I have based this thesis. As long as there is no cure or vaccine and the access to medication is limited for developing countries, prevention programmes is the only way to go to cope with the epidemic. A better understanding of the Ugandan HIV/AIDS programmes can therefore help us in moving closer to a solution to prevent more people from catching this deadly disease.

Chapter two will introduce the reader further into the Ugandan social and political background. In chapter three the theoretical approaches will be introduced with a strong focus on the different approaches' view on the five selected variables. Chapter four looks closer at the Ugandan HIV/AIDS programmes and how they are organised. Chapter five will attempt to understand how the different factors have influenced the Ugandan HIV/AIDS programmes. I will examine how these findings correspond to theoretical approaches and whether new approaches must complement the classical implementation theories.

2 Ugandan background

2.1 Introduction and political background

> *"But the Kingdom of Uganda is a fairy-tale. You climb up a railway instead of a beanstalk, and at the end there is a wonderful new world."* (Winston S.Churchill, My African Journey, 1908, in Ofcansky 1996: vi)

While Churchill characterised Uganda as the "Pearl of Africa", the country has become more known in the past decades for ethnic rivalry and its brutal past. After independence from British rule in 1962, the early years were marked by political instability and social violence. Various ethnic and religious divisions in the Ugandan society have been made at least partly responsible for instability, resulting in eight different governments, four of them achieved by military force before 1986 (EIU 1992-93). Much violence was expressed through the Nilotic people in the north against the Bantu in the south. Colonialism has also made a contribution to these differences as the North was militarily dominant until the National Resistance Movement's (NRM) takeover in 1986 (EIU 2002).

The first Ugandan constitution allowing a federal state was suspended already in 1966 by the Prime Minister Obote. He declared himself President as he turned the Congress under his control and became a dictator dependent on the army with a wish to transform Uganda into a socialist state (Mugaju 1996: 11, 15; EIU 1992). Idi Amin replaced Obote in a Military Coup in 1971. The initially popular rule of Amin soon, however, turned into a reign of terror (Ofcansky 1996: 44). His army led several attacks on the people of Obote, the Langi people in the North and their Acholi neighbours, killing the army and thereafter the civilians in the most gruesome ways (EIU 2002; Mugaju 1996: 18). Civilians in the South were also killed, especially Christians[19]. An estimated number of 300.000 people were killed in Uganda during his seven-year regime (EIU 1992). Lawlessness, collapse of public institutions and infrastructure, as well as economic catastrophes marked the following years. Deportation of 70.000 business-men and handing over of businesses to Africans led to total collapse (Mugaju 1996: 19). The regime of Idi Amin came to an end in 1979

[19] Idi Amin wanted to kill all Christians who made up around 80 percent of the population (Mugaju 1996: 18)

when he was overthrown by a Tanzanian army supported by oppositionists having escaped from Uganda (EIU 2002).

The following two governments of Lula and Binaisa only stayed in office for a short time. An election in December 1980 brought Milton Obote and his Uganda People's Congress back to office, although many people questioned its fairness of the election. As Obote returned to power the 27th May, 1980 he was given a warm welcome from many Ugandans as he was portrayed as the only man experienced enough to lead the country (Mugaju 1996: 22). Obote's strategy was to revive the economy and to maintain good diplomatic relations with the western powers[20] (Mugaju 1996: 23). In spite of some economic success, the government was unable to attract foreign investment (EIU 2002). From 1981 to 1985 the state remained de facto a one-party state and by the end of 1983, the National Resistance Movement (NRM) had emerged as the only real threat to the present regime (Mugaju 1996: 56). Obote responded to the opposition by use of military power which by late 1984 had resulted in deaths of over 300.000 people (Tumusiime in Ofcansky 1996: 52). By 1986, the NRM/A marched to Kampala, seized power and Yoweri Museveni became Uganda's president (EIU 2002).

2.2 Social and economic conditions

At independence Uganda had the opportunity of great development. However, when Museveni took over the Ugandan future looked anything but bright. By 1985 Uganda was on the verge of fragmentation as different armed fractions controlled different parts of Kampala and areas of the country (Leggett 2001: 02). In addition, the heritage of murders and massive refugee problems had to be solved, and there was a desperate shortage of essential goods such as soap, sugar and salt (Ibid). The economy lay in ruins and the politically state machinery was in shambles (Mugaju 1996: 27). Human resources were tapped as many people in the educated elite had been killed or left the country, and many educated Asians had been expelled (EIU 92-93). Lack of investments and maintenance skills led to a fall in capital assets in agriculture, transportation and manufacturing (Ibid). Inflation rates were extremely high.

[20] Obote embraced the policies of the International Monetary Funds (IMF) and the World Bank as he started to adopt their economic strategies (Mugaju 1996: 23).

Smuggling was part of people's lives and trade was impossible within and outside Uganda (Leggett 2001: 02). Only subsistence farming and coffee production had survived the regime of Idi Amin (Ibid). While Uganda's social indicators in the 1960s were mostly much better than other low-income countries, in 1986 they were similar to the ones of low-income countries South of the Sahara with high birth and death rates, high fertility rates and low life expectancy at birth (Hansen/Twaddle 1991: 25). In 1990 Uganda had become the 28th poorest country in the world (UNDP).

Table 2.1 Development situation in Uganda at the time of NRM's takeover (UNDP 1990)

Life expectancy at Birth (1987)	Adult Literacy Rate (1985)	HDI (Human Development Index)	GDP per capita (PPP- US $)	HDI minus GDP rank[21]
52	58	0.354	511	7

As a British colony Uganda had developed one of the finest Western medical services in sub-Saharan Africa (Obscansky 1996: 82). However, "(...) the Amin era and its aftermath resulted in neglect of health infrastructure and loss of resources" (EIU: 02). Doctors, nurses and medical technicians of different origins moved out of Uganda. Thus, severe personnel shortages throughout the health care sector occurred (Obscansky 1996: 82).[22] The collapse of health infrastructure contributed to higher mortality amongst children from treatable illnesses (due to lack of vaccination) and increased mortality rates amongst patients treated in hospital (Hermele 1989: 84-85). Epidemics spread fast due to a run-down health system as well as under-nourishment, lack of safe water bad hygiene etc (Hermele: 1989: 85).[23] Simultaneously, UNDP reports of simultaneous improvements in people's life expectancy (from 1960 to 1986),[24] rising adult literacy rates[25] and reduced "under five-mortality rates"[26] (Ibid).

[21] A positive figure shows that the HDI rank is better than the real GDP per capita (PPP USD) rank, a negative the opposite (UNDP 2003).

[22] From 11.110 physicians in 1965 the number in 1984 was 21.900 (Hansen /Twaddle 1991: 24).

[23] In the countryside the situation was worse and in the Luwero-triangle the infant-mortality rate reached 300 thousandth, three times as high as in the rest of the country (Hermele 1989: 85).

[24] In 1987 life expectancy in Uganda was 52 years, a rise from 48 years in 1975 and 43 years in 1960 (UNDP 1990).

[25] Rose from 41percent in 1970 to 58 percent in 1985 (UNDP 1990)

[26] Dropped from 224 (in a thousand) in 1960, to 169 in 1988 (UNDP 1990)

Table 2.2 Uganda's Health situation in 1986 (UNDP 1990; 2003)

Pop. w/access to Health services: 1985-87 (percentage)	Maternal mortality rate 1980-87	Thousands of people per doctor (1984)	Infant mortality rate (1970)	Health Expenditure of GDP (1986)
61	300	21.9	110	0.2

The collapse of social infrastructure also had a severe effect on the best education systems in tropical Africa at independence. This can be observed through a relative decline in primary school enrolment between 1965 and 1980 (in contrast to sharply rising trends in the rest of South Saharan Africa) (Hansen/Twaddle 1991: 25). In 1965, 67 percent of the primary school age group was enrolled in school, but in 1985 only 50 percent was enrolled (Ibid).

2.3 Uganda Today

The NRM government brought a ten-point program forward at the time of their takeover. The main points were: restoration of democracy, security of person and property and unity of Uganda. With the restoration of democracy Museveni claimed that both village committees and parliamentary democracy were necessary. By security of person and property the following was stated: "The people of Uganda should die only from natural causes which are beyond our control, but not from their fellow human beings" (Legum 1987). By unity of Uganda he wanted a change from the past regimes of sectarianism, which had put people up against each other. His Uganda should be a united country where all religions, tribes and individualities were welcomed (Ibid)[27]. In establishing democracy, the government understood that in a poor society where people are hungry, one cannot enjoy or practice democracy (Mugaju 1996: 29). Museveni argued that multi-party democracy is not right for all countries and for Uganda this system had been a part of past problems as it emphasised the differences rather than the similarities (Leggett 2001: 05; Obscansky 1996: 59). In order to secure stabilisation of Uganda Museveni's introduced a zero-party movement based system (Ibid). Simultaneously, he announced the absence of

[27] Museveni also wanted Uganda to cooperate closely with the other East-African countries (Legum 1987)

elections for 5 years and decided to "prevent political parties from holding meetings unless approved by authorities" (Legum 1987). Originally this was a system put in place in a transition period until the Ugandan society was ready for multipartyism (Mamdani in Human Rights Watch 1999). The Constitution of 1995 legitimised the "no party state" and committed the country to another five years of "no party rule" with ban on political activities controlled by the NRM. In 1996 the President and the Parliament were formally elected to power under a new constitution. The referendum of 2000 resulted into over 50 percent vote against bringing back political parties, leading Uganda to keep the no-party system (EIU 2002). In the Presidential election of 2001 Museveni was re-elected for his third five-year term by 75 percent of the votes (Ibid). International agencies have questioned whether these elections were free and fair. Museveni's continued ban on party politics has also been criticized, and his zero-party system is said to be a one-party system in practice

In February 1986 Museveni announced the system of Resistance Councils (RCs) as part of the Movement System as a way of introducing popular democracy to Ugandans (Obscansky 1996: 59). These Councils were set up at village, parish and sub-county level, and were later expanded to county, district and national level (Mugaju 1996: 28). All Ugandans are members of this five level movement system whether they want to or not, as they are all members of a village (Human Rights Watch 1999). In 1989 the first election was held to these Committees (Hermele 1989: 106). At national level the National Resistance Council became the law-making body of Movement System (Ibid). In the 1997 Local Government's Act the Local Councils (LCs) replaced the former Resistance Councils. And the Constitution (1995) and the Local Government Act (1997) transferred more power from central level to these local governments in several areas (Human Right Watch 1999).

According to Human Rights Watch (1999) an important part of the local council structures serve as partisan NRM bodies during election times and target multipartyists and their supporters for abuse during these periods. Local councils often mobilise in support of NRM candidates and can thus influence the success of a candidate. Many critics thus see this system as a one-party state rather than a system without political

parties. In addition, civil society in Uganda is fairly restricted as NGOs have to be formally registered in order to operate. And the government exercises considerable control over nongovernmental organizations (NGOs) by delaying or threatening to withdraw their registration, which must be sanctioned by a government-controlled board and can be quickly revoked. Although the NGO Registration Statute sets no such requirements, NGOs must function as non-political and non-sectarian organisations, and practice a significant amount of self-censorship of their programmes in order to obtain and maintain registration (Human Rights Watch 1999).

Museveni has managed to maintain good relations with the west despite his denial of multiparty-democracy, corruption within the government and a large record of human rights violations (Ofcansky 1996: 59). His early embracement of the economic policies of IMF and the World Bank with liberalising trade, privatisation and fiscal and monetary discipline has largely contributed to this positive relationship (Leggett 2001: 02). Since 1986, there has been an impressive transformation of Uganda's commercial, economic and social infrastructure (Leggett 2001: 03). A relatively stable Uganda combined with foreign aid has contributed positively in building up the country's economy, and the country has become a model of success for structural adjustment policies (EIU 2002). The results are visible: inflation has decreased dramatically from over 200 percent in 1987, to 4 percent in year 2000 (Leggett 2001: 03). Since 1986 Uganda has experienced an average early economic growth of over 6 percent through most of the 1990s (EIU 2002). From having a GDP per capita of 511 in 1987, the figure today is 1490 (UNDP 19902003). Simultaneously, Uganda's score on the international Human Development Index has improved from 0,386 in 1985 to 0,489 in 2000 (UNDP 2003).

Table 2.3 Recent social, economic indicators for Uganda (UNDP 2003)

Life expectancy at Birth (2001)	Adult Literacy Rate (2001)	HDI	GDP per capita	HDI minus GDP rank
44,7	68	0,489	1,490	1

As under colonial rule, agriculture remains the most important sector of the Ugandan economy (Leggett 2001: 54), accounting for about 42 percent of GDP with subsistence farming countering for almost half of the incomes and employing over 80 percent of the work force (EIU: 02). The Ugandan economy is largely dependent on high international coffee prices leading to a vulnerable economy over which they have very little influence (Ibid; Ofcansky 1996: 100). A significant part of the Ugandan economy is informal and "non-monetary" as families take care of their own needs and don't take part in the trade-market (Ibid). Uganda is largely dependent on foreign aid. According to Leggett (2001: 60) Uganda's macroeconomic stability is due to the increasing level of foreign aid, and not real changes in the economic capacities of Uganda. From 1986 to 1997 donor support increased from US$ 200 million to US$ 850 million (Leggett 2001: 60). The negative aspect of the inflow of aid was a rapid increase in the size of the foreign debt (EIU 2002). In 1999 Uganda had a debt on US$ 4.1 compared to US$ 1.2 in 1986 representing 64 percent of GNP. The debt represents more than 525 percent of the value of exports of goods and services (EIU 2002).

The GoU started the Poverty Eradication Action Plan (PEAP) in 1997 recognising "that the benefits of growth didn't reach the poorest Ugandans" (Leggett 2001: 64). According to the Uganda Poverty Status Report (1999) there has been a decline in absolute poverty from 56 percent in 1992 to 46 percent in 1996, and around 35 percent of Ugandans live below the poverty line. Economic growth has reduced the overall proportion in poverty quite substantially (Uganda Poverty Status Report 1999: xiv). Poverty reduction has however been uneven as the poorest 20 percent of the population did not benefit much (Ibid). Between year 1990 and 2000, 82 percent of Ugandans lived on less than one US$ a day and 96 percent of the population live on less than two dollars a day (UNDP 2003). This gives one of the highest poverty rates in Southern Africa (Ibid). Corruption among civil servants and politicians is an issue aggravating the situation for the poor. Simultaneously there is an emerging elite in Uganda that is heavily benefiting from the economic growth of the country as they have the money, connections and access to information (Leggett 2001: 62).

Most people have, however, started to benefit from the government's emphasis on basic social services (Leggett 2001: 63). Life expectancy has decreased from the late 80s[28], largely due to the many deaths of the HIV/AIDS epidemic, but is higher than previous years and still higher today than in the late 90s.[29] According to WHO/AFRO ([online]) only around 49 percent of the Ugandan households have access to health care facilities, which is due to lack of infrastructure especially in rural areas. In addition most Ugandans have to pay for treatment if they get sick and as people delay going to get treatment, illnesses such as malaria get more serious (Leggett 2001: 63).

Table 2.4 Uganda's Health situation today (UNDP 2003)

Pop. w/access to health services: 2000	Matern.mortal rate pr. 100 thousand (1985-2001)	Physicians (per 1000, 000 people (2002)	Infant mortality rate (2001)	Health Expenditure of GDP (2000)
Affordable drugs: 50-79 percent Improved sanitation: 79 percent	510	5	79	Public: 1.6 Private: 2.4, Per capita: 38

More than 50 percent of Ugandans do not have access to clean water, which make them vulnerable to cholera and diarrhoea (Leggett 2001: 63)[30]. Promising signs are expressed by the infant mortality rate which decreased from 110 per life births in year 1970 to 81 in 2000 (UNDP 2002). Furthermore, 68 percent of the adult population of Uganda was literate in year 2000 compared to 58 percent in 1985 (UNDP 1990; UNDP 2003)[31]. It is in fact within the education sector the biggest improvements in Uganda with the introduction of Universal Primary Education (UPE) (Leggett 2001:03). Previously more and more children were dropping out of schools due to the school fees (Leggett 2001: 65). The figure of enrolment in schools increased from 2.7 million in 1996 to 5.3 million in 1997 and 6.56 million in year 2000 due to the introduction of UPE (Uganda Bureau of Statistics 2001). The number of primary schools and secondary schools has increased partly for the same reason (Statistical Abstract 2001; Leggett 2001: 67). However, school fees may still prevent many

[28] Life expectancy at birth in Uganda was only 44.7 years in year 2001 compared to 52 years in 1987 (UNDP 2003).

[29] In 1997 life expectancy was as low as 39.6 years (UNDP 1999).

[30] Between 1995 and year 2000 malaria was the highest cause of death among Ugandans, followed by pneumonia, worms and diarrhoea (Uganda Bureau of Statistics 2001:54).

[31] Youth literacy rate has also increased (15-14 years) from 65.5 percent in 1985 to 78.8 percent in year 2000 (UNDP: 2002).

children from access to *higher* education as only around 40 percent go on to secondary school (Leggett 2001: 67-68)[32].

Women are very important in the Ugandan society as they are the caretakers in the family and perform 90 percent of the domestic labour, as well as 80 percent of agricultural labour (Mygenyi 1998). However, cultural customs and limited ownership and control of agricultural production such as land, information, technology and training have undermined the woman's position in society, keeping her subordinate and highly dependent on the man (Mygenyi 1998; UNDP 2002). "They are the most underprivileged ones living in the undesirable conditions of the vicious cycle of underdevelopment" (Lubwama 1990: 49) Women make around 2/3 of the money made by their male counterpart, and only 57 percent of women are literate compared to the 75 percent of men (UNDP 2002). Girls drop out of school more than boys, and due to their dependency on men and extreme poverty women have been more vulnerable to diseases such as HIV/AIDS. Nevertheless, with affirmative action policies of the Government more women today take higher education and are involved in politics at all levels. Through the Local Councils and at National Level 27 percent of the ministers are women (Mygenyi 1998). Women's organisations and associations have been established, enabling women to express their point of view (Ibid). Nevertheless, the government's reforms are criticised for not addressing gender issues at family level. Many consider issues like sexual and domestic violence, wife-inheritance, division of labour, property ownership etc. to be private issues and not matters for the state (Ibid).

Even though there has been observed great changes in Uganda, it is important to stress that there are great differences within the country. Economic growth and stability/ security is highly visible in the South, around Lake Victoria, a shift from the brutal violence of the past regimes and progress in the reduction of ethnic tensions (Obcansky 1996: 58). People in the North-East are poorer, have less access to public services that are of worse quality. Their freedom and security is also very limited.

[32] There are also high dropout rates in secondary schools especially for girls due to a large amount of orphans and widespread poverty.

They tend to oppose the government and feel excluded and unprotected due to the government's lack of concern and almost non-existent education (Leggett 2001: 05, 30). There is "chronic insecurity in parts of Northern and Western Uganda leading to social dislocation and economic underdevelopment in the most affected areas" (Leggett 2001: 03). The Lord's Resistance Army (LRA) has for the last fifteen years under their leader Joseph Kony terrorised the people of Kitgum and Gulu instead of fighting the government's army. They have no political agenda or alternatives, but the government of Sudan supports them and their behaviour has extremely violent consequences for civilians (Leggett 2001: 29, 30). Over 20.000 children have been abducted by this army (Leggett 2001: 31). People have been driven from their homes, separated, killed and raped. In such an environment the HIV/AIDS epidemic normally spreads fast (Leggett 2001: 05, 30).

2.4 Conclusion

The Ugandan people have experienced many years of insecurity and brutality since the bright outlook at independence in 1962. Amin and Obote destroyed the country through civil war and dictatorships. Today Uganda is more stable and in many areas the country has witnessed progress compared to the situation when Museveni's NRM government came into power in 1986. Economic growth has developed and simultaneously the Ugandan government has focused on building up infrastructure, health and education etc. Despite progress, Uganda is still one of the poorest countries in the world ranging number 147 out of 173 countries at the Human Development Index. People are struggling for their lives and women are still inferior to men. The Northern part of Uganda is lagging behind and experience insecurity in their daily lives, which the government has difficulties in controlling. Uganda has also been criticised for human rights violations and for being one of the most corrupted in the world. Museveni's recipe on democracy with no parties is also questioned and the UN considered the last election not free and fair. However, in the fight against the HIV/AIDS epidemic Uganda has been and is still portrayed as a good example, and people from other countries come to Uganda to learn how to deal with the epidemic.

3 Theoretical Approach

3.1 Introduction

In the 1960s and early 1970s many countries in the Western world instituted programmes with the intention to improve people's health, expand educational opportunities reduce pollution etc. Implementation theory came up seeking to explain the apparent failures of these programmes such as the ambitious Social Programmes; "War on Poverty" and "Great Society" (Sabatier 1986a; Kjellberg/ Reitan 1995: 138). The initial contribution to implementation theory came from Pressman and Wildavsky who conducted a pioneer study in 1973 where they thoroughly examining factors important for policy implementation (Ingram 1990). Their study was later to become a contribution within the "top-down" approach of implementation research, as a contrast to the later "bottom-up approach". These theoretical contributions have very different points of departures, and they emphasise the importance of different actors involved in the implementation of public programmes. Whereas the "top-down" approach emphasise the importance of formal actors like politicians and bureaucrats, and a centralised state and existence of resources, the "bottom-up" up approach points at the power of the grassroots: the involvement of civil society and local government's authority to address their own needs (decentralisation).

Hence, classic implementation theories address several of the factors which at the time of Museveni's takeover and his announcement of the AIDS Control Programme were either absent or very limited in the Ugandan society. The country was in economic ruins after the many years of terror-regimes with extremely limited financials resources, absence of external donors, and there was even a lack of state power, institutions and authority. Health services offered to people were almost non-existent, and the organised civil society was very weak. Government officials had also been under a "rule of the jungle" mentality of previous tyrants. Thus, as Uganda lacked so many of the factors selected for this study, one would not expect them to have played an important role in understanding the relative success of fighting HIV/AIDS. It is therefore a challenge to examine if some of the factors emphasised by various

implementation scholars have actually had a positive effect on these programmes or if Western implementation theories are not at all relevant in this setting

3.2 Theory on implementation of public programmes

"Top-down" approach

The "top-down" approach to implementation of public programmes is often described as "forward-mapping" or "decision-oriented". Adherents assume policy to be formulated at the top and transferred and implemented at the bottom (Younis/ Davidson 1990). In order to explain success or failure in implementation, they start with a policy decision approved by the government, and thereby see if the implementing officials and target groups have followed the goals of the procedures and policy (Sabatier 1986a). Adherents of the "top-down" approach distinguish clearly between different stages in policy formulation/decision-making and implementation. They focus on the need for control of actors involved and how (…) "official policy-makers can use a variety of control mechanisms and institutional arrangements to guide social-change" (Kaufman: Ch.10 in Sabatier: 1986a). They emphasise the importance of formal structures/ institutions in the implementation process and the formal actors involved in this process: the bureaucrats and the policy-makers[33].

The "top-down" theory does not explicitly include *political will/commitment* as a determinant factor for success in implementation of public programmes. However, adherents have argued for a general need for interest, responsibility and commitment from various actors involved in implementing programmes, including politicians, and especially the political elite and executive sovereigns are brought forward[34]. In addition, they point at *political support* as one of the preconditions of success. It is from this standpoint one can argue that political will/ commitment is a necessary condition within this approach. Mazmanian/ Sabatier (1983: 30-31) express a need to maintain political support throughout the long implementation process, in order to

[33] The "top-down" approach also focus on other factors than the factors introduced in this dissertation such as clear objective and consistent objectives, adequate causal theory, legal control mechanisms (Sabatier/ Mazmanian 1987,1980 in Sabatier: 1986b), but these factors will not be included in the thesis.

[34] Downs 1967; Murphy, 1973; Bardach, 1974; Sabatier, 1975 in Sabatier 1986b.

overcome delays in seeking cooperation among a large numbers of actors with different interests. The authors also claim political support to be essential in order to allocate scarce government resources as well as they emphasise how *socio-economic conditions* should not undermine the political support (Ibid). This position is also brought forward by Van Meter/ Van Horn (1975) as they recognise that political support will (…) "make more available resources which will facilitate administration".

For adherents of the "top-down" approach the bureaucrats/ government officials are the most essential actors involved in formulation and implementation of programmes. They believe the support of bureaucrats goes hand in hand with the support from politicians (Sabatier 1986b). "Top-downers" claim the commitment of government officials to policy objectives, and skills in utilising available resources, is critical[35]. Mazmanian/ Sabatier (1983: 28) argue that especially when programmes seek to change the behaviour of target groups, the implementers must be strongly committed. This support is expressed through e.g. mobilising support among target groups and other government officials and representing the agency's case in the media (Mazmanian/ Sabatier 1983: 35). They claim the degree of commitment will increase when a new agency is established after an intense political campaign, leading to high visibility and prioritisation of the program (Ibid). Furthermore Mazmanian/ Sabatier claim one of the reasons for bureaucratic support and commitment is better informal oversight and more efficient channelling of the agencies' legal and financial resources (Ibid, p. 33). Van Meter/ Van Horn (1975) assert that the bureaucratic implementers' understanding, acceptance and belief in the objectives of the policy are an essential precondition. Negative preferences will lead to open defiance of the programme's objectives and subordinates may refuse to participate. The question of government officials' support is also a question of what bureaucrats are essential-the ones who are closer to the decision or the ones who are closer to the target groups.

Several "top-downers" include *resources* as a socio-economic condition, which can constrain the behaviour of the implementers and limit the possibilities for success. Consistent with Gunn adequate time and resources must be available to the programme

[35] Lipsky, 1971, Lazin, 1973, Levin, 1980 in Sabatier 1986b

(Gunn 1980: 05 in Younis/ Davidson 1990). Van Meter/ Van Horn (1975) consider both sufficient *economic and human resources* to be critical for successful implementation. These authors claim only a policy decision can provide the type and extent of services such as technical assistance (Ibid). Mazmanian/ Sabatier (1981, 1983) believe financial resources are important in order to improve the ability to guide the behaviour of street-level implementers (Sabatier 1986a). In addition Mountjoy and O'Toole cite the provision of resources and clear instructions as determining factors for effective implementation in order to avoid unanticipated voluntary activity (Younis/Davidson 1990).

Supporters of the "top-down" approach do not emphasise the importance of including informal actors such as civil society in the implementation process. On the contrary, Pressman/ Wildavsky (1973) claim support of official policy-makers is important to affect the outcome of local negotiation more than the informal "street-level bureaucrats" (in Sabatier 1986a). They believe organisations have modest influence in implementation of public programmes and describe them as part of "basically impediments" (Ibid). Nevertheless, the "top-downers" wish a certain control of this group (Sabatier 1986a). Mazmanian/ Sabatier reject hierarchical control of interest groups in the sense of tightly constrained behaviour. Nevertheless, they argue for a certain control of these groups as the behaviour of street level bureaucrats and target groups should be kept within acceptable bounds over time (Mazmanian/Sabatier 1979: 489-92, 503-4 in Sabatier: 1986b).

Despite a certain negative attitude to the *involvement* of civil society expressed by the "top-down" approach, they still believe the *support* of these groups might be important. For instance Mazmanian/ Sabatier claim support of interest groups is one of the necessities, in addition to the support of other actors: politicians, general public and bureaucratic sovereigns (Mazmanian/ Sabatier 1983: 30). Van Meter/ Van Horn (1975) also bring forward the importance of general mobilisation in support of the policy as one of their "economic, social and political conditions". They claim a certain mobilisation of citizens and interest groups to the program might increase the pressure

of the government officials to carry out the programmes efficiently, even if the program does not coincide with their beliefs and preferences (Ibid).

According to the "top-down" approach central level control of the planning and implementation of public policy/ programme is the ideal, and decentralisation with local level control has a negative impact. Adherents consider a strong central state with direct implementation of programmes to be a necessity. For instance Mazmanian/ Sabatier see the need for central guidance and control of the local implementers to make sure they follow the policy decision, and various factors can improve their ability to guide the street-level implementers (Sabatier: 1986a). Van Meter/ Van Horn (1975) believe that a decentralised system of governance where autonomy is enjoyed by the state and local governments, results into programs having a small impact. They claim the more hierarchical control and the less actors involved in planning and implementation of programs and policies, the better (Ibid).

"Bottom-up" approach

The "bottom-up" approach represented by e.g. Elmore, McLaughlin and Whetherley/ Lipsky[36], starts by looking at the actors involved and networks created in the policy problem rather than the policy decision taken by central government (Sabatier 1986a; Banik/ Kjellberg 2000: 153). "Bottom-uppers" criticise the "top-downers for drawing a clear distinction between policy formulation and implementation as no clear distinctions can be made (Sabatier 1986b). They also consider the "top-down" approach puts a too narrow focus on the central decision-makers as the key-actors, and neglects other actors such as the private actors, street level bureaucrats and local implementing officials (Ibid). "Bottom-uppers" also criticise the "top-down" approach for being difficult to employ when there is no dominant policy or agencies and a variety of actors are involved. This complex situation is often the case in social-service delivery (Ibid)[37].

[36] Elmore (1982), McLaughlin (1978) in Ingram 1990; Wheatherly/Lipsky 1977 in Younis/Davidson 1990

[37] Elmore questions "the assumption that explicit policy directives, clear statements of administrative responsibilities, and well-defined outcomes will necessarily increase the likelihood that policies will be successfully implemented" (Elmore 1982).

The “bottom-up“ approach, unlike the “top-down” approach, does not bring forward the support from formal actors such as politicians. Instead this approach focuses on the substantial limit of central government to guide the behaviour of local implementers and target groups (Sabatier 1986a)[38]. Elmore (1982) considers the ability of actors at one level to influence the behaviour of other actors to be limited, and questions the importance of politicians and political control in implementation. He claims (…) “The notion that policy-makers exercise some kind of direct and determinant control over policy implementation might be called the ‘noble lie’ (…)” (Elmore 1982: 20 in Younis/Davidson 1990).

Most adherents of the “bottom-up” approach do not include the existence of resources in their analysis, and take them more for granted**.** However, efficient *channelling* of resources is important according to Elmore. Resources should be given to those in direct contacts with the target group-such as organisations and other street-level bureaucrats (Elmore 1982). Policy-makers should instead of seeking control over the organisations make the most of their human resources. They should allow for implementers to fully utilise the organisations’ professional experience, and support them by the “strategic use of funds” (Elmore 1978: 605 in Younis/Davidson: 1990).

The “bottom-up” approach emphasises the importance of informal actors such as the “street level bureaucrats”, meaning those who interact directly with the target group (teachers, social workers, priests, traditional healers etc.) in service delivery rather than the formal actors[39] (Sabatier 1986a). They argue that civil society organisations are more essential actors in implementing programs as they have more influence on regulation of people’s behaviour than government officials (Sabatier 1986a). Elmore believes in the mobilisation of local skills and inclusion of competence from the target-groups in formulating and implementing programs[40] (Kjellberg/ Reitan 1995: 155). He claims “(…) the diversity in the performance of the task is an important

[38]This will be further examined in a later section looking at decentralisation vs. centralisation in implementation of policies.

[39] According to Weatherly/ Lipsky the street level bureaucrats are those who have direct contact with the public and are required to make decisions about people’s life on a daily basis (Wheatherly/ Lipsky 1977 in Younis/Davidson 1990)

[40] There is a close connection between local level authority and civil society involvement which a later paragraph will further examine.

source of knowledge about how to do it better" (Elmore 1982) He also asserts: "organizations can be remarkably effective devises for working out difficult public problems (…)" (Elmore 1982). However, in order to employ organisations successfully in public policy, government must know of their competence, performance and the resources required, and whether or not their influence will have substantial effect on the problem the policy is trying to solve (Elmore 1982).

Adherents of the "bottom-up approach" believe, in contrast to the "top-downers", that control of street-level professional is neither possible nor desirable (Sabatier 1986a). They believe that elected policy-makers neither at national nor at local level seldom can exercise effective control over "street-level bureaucrats" as the communication and control between them is limited (March/Simon 1958, Grunow: Ch.13 in Sabatier 1986a). For Elmore (1982) the control of organisations work against the principle of reciprocity, as diversity in performance is an important source of knowledge and can lead to improvement on the outcome. "Bottom-uppers" believe that instead of control there should be trust between government and civil society and "(…) one should give them the resources required and trust them to do a good job" (Sabatier 1986a).

Adherents of the "bottom-up" approach are more positive to decentralisation in policy implementation and criticise the "top-down" approach for focusing too much on central governing and control. They wish for decisions to be taken closer to people, and implementation to be conducted by local government. The decision-makers and implementers at local levels know more about people's needs and programs become more efficient. Elmore is one of the authors having a clear decentralised position. He claims that the less hierarchical control and the closer one is to the source of the problem, the higher is the possibility that an intervention will reach the behaviour it attempts to change (Elmore 1980: 28-29 in Kjellberg/ Reitan 1995: 153 and Elmore: 1982). The authors see implementation as a process of learning where policy-makers change their politics and adapt them to the problems they seek to improve. Hence, the programmes do not to turn out to be standardised and abstract (Elmore 1980: 27 in Kjellberg/ Reitan 1995: 155). According to Elmore there is no need for control from the centre. Even if the top knows what the bottom is doing any attempt to tightly

circumscribe the behaviour of professionals is likely to be counterproductive (Elmore 1978 in Sabatier 1986a).

Sabatier (1986b) has brought together the two approaches in a synthesis. According to Sabatier the most useful principle of aggregation when analysing is by “belief system”. A belief system is “(…) actors from various public and private organizations who share a set of beliefs and who seek to realize their common goals over time” (Sabatier 1986b). Thus, he wants to use the networking methodology to identify the actors, but also to look at socio-economic conditions and legal instruments that influence perceptions, resources and participation of actors and constrain behaviour. According to Sabatier both implementation approaches can be criticised on decentralisation vs. centralisation of programmes: “Just as top-downers are in danger of overemphasizing the importance of the Centre vis-à-vis the Periphery, bottom-uppers are likely to overemphasize the ability of the Periphery to frustrate the Centre” (Sabatier 1986b).

3.3 Development theories

Grindle/ Cleaves

In her edited book Merilee Grindle (1980) discusses policy and implementation in third world countries. She criticises studies which range variables that intervene in the process of implementation[41], and who has a too narrow focus on administrative apparatus and characteristics of the bureaucratic officials. The author nevertheless agrees with the “top-down” approach as “means are designed and pursued in the expectation of arriving at particular ends”[42], and where the evaluation of programmes is made “ (…) by measuring program outcomes against policy goals” (Grindle 1980). Grindle points at implementation in third world countries as different from implementation in the developed world[43]. The author shows us the importance of evaluating the *context* in which different policies are implemented in these countries.

[41]See Bardach (1977): “The implementation game”; Van Meter/ Van Horn (1975): “Policy implementation Process”

[42] Van Meter/ Van Horn (1975) “The implementation process”

[43] For instance high concentration of political activity on the implementation process in third world countries leads to more complexity and difficulties (Grindle 1980).

Hence, she brings to our attention the need for relating implementation problems to the characteristics of the *political regimes* in which policies/programmes are implemented.

According to Grindle (1980) formal actors such as bureaucrats and politicians have an important function also in developing countries, but should be evaluated on the basis of the current political regime. A program's success may be affected by the priorities of political officials, and responsiveness is essential in order to e.g. provide for the allocation of resources. Furthermore, the author considers support and understanding from public institutions and bureaucrats of the environment in which they operate. This will ensure responsiveness to the needs of the target groups and flexibility, support and feedback to the programmes.

Grindle (1980) also claims that bureaucrats must make sure there is *political support* and *political commitment* at national as well as at local level. Her research suggests that in a more open, democratic environment, elections impose a greater degree of responsiveness than under authoritarian regimes. This responsiveness to people's needs leads to better adapted and more efficient programmes. Grindle (1980) asserts the motives for politicians to support a policy are not always noble and depends on whether or not the program is in any way a threat to the existing system. The author only considers political commitment/ support to be a necessary factor in implementation if there is *real* commitment and it not only *lip-service*. This point is further elaborated by Cleaves' article who considers "more prudent political or bureaucratic leaders might hesitate to implement even modest changes if their power was on decline" (Cleaves 1980). He asserts that in times of national resistance to a program, there could be a strong effect of the arrival of a reform leader with deeply felt commitments in order to ensure success.

Grindle (1980) claims that the type of regime will also decide whether or not the involvement of civil society will be a positive contribution to policies/ programmes in third world countries. She believes that in certain regimes civil society and interest groups might not represent the interests of its citizens but rather protect the interests of the existing systems and the politicians. Thus, their participation in formulating and

implementing policies in many cases do not assure responsiveness to people's needs and more efficiency. Cleaves (1980) claims that in an open political system- characterized by pluralism: (…) "a large number of relatively autonomous interest associations, political organizations and governmental agencies" can enhance policy implementation (Cleaves 1980). He sees private organisations as playing a positive and important role in these open societies, and when their interests support the public programmes, there is a greater possibility of success. Cleaves claims it is often misleading to consider policies in these systems as simply "public" or "governmental" because the policy of private groups often has an effect on the public domain. The success of a programme/ policy increases when public and private resources eventually support matching goals[44].

Consistent with the research of Grindle (1980) implementers must be able to control the *distribution of resources* to achieve the goals of their programmes. Grindle (1980) and Cleaves (1980) focus on the special situation of the third world countries where the scarcity of available resources lead to more problematic implementation of policy and problems in setting of a political conflict. Willingness of regimes to be responsive to demands does not always equal their capacity, and the lack of resources will thus not lead to successful outcomes (Grindle 1980). In order to generate extraordinary resources for problematic policies the choices are either by revolution to change power relations or through the bureaucracy (Cleaves 1980). According to Cleaves (1980) the possibility of the latter option varies according to type of system in the country. When public and private groups are cooperating in a policy (sort of pluralism) this "can enhance policy implementation *if public and private resources support compatible goals*, but it can also entail costs if power is widely distributed in a policy area where there is no room for change" (Cleaves 1980: own italic).

Looking into Grindle's studies (1980) the question of whether or not programmes should be decentralised is a question of the ability of central government to control the implementation. The author finds decentralisation to be a good strategy when central

authorities are able to have some form of control over local authorities to make sure their activities are kept within the boundaries of the programs. However, if there is little power from the centre to control local agencies, she argues the activities should be directed from the centre. Thus, also here it depends on the structure of political institutions and the type of political regime in which the program is implemented[45]. However, an implicit argument of decentralisation is brought forward as she claims constraints on communication between superiors and subordinates in third world bureaucracies, may mean that national level plans are not adapted to realities.

Turner/ Hulme

In Turner and Hulme's analysis of development we recognise an argument of the "top-down" approach as they claim that a strong political elite will be necessary to mobilise different kinds of resources, but also to get clear-sightedness into the programmes (Turner/ Hulme 1997 in Ingram 1990). These researchers acknowledge that lack of political will and commitment and weak institutional capacity can to a certain degree explain failures in policy implementation (Turner/ Hulme 1997: 79). Strong and consistent leadership from e.g. prime-ministers and other ministers is a necessity for successful reforms and implementation suffers if the commitment wanes: (...) "schedules are not met, aims are not achieved and accountability lapses" (p.130).

Even though issues such as education and health are "public goods" and primarily the responsibility of the state, private involvement leads better quality of services and more resources (Van der Gaag 1995, p.4 in Turner/ Hulme 1997: 127). Also in very poor countries the inclusion of private partners is a way of overcoming poor bureaucratic performance and force the public sector to develop the countries through participatory goals (Turner/ Hulme 1997: 88). Thus, Turner/ Hulme like the "bottom-up" approach do not have a strong faith in the bureaucracy in itself. The authors claim that for successful development interventions, the state and the bureaucrats should have limited influence and power and the private sector should be the most important actors (Turner/ Hulme 1997: 18-19). Contrary to either of the classic implementation

[45] A study done by Rothenberg "suggests that under conditions of fragmented political power decentralisation is not a useful strategy for achieving policy goals" as this could paralyse the whole implementation process (Grindle 1980).

theories the governments should through public action pursue development goals and *cooperate* with the NGOs, private sector and other institutions of civil society. (Turner/ Hulme 1997: 57). These actors should make agreements, plan, coordinate their actions and distribute resources. A consequence of this cooperation, according to the authors, might be a narrowing of the gap between policy intention and implementation, thus enhancing the chances of success (Turner/ Hulme 1997: 91).

According to Turner/ Hulme whether or not to decentralise is a question of the content of the programme. If there is a need for flexibility, innovation and responsiveness, one should decentralise, but if there is a large number of standardized product or services then centralisation is more efficient (Turner/ Hulme 1997: 108). They point at third world's bureaucratic cultures having executed a centralised "top-down" approach to decision-making and implementation of programs with little influence of civil society (p.113). These programmes did not meet the needs of the target groups as centralisation led to an absence of flexibility and bureaucrats committed to participatory measures (p.114). We recognise here arguments made by the "bottom-up approach" that decentralisation leads to more involvement of civil society[46].

Rondinelli/ Montgommery

Rondinelli/ Montgommery (1991) point at one of the necessary characteristics for development programmes to be *mobilisation of resources* and *political support*. A developmentally oriented leadership should be focused on the issue in which to deal. Thus, these authors emphasise some of the same factors as the "top-down" approach. They point at strong political leadership and long periods of political stability allowing the more successful developing countries to create strong public and private institutions/ structures to establish and pursue goals for development. Thus, in line with Turner/ Hulme they also emphasise a need for consistent and *stable* support from political leaders[47]. Lack of stability in sustaining a regime has led to less political commitment and lack of success in development. According to Rondinelli/

[46] However, the authors also have certain reservations to decentralisation of programmes as one should be careful to prevent that not an enormous amount of needs, wants and demands will be expressed which the state couldn't handle, which would cause risk of alienation (Turner/ Hulme 1997: 114).

[47] According to Adamolekun (in Rondinelli/Montgommery 1991), in most African countries the state remains fragile because the central authority has had to cope with conflicts such as civil wars, revolts and massacres.

Montgommery, political leaders in successful countries have also been able to mobilise resources to change priorities and directions to achieve their goals (Ibid)[48].

Rondinelli/ Montgommery (1991) assert that in the most successful countries the state has taken a strong role in guiding the development activities, especially in the beginning. They also believe the support from a well-trained and developmentally oriented government bureaucracy is important in mixed economies. Nevertheless, they support Turner/ Hulme (1997) and Cleaves (1980) as they speak for public administration to encourage private sector involvement in development as this sector can offer important services to the population. The role of public officials is thus to guide the initiatives of private organisations engaged in development. Consequently, they claim cooperation between public and private sector can lead to successful programs if *they pursue the same goals of development*. Rondinelli/ Montgommery (1991) believe that public officials can identify the necessary changes and implement them effectively, but they can also "create conditions that allow nongovernmental organizations to do so". Hence, in order to understand development one must not only look at public administration as the relationships among a variety of organisations and groups in society increases the government's capacity[49].

As Rondinelli/ Montgommery (1991) point at "the ability to adapt, change and re-channel resources in a pragmatic and responsive manner as social, economic and political conditions change". The authors emphasise the importance of understanding the necessary structures for resource-mobilisation and channelling. Their studies confirm a need "to create effective structures and processes for mobilizing and using domestic and externally supplied resources purposively to attain their development goals (…)" (Rondinelli/Montgommery 1991). We notice that development theorists also look to external resources in addition to internal, an aspect which is absent in classic implementation theory.

---

[48] For instance in the case of Ivory Coast (…) "the single party has been a channel of political recruitment, a means of mobilizing political support and a mechanism for participation" (Rondinelli/ Montgommery 1991).

[49] For example in the case of Costa Rica: "the creation of a strong development administration capacity was the result, again, of close public and private sector cooperation" (Rondinelli/ Montgommey 1991)

Other development approaches

The state-centred approach to development came up in the 1970s and early 80s. They viewed the *state* as "a primary motor force behind social and economic occurrences on the continent and state leaders where held responsible (…)" (Chazan et al. 1999: 21). Adherents placed political factors at the centre of investigation and analysis of the African processes (Ibid). They focused on political leaders and their will/ support to different programmes to be essential for this approach (Chazan et al. 1999: 22). However, the 1980s "neo-liberalism" brought in an increasing understanding that the bureaucratic state is not a very efficient actor for success in development. Instead countries should reduce the state's size and operations, while encouraging private sector growth and initiatives (Ibid). Large financial institutions such as the World Bank and the IMF through their SAP programmes were important adherents of this approach in the 1980s[50]. However, these actors have been criticised by various actors for not laying enough emphasis on the state institutions. For instance Abrahamsen point at these programmes leading to a reduction of the state and its institutions in public service delivery. Hence, people have to rely on private initiatives which can not ensure for people's needs like the state (Abrahamsen 2000: 53-56, 77).

According to Jain (1992) government officials have an important role to play and "bureaucracy has emerged as the most important institution to plan, perform and deliver public goods". However, this author claims that bureaucrats can also be a hindrance for efficient policy implementation if they only take their own interests into consideration, and are not responsive and sensitive to people's needs. The author claims collaboration of bureaucrats, organisations and private citizens could give the bureaucracy valuable information about the effect of the programmes on the beneficiaries.

A study conducted by Materu et al. (2000) looks into the possibility of decentralised joint action in development. These authors claim political commitment, going beyond lip-service, has created an enabling environment as national politicians have supported cooperation between government and civil society at local level of government (p.48).

[50]Information on World Bank's theory of implementation of health programmes will be addressed in section 3.4

Like Jain (1992) they also point at the need for local level officials' support to involvement and partnership with private organisations in order to avoid duplication and conflict. This support will "(…) assure better priority setting, enhance resource mobilisation and lead to more effective implementation" (p.37). Through more intensive and systematic interaction between governmental and non-governmental actors the authors believe they can hold one another accountable, and build trust and better understanding (p.37). Materu et al (2000: 41) point at several cases where joint action helps overcome the lack of trust between the state and the private sector as actors recognise the comparative advantages and skills of each group[51].

Materu et al. (2000) observe that the previously discussed building of confidence between various actors has helped "in stimulating local resource mobilisation" (p.39). Even though they claim local agencies should provide resources, they also consider external agencies as a necessity in bringing in needed funds to developing countries (p.33). The authors claim decentralisation is positive both for the efficient cooperation between the state and civil society, and for an efficient channelling of resources (p.13). They emphasise that local governments can provide an institutional framework, which facilitates the participation of different local actors (p.18). With decentralisation we hence see an increasing involvement by people and communities in decisions that affect their lives, and service provisions are likely to reflect local needs more accurately (p.15). Joint action at decentralised level has "helped strengthen local capacities and engendered confidence within the community in its ability to address its own development challenges" (Materu et al. 2000: 15). Nevertheless, the authors are pointing to the fact that decentralisation is not necessarily better than centralisation if delegation of power is not followed by enough resources. In developing countries financial constraints are caused by a weak revenue base and preservation of resources at the centre. This situation leads to lack of necessary resources and technical capacities for the local governments to carry out their responsibility (p.15).

[51] "The aim is rather to involve different actors (local authorities and non state actors including various community groups, local businesses, trade unions etc.) in formulation and implementation of development programmes while emphasizing the role and responsibilities of each of them and in working towards policy coherence" (Materu et al. 2000: 20)

3.4 Theory on implementation of health programmes

World Bank

The World Bank considered in the WDR of 1993 *political will and political leadership* as necessary prerequisites for health reforms and programmes to be successfully implemented almost everywhere (WB 1993: 15, 165). In the report "Investing in Health in Africa" (1994), the World Bank cleared out *strong political commitment* as one of the preconditions for efficient health programmes also in *African* countries. In this report the Bank even pointed at strong governmental will in order for early political initiatives to be taken in *fighting HIV/AIDS (*WB 1994: 100). The report points at HIV/AIDS to be a special case, and when dealing with the epidemic, circumstances make it tempting for countries and individuals to put off dealing with the issue until it is too late to prevent a widespread epidemic[52] (WB 1994: 100). This is due to the fact that sexuality is involved, political benefits are small and issues are controversial (Ibid). In accordance with the "top-down" approach the World Bank believes political commitment is important also for the *allocation of financial resources*[53] and for efficient co-operation between the government and the non-governmental sector (WB 1993: 43).

The World Bank focuses primarily on the need for *financial* resources. As they examine what is needed for *HIV/AIDS interventions* to have a successful outcome they end up with "(…) a combination of strategies, backed up with *adequate resources* (…)" (WB 1993: 100, own italic). The Bank points at poor economic conditions in African countries and reduction of their per capita health sector expenditures preventing these countries from efficiently implementing health programmes (WB 1994: 03, 43). According to the WB donor resources should be increased and better channelled (WB 1994: 04, 43; 1993: 15)[54]. However, the Bank claims *governments* should play an important role in coordination of these resources to avoid the systems

[52] There is also a seven-to-ten year lag between HIV infection and development of AIDS (WB 1994: 100)

[53] The Bank describes how one can see shortage of political commitment to health programmes through lack of necessary institutional and financial changes, and reluctance to appropriate a larger share of government funds to health purposes (WB 1994: 03). Formulation of strategies will help to persuade donors to be financially committed (WB 1994: 41, 155).

[54] We recognise arguments from the discussion on development as the Bank points at economic growth leading to more internal money and a better chance of success.

from becoming fragmented, and to make sure national leaders take their responsibility (WB 1994: 155)[55]. In order to acquire more *human* resources the WB also believes the government should use more effective policies to finance training (WB 1993: 12). Internal resources to health programmes can also rise by promoting private-public cooperation and include e.g. NGOs hospitals in the government health-systems (WB 1993: 168-170).

There are similarities between the World Bank and the "bottom-up" approach as they both emphasise the need for involvement of informal actors such as civil society[56]. The WB claims that in an African environment private providers, mainly religious NGOs, are often more efficient, have a higher quality of services and a more direct influence on the target groups than the government (WB 1993: 05). In addition civil society often uses more creative methods to promote health education and information such as theatre, dancing, films etc (Ibid). However, contrary to the "bottom-uppers" the World Bank believes in *collaboration* between public and nongovernmental sectors as this will increase efficiency and concentrate more resources to programmes (WB 1994: 05). In addition the Bank claims that inclusion of organisations in health service provision is most efficient in combination with decentralisation[57].

The World Bank does not wish for civil society to fully substitute government action, but wants governments to reduce their direct engagement where NGOs "show the potential for an increasing role"[58] (WB 1994: 09; 1993: 55). In line with the "bottom-up" approach the WB does not want government to unnecessary regulate the activities of civil society. Nevertheless, government should provide them with an enabling legal environment for the establishment and registration of their activities (WB 1993: 58, 125). The World Bank claims government can lack capacity and competence to administer and implement policies as well as they might be corrupt (WB 1993: 59).

[55] Governments should "develop national health policies and strategies and provide leadership to donors to help put them into effect" instead of planning strategies around the available donor-funding (WB 1994: 155, 170).

[56] For instance in distribution of public goods such as information about malaria and HIV/AIDS which are supposed to be given to the people by the government, non-profit NGOs may supply some of the needed goods (WB 1993: 55).

[57] According to the WB (1994: 42) involvement of local community groups is important for success and sustainability in health programs as it will lead to more trust between government officials and communities, and the programmes are more accurately designed to people's needs and cultures.

[58] Bureaucracy together with politicians should support and understand the importance of civil society (WB 1994: 43).

Thus, in line with the "bottom-up" approach the WB claims government officials are not as efficient as civil society, but they still believe government should have a role to play in implementation of programmes [59].

In line with the "bottom-up" approach the World Bank values decentralisation and explains how this policy "(…) can improve both efficiency and responsiveness to local needs in planning and management of government health services" (WB 1993: 128). They claim hierarchical and centralised structures are severe obstacles to successful health programmes in Africa (WB 1994: 43)[60]. On the contrary, decentralisation will create better institutional arrangements, thus improve the channelling of resources. The World Bank wants to combine decentralisation and involvement of civil society- as community participation and public support at district level leads to success (WB 1994: 110). In addition participatory decision-making will develop a sense of ownership in local communities (WB 1994: 121). Central authorities, should formulate policies, allocate resources and monitor activities at the lower levels, whereas the local governments are responsible for the implementation of activities (WB 1994: 17). With local government control the Bank asserts that passing of information and coordination between various actors, such as government and NGOs, could improve. Districts should play an important role in the coordination and supervision of the activities (WB 1994: 117-118). The World Bank considers successful decentralisation of health services requires sufficient financial and human resources as well as mechanisms of communication between the different levels of authority (WB 1994: 17, 168, 171)[61].

World Health Organisation

The World Health Report, 2000, examines the health system's performance and differences in health system's efficiency to organise and finance themselves (WHO 2000: xiii). There are three different ways in which health services can be organised: (…) "via hierarchical bureaucracies, through long-term contractual arrangements

[59] World Bank also emphasises bureaucratic and political commitment for involvement of local communities and non-governmental organisations in decision-making and implementation (WB 1994: 43).

[60] Centralised systems cannot provide the necessary "(…) organisational framework, managerial processes and financial and human resources (…)" (WB 1994: 43).

[61] Thus, donors should help strengthening the public institutions that finance and deliver health services, but also here governments should have the lead (WB 1994: 168, 171).

under some degree of non-market control, and as direct, short-term market-based interactions between patients and providers" (WHO 2000: 62)[62]. In line with the WB and development theories, WHO speaks for *collaboration* between public and private sector through long-term contracting. The intention is "to achieve combined advantages of greater flexibility and innovation while maintaining overall control over strategic objectives and financial protection" (WB 2000: 63). WHO agrees with the "bottom-up" approach that private organisations "(…) might be more important than public resources directed through the health ministry" (WHO 2000: 120, 128)[63]. However, WHO also consents with the "top-down approach" in the need for coordination and regulation of NGOs. Governments should thus cooperate with the private sector-share information about the resources and interventions of the organisations, in order to get an oversight and regulate their behaviour (Ibid).

WHO wants the ultimate responsibility for the overall performance of a country's health system to always lie within government, although the organisation does not explicitly point at *political* commitment as a necessary factor (WHO 2000: 63) However, *bureaucracies* should have a strong sense of commitment and responsibility in order to establish efficient contractual relationships (WHO 2000: 63). According to WHO, health systems in low and middle-income countries are centralised and ineffective, and the bureaucrats do not recognise the most important actors in the fields: the "nongovernmental providers and health actors in other sectors than health" (WHO 2000: 120).

WHO (2000: 95) points at three different possibilities for health systems to collect financial resources: revenue collection from e.g. organisations and donors, pooling of resources as insurance and purchasing interventions from the private sector. Thus, also WHO claims donors and private sector have a role to play in financing health services/ programmes. For countries that need more financial resources WHO considers one

[62] WHO claims hierarchical controls are better in situations where there is a need of strong coordination in health services. However, as bureaucracies are not efficient, they can become a tool to the self-interests of the bureaucrats and often produce care that is unresponsive to people's needs (p.63). On the other side markets are better where there is a need of flexibility and innovation, but totally dependency on markets (…) "is less successful for health as *the markets work more poorly for health care"* (WHO 2000: 63).

[63] When dealing with programs to control infectious diseases (e.g. malaria, tuberculosis and HIV/AIDS), WHO claims implementation as sometimes more effective when carried out under contractual relationships with local providers, than as vertical programmes isolated from other services (WHO 2000: 64).

should raise the level of public finance for health. In poor countries, however, obstacles appear. These countries (…) manage to raise less, in public revenue as a percentage of national income than the middle-and upper income countries" (WHO 2000: 139). Simultaneously, ministries of finance in developing countries are often sceptical of the claims of need for resources by the health sector (Ibid). "These inefficiencies in collecting and pooling revenues reduce both the funds available for investment and for providing services, and people's access to those services that can be financed" (WHO 2000: 113).

WHO points at the need also for human resources: "the performance of health care systems depends ultimately on the knowledge, skills and motivation of the people responsible for delivering services" (WHO 2000: 77). According to the organisation governments should be responsible of continuing education and training of health service personnel, and to make sure of better geographical distribution throughout a country (WHO 2000: 79). However, WHO claims most inputs for health services are produced by the private sector with the exception of skilled human resources (Ibid).

According to WHO (2000: 64) a balance between the need for oversight should be combined with sufficient flexibility for local implementers to innovate and adapt health policies to local needs. Thus, in many aspects WHO speaks for programmes to be decentralised. The organisation claims decentralisation "should be designed to increase accountability and should give central government and ministries a new role, focusing on overall regulation and monitoring" (WHO 2000: 139). However, accountability and responsiveness from government officials are important when autonomy increases[64] (WHO 2000: 110). In this case, there is a possibility of increased resources from donors, which again will contribute further to success (Ibid). Nevertheless, with increased autonomy overall central policy and guidance is necessary to ensure coordination between public and private resources to avoid fragmentation and reduced efficiency (WHO 2000: 68, 91).

[64] In many cases "central governments reassert control in a heavy-handed fashion" when dealing with politically sensitive issues (WHO 2000: 69).

Other health approaches

Cassels (1995) supports the "top-down" approach as she points at the health sector programmes requiring political leadership and support. Without political support the author claims government might easily be placed on the sideline of reforms, or they might not be initiated. The author sees the context in which policies will be implemented to be of importance both for political support and for the availability of resources[65]. To improve the functions of the bureaucracies the countries should track the distribution of financial and human resources especially as they collaborate with other actors such as NGOs (Ibid). Cassels (1995) agrees with the "bottom-up approach" that local government control, at least in theory, offers the advantage of making health services more accountable to the public. However, due to limited capacity the centre must ensure enough financial and human resources to the districts and control the distribution of these resources.

Lorgen (1998) is, like the "bottom-up" approach, very positive to the involvement of civil society and points at the need for participation of NGOs in order to attract resources from donors. The author believes NGOs activities can contribute with development of human resources through training of "government staff or assist in the development or reorientation of government programme" (Lorgen 1998). She agrees with the WB and WHO that NGOs have "a comparative advantage to the image of the state as a corrupt or inefficient institution (…)" (Ibid). The author sees a possibility of the involvement of NGOs to strengthen the capacity of the government through collaboration, and believes the *quality* of the *relationships* between NGOs and governments decides if these organisations accomplish their goals (Edwards/ Hulme 1994 in Lorgen 1998). Thus, like WHO, Lorgen does not want the state to be put on the sideline of health programmes. In her article Clark asserts that NGOs can "oppose the state, complement it or reform it, but they cannot ignore it" (Clark 1991: 75 in Lorgen: 1998). There should also be *some* government control in order to avoid more donor dependency (Lorgen 1998). The state is important to ensure national coverage of health services as NGOs often work in limited geographical areas.

[65] During crisis or emergence of civil war lack of financial and human resources does not create an enabling environment for health policies to be efficiently implemented (Cassels 1995).

In Zwi/Mills' article (1995) the term *political will* is criticised by Reich as analytically vague, even though the term is often cited as a necessity for success in health gain. Like Grindle/Cleaves (1980) Reich considers it to be better to examine the context of the policies: the history and socio-culture in which a policy is to be implemented as well as to analyse the characteristics of the political regime, the political/ economical interests in place (Ibid). Zwi/ Mills (1995) are like the "top-down" approach more reluctant to the involvement of the private sector in health programmes and contracting of services, as this has not been proved efficient in poor countries. A danger of liberalisation of services is fragmentation and duplication of service provisions, especially if the state is weak and there is lack of coordination between the actors.

Ugalde/ Jackson (1995) criticise the World Development Report, 1993 (World Bank) as they claim this report to be a contribution to the traditional neo-liberal approach. The authors claim this report "(…) minimizes the role of the governments in public health interventions and health care delivery, places most of the responsibility of health on individuals (…)" (Ugalde/ Jackson 1995). They point at evaluations[66] of private hospitals in Brazil[67], which have questioned the efficiency, quality and ability to reduce costs. Ugalde/ Jackson believe that the public sector is not always efficient but instead of limiting its role, they want to improve its efficiency. The authors agree with the WB that many third world countries have paid little attention to how scarce resources are being used, but believe they put too large emphasis on increased financial resources and especially economic growth. The major obstacle to health is not the absence of resources, which are often there, but *how resources are being used*. The question of a country's power-relations, who controls the resources, is more important. Resources are often in the hands of the local, national and world leaders with the quest to stay in power more than a real interest for their people (Werner; 1998, p.3 in Ugalde/Jackson 1995). The article also criticise the WB's recommendation of decentralisation as this is a complex process which cannot be

[66] By Rodrigues, 1989; McGreevy et al.; 1985 in Ugalde/Jackson 1995.

[66] "In developing countries where the public system has a near monopoly on health service delivery, a mixed system that exposes public service to competition is *likely* to reduce costs" (WB 1993: pp.125-6 in Ugalde Jackson 1995).

[67] The Brazilian hospitals has to some extent followed the WBs advice with a mixed system (Ugalde/Jackson 1995).

recommended to all countries. Instead, one should take the country's historical, political, social and geographical realities into account (Collins 1989 in Ugalde/Jackson 1995). They claim decentralisation can even be a measure to increase central control rather than a response to pressure from below (Gonzalez-Block, 1991, p.85 in Ugalde/Jackson 1995)[68].

3.5 Conclusion

The theoretical point of departure in order to examine the relative success of the Ugandan HIV/AIDS programmes is the two different approaches within implementation theory: the "top-down" approach and the "bottom-up" approach. On the one hand the "top-down" approach focuses on the importance of support/commitment by formal actors such as politicians and government officials and the availability of resources. While on the other hand, the "bottom-up" approach stresses the involvement and support of "street-level bureaucrats", such as civil society, in order to succeed in implementation of public programmes. And while "top-downers" wish for decision-making and implementation of programmes to be centralised, "bottom-uppers" speaks for a decentralised approach with more local level control. Development theorists and health theorists look more into the cooperation between formal and informal actors, and the political context in which the programmes are implemented. In addition, they do not take resources for granted in countries where resources are scarce, and inclusion of external donors is crucial.

[68] For instance (…) "in the case of Mexico, decentralization actually *increased* the power of the federal government in local decisions" (Ugalde/ Jackson: 1995).

4 HIV/AIDS programmes in Uganda

4.1 Introduction and the National Policy on HIV/AIDS

> *The GOU fully recognizes that HIV/AIDS poses a real and serious threat to the socioeconomic life and development of the country. All Ugandans have individual and collective responsibility to be actively involved in the HIV prevention, AIDS care and mitigation of all its perceived consequences* (UAC: 1997: 01). These activities should take place: *(…) in a coordinated way at the various administrative and political levels down to the grassroots level* (UAC 1993a: vii.)

There is not *one* adopted policy (statute) on the fight against HIV/AIDS in Uganda. However, various government directives have been announced, such as these citations from the two first National Strategic Plans (NSPs). In 1996 altogether around 44 policy statements had been agreed upon, which have evolved around several issues dealing with the fight against AIDS[69] (UAC 1996 in UAC 1997a: 01). Even though these policies have not been approved by the Cabinet, they are operational and act as guidelines (UAC 1997a: 01-02). Policies have involved testing, condom use, treatment, counselling, care and support of People Living with HIV/AIDS (PLHAs). Furthermore, policies comprise mitigation of the socioeconomic effects of HIV/AIDS at all levels: family, community and national (UAC 1997a: 02).

In addition to the early establishment of the Aids Control Programme (ACP) in 1986, the Aids Commission (UAC) and its Secretariat was constituted on March 13th, 1992 by a Statute of Parliament[70]. The Ugandan Government has since 1986 also had "a policy of openness" and political commitment to the HIV/AIDS epidemic (UAC 2000: 01). Policies have also been made through persistent and continued collaboration between civil society, government and donors. This cooperation has been expressed by various actors and documents and even in the Statute of the UAC.

Various interventions have sought to raise people's awareness on HIV/AIDS and change their sexual behaviours. Numerous actors have participated in programmes as they have stretched from local level responses to high level government initiatives.

[69] Even though these are figures from 1996, they give us an idea of the amount of policy proposals in fighting HIV/AIDS.

[70] The Statute Suppliment no. 2 to the Uganda Gazette No.11 Volume LXXXXV dated 13th March 1992.

According to the "Inventory of Agencies" (2001) a total number of 717 agencies are involved in HIV/AIDS control activities today [71] (AMREF 2001: viii). National Strategic Frameworks/Plans (NSF/Ps) have been formulated by the Uganda AIDS Commission (UAC) since 1992 setting these aims for the national HIV/AIDS programmes: 1) to stop the spread of the epidemic, 2) to mitigate the impacts of the HIV/AIDS epidemic[72], and 3) to strengthen the national capacity to respond to the HIV/AIDS epidemic and mobilise resources (UAC 2000: 03).

One of the most important components of the Ugandan response has been "Information, Education and Communication" (IEC), which is centred on the promotion of safer sexual practices and on helping PLHAs to live positively with HIV/AIDS, thus limiting further spread. Both government institutions and NGOs have been involved in IEC development and distribution (UAC 2000: 19). According to the latest "Inventory of Agencies" around 69 percent of all agencies (78 percent in 1997) execute preventive interventions today (AMREF 2001: 17). Activities comprise community sensitisation and education to bring about positive behavioural change, voluntary counselling and testing (VCT), control of sexually transmitted diseases and prevention of blood-borne HIV transmission (AMREF 2001: viii). This study will set the major focus on the agencies' preventive activities in order to reduce the HIV/AIDS epidemic.

4.2 Government programmes

When HIV/AIDS was first diagnosed the country had few resources and modest knowledge on how to fight the disease. Hence, the first responses to the epidemic were few and sporadic (Kaleeba et al. 2000: 04). The first government organised response to the epidemic was launched in 1985 with the introduction of the National Committee for Prevention of AIDS (UAC 1997a: 13). However, combating HIV/AIDS was already part of the programme of the "National Resistance Movement" (NRM) when they seized power in 1986 (Damgaard 2000). According to our informants the NRM

---

71 This was a 30% reduction from 1997 due to stricter criterion of identifying agencies in 2001 and due to the termination of the STI project (AMREF: 01: viii).

72 Involving care and support of People Living with HIV/AIDS (PLHAs).

government has since its takeover up to now continued to have "the fight against HIV/AIDS" as one of their priority areas. Politicians at all levels have been engaged in order to spread information about the epidemic and raise money to these, with the President of Uganda as the most important actor.

Already in October 1986 the new NRM government established the AIDS Control Programme (ACP) in the Ministry of Health (UAC 1997a: 13). Various preventive programmes were started in order to reach out to the population, to raise awareness and reduce their risk behaviour. The ACP's overall objectives were to reduce the spread of HIV and to mitigate the impact of the epidemic on communities, families and individuals (UAC 1993a: 13). The major functions of the programme in its initial phase were epidemiological surveillance, ensuring safe blood supply, providing of *HIV/AIDS information, education and communication (IEC)*, patient care and counselling and control of STDs (Kagimu et al 1996: 03, own italic). General awareness- campaigns were set into life without much focus on behavioural change, but intended only to distribute information to people at national, district and grass-root level. Mass media and sensitisation campaigns spread the message through radio, newspapers and TV (Hyde et al. 2001: 19; STD/AIDS Control Programme 2000: 37).

Informants point at the government primarily spreading the messages of HIV/AIDS from central level during this initial phase. Central institutions had the responsibility to make decisions and implement the programmes from national to local levels. MOH coordinated the national response of the epidemic during this time period, whereas the participation by other sectors and institutions were limited and very *ad hoc* in nature (UAC 1993a: vi). Nevertheless, some civil society organisations also participated in the early response at national levels. For instance, The Aids Support Organisation (TASO) was established already in 1987[73] and the Aids Information Centre (AIC) in 1990. Moreover, various CBOs responded spontaneously.

In Masaka District a number of emergency measures were early put in place. These aimed at raising awareness and mitigating the social and personal impact of HIV/AIDS

[73] There will be further information on the involvement of civil society in section 4.3.

(MDLG 2002: 06). "Prior to the STI project, activities for HIV control were mainly implemented in a vertical manner from the Ministry of health and by non governmental organisations" (MDLG 1999a: 03) District IEC campaigns mainly focused on raising awareness and preventing sexual transmission of HIV (Musisi 2002; MDLG 2002: 06). Simultaneously, care for PLHAs was initiated by NGOs (MDLG 2002: 06). Thus, NGOs, religious institutions together with the District Medical Office and the MOH were actors involved in the 1980s (Musisi 2002). Informants in Masaka also point at the early response being directed from the centre using central level resources, whereas few decisions were made at district level.

The Multisectoral Approach (MSAP)

Already in 1988 a review of the HIV/AIDS activities recommended more programmes to be carried out at lower levels with inclusion of actors like civil society, local level politicians and all public sectors (Kagimu et al. 1996: 03). From around 1990 the GOU determined that HIV/AIDS was not only a health issue, but an issue influencing all sectors. Thus, in 1990/91 the Multisectoral Approach (MSAP) was launched and several departments established their own programmes. Currently there are 13 Aids Control Programs (ACPs) under 12 different ministers (Ibid). The Statute of the UAC announced a change in the response: "Multisectoral Approach means active involvement of all sectors including non-governmental and community based organizations in HIV/AIDS prevention and control"[74].

Informants at both levels, as well as the NSPs, emphasise that government programmes have become more and more decentralised[75]. Moreover, the programmes have to a greater extent involved the private sector, as government officials collaborate with civil society in planning and implementation of activities. Since 1993, decentralisation has been part of the NSPs' agenda, and more control has been given to district administrations or local governments (UAC 1993a: 03). "The implementation of HIV/AIDS interventions have been decentralised throughout the country, with each

[74] The Statute Supplement no. 2 to the Uganda Gazette No.11 Volume LXXXXV dated 13th March 1992.

[75] For more information on the coordination see 4.3.

district having and annual work plan for HIV/AIDS prevention and control" (STD/AIDS Control Programme 2000: v). Informants at both levels confirm that in the districts public and private partners plan and implement their own HIV/AIDS programmes. However, they have to follow the national guidelines and policies set by the national level. At national level the AIDS Commission establishes and coordinates the Multisectoral Approach (MSAP), develops national policies and implementation guidelines, integrate the support and monitor all AIDS control activities throughout Uganda[76] (UAC 1993a: 11). Coordination of programmes occurs at national, regional and district levels and the NSPs intend to facilitate the actors' response (AMREF 2001: vii). In 1992 District AIDS Coordination Committees (DACCs) were established by UAC to coordinate the approach in all the then existing 39 districts (UAC 2002). In some districts AIDS committees were also formed at sub-county, parish and village levels (Ibid). DACCs were replaced by DHACs in 2000 to be chaired by a District HIV/AIDS Focal Officer. DHACs include all Heads of Departments, PLHAs and local and international NGOs (Ibid). The *health* policy reforms have also decentralised AIDS control to districts, sub-districts and communities. This reform promotes collaboration with the education sector and partnerships with churches, NGOs and PLHAs (Okware et al. 2001).

Informants emphasise how the response to the HIV/AIDS epidemic has changed from primarily seeking to raise awareness, to a stronger emphasis on influencing people's sexual behaviours. Whereas the original messages against AIDS were fear-based with messages such as "AIDS kills", they have changed into media campaigns stressing compassion, solidarity and hope (Kaleeba et al. 2000 in Hyde et al. 2001: 22). Government's prevention campaigns have continued with a stronger focus on behavioural change, and additional education campaigns are carried out through the private sector[77]. The ACP in the MOH has especially targeted vulnerable groups (women and youth) and focused on inter-personal communication and a deeper understanding of the issue (STD/AIDS Control programme 2000: 37). They also make

[76] Rwomushana (1999) claims the coordination is not entirely centralised as UAC is facilitator, participatory and all inclusive and not controlling, directing or supervising.

[77] The HIV/AIDS Programmes of civil society will be elaborated on in the following section.

use of additional channels such as 14 FM stations[78], the popular press, public campaigns and interpersonal communication to spread the message of abstinence, faithfulness and condom-use (Hyde et al. 2001: 18).

The Ministry of Health together with AIC, manages 54 HIV testing centres in 22 districts of Uganda where they provide Voluntary Counselling and Testing (VCT) services (STD/AIDS Control programme 2000: 41). The MOH is also, in cooperation with NGOs, responsible for counselling and home-based services. In order to ensure mitigation of the impact of the epidemic the ACP has (…) trained thousands of health personnel in HIV/AIDS counselling and related skills, and has also trained volunteers as community AIDS workers, counselling aides and peer educators" (Hyde et al. 2001: 18). Informants also point at a recent change of the government's response to the HIV/AIDS epidemic as it today involves the treatment aspect: provision of VCT to pregnant women, and a recent programme providing some people with ARVs.

As adolescents are the key target groups of many programmes, interventions have been implemented in the education sector. With the help from UNICEF the Ministry of Education and Sports started their programmes as early as in 1986 (Hyde et al. 2001: 20). HIV/AIDS education has been introduced in the primary education system, and in the last year of primary schools this issue is also included in the curriculum (Hyde et al. 2001: vi; STD/AIDS Control Programme 2000: 16). However, in secondary and tertiary schools HIV/AIDS is not yet included in the curriculum, but peer-groups and NGOs have spearheaded the campaign against HIV prevention[79] (STD/AIDS Control Programme 2000: 60). The NGO "Straight Talk" provides information to students about HIV/AIDS through their newspapers "Straight Talk" and "Young Talk", and through their radio-shows and peer-clubs in schools (Hyde et al. 2001: 10).

Other government departments have carried out AIDS programmes in Uganda, especially the Ministry of Defence, Ministry of Labour and Social Affairs, Ministry of Information and Ministry of Local Government. These programmes have contributed

[78] During the 1990s the GoU passed legislation which removed government control of mass media (Kaleeba et al. 2000: 12)

[79] Even though the latest strategic plan of the ACP, MOH seeks to introduce the subject in the curriculum of secondary/ tertiary schools (STD/AIDS Control Programme 2000: 30, 60)

to the prevention of the epidemic, mitigation of its impact and capacity building within their areas of jurisdiction (Hyde et al. 2000). Since 1995 the Ministry of Local Government has been involved in HIV/AIDS prevention and control activities mostly through capacity building at national level as well as training of local level governments officials and political leaders (MOLG 2000: 07-08).

HIV/AIDS programmes also exist as a component of the communicable diseases under Uganda's Poverty Eradication Action Plan (PEAP). HIV/AIDS activities are also included in the Primary Health Care (PHC) package, which is part of the health sector strategic response (STD/AIDS Control Programme 2000: 27). All health units provide (HC3 and above) counselling and psychosocial support to individuals/families affected and promote behavioural change through IEC programmes and VCT services (MOH 2000: 19). In addition the STIP and MAP projects launched by the GOU in collaboration with donor agencies have been extremely important projects in order to channel information on HIV/AIDS[80].

In Masaka District the focus of the HIV/AIDS activities from the early 1990s was still on prevention of the disease. In addition, mitigation of the impact of the epidemic and strengthening of district capacity for STD/HIV/AIDS control became other objectives (Musisi 2002). In this time-period the District IEC campaigns were supported by the ACP and care was provided by NGOs. There was an establishment of AIDS Clinics/ Pastoral Care counselling and Mobile Home Care services and of VCT centres in two hospitals and one health centre. Government and civil society trained peer educators such as Community Counselling Aides, Behavioural change agents, home care volunteers and health workers in STD management. In addition, effective T.B. management and home visiting was supported by STIP and DISH 1 (Musisi 2002). DISH projects financed by the USAID have also been implemented in the district in close cooperation with the District Medical Office (MDLG 1997). Currently, HIV/AIDS interventions are: Community HIV/AIDS led initiatives (component of the MAP project), adolescent friend Reproductive Health Services (supported by DISH

[80] These projects will be elaborated on in the section 4.4.

2[81]), District Response Initiative (DRI) (supported by UNICEF) and improved clinical management of AIDS patients e.g. (ARVS) (Musisi 2002). Informants also point at health education in primary and secondary schools including training and peer-educator programmes[82]. From 1996-1997/98 there was a program sponsored by DISH (USAID) in schools with competitions in secondary school-script writing and drama tours. This project also sensitised local leaders at the lower levels, formed health clubs in district institutions and sensitised on STDs and held mass media campaigns on STDs (MDLG 1999a:03). According to informants Masaka district has also recently opened up a clinic in Masaka Hospital providing free ARVs to a few citizens.

All sectors are involved in Masaka's response today: Health, Education, Production, Security, Planning administration and Gender and Community Development (MDLG 2002: 07). Informants explain how the district has constructed integrated work-plans with all relevant actors involved in HIV/AIDS activities to the STIP, MAP projects from 1995 to this day. Civil society and government departments (all sectors) gather in their DACC/DHAC to make a district plan according to the guidelines set by central level (Musisi 2002 [interview]).

4.3 Civil society programmes[83]

Civil society organisations have since the early beginning of the response to the epidemic, and especially since the start of the MSAP, been referred to as partners by the government (UAC 1993a: 37). The "Inventory of Agencies, 2001" claims that CBOs[84] constitute 21.9 percent of the agencies involved in HIV/AIDS activities in Uganda, while NGOs[85] comprise 17.2 percent (AMREF 2001: 09). According to our informants and several reports civil society organisations have channelled much information on HIV/AIDS, especially when it comes to care of the PLHAs.

---

[81] During my stay in Masaka the District's Health services office got to know that DISH 2 would not further implement activities.

[82] There are dramas/ essay-competitions and videos are shown in school to promote STD-sensitization and behavioural change (Namisangov 2000: [interview]).

[83] Only some of the most important civil society organisations will be looked into in this chapter and the organisation "Straight Talk" was referred to in section 4.2.

[84] CBOs: (…) "agencies that are founded or initiated within the local communities and operated by community members with donor support or funds delegated through the Local Government (AMREF: 01: 09).

[85] NGOs: (…) "agencies that have a national portfolio with a central governing body and peripheral operation branches spread out in the country" (AMREF: 01: 09)

Communities responded at various levels to the epidemic by organising groups to educate their people concerning HIV prevention and support to PLHAs (Kagimu et al. 1996: 04). Around 28.4 percent of the agencies, mostly NGOs and CBOs, are engaged in home-based care and support to the PLHAs and community outreach services (AMREF 2001: 19). These organisations distribute their information through peer-education, receptive post-test clubs and communal forums for mutual spiritual and moral support (Ibid). Several of these organisations, such as TASO, were initiated by and for PLHAs.

TASO has since 1988 offered many services in order to fight HIV/AIDS in Uganda. Care of PLHAs is the major one as the organisation provides them with medical treatment, counselling and nursing care (TASO 1995: xi). Their slogan is: "Living Positively with AIDS", and openness about the disease is highly encouraged (Hyde et al. 2001: 18). Through counselling of the PLHAs and their families the organisation contributes with information to people on how to protect themselves and others from the HIV virus. In addition, TASO sensitises community leaders through community gatherings and meetings in the Resistance Councils[86] etc (TASO/WHO 1995: x). Since 1995 music, dance and drama groups in TASO counselling centres have become very instrumental in educating communities (TASO 1997: 11). TASO has since 1990 trained counsellors and community-AIDS educators also for other organisations, wishing to integrate HIV/AIDS care and prevention in their services (TASO 1997: 18).

National Community of Women Living with HIV/AIDS in Uganda (NACWOLA) is an organisation with a mission to "improve the quality of life of women with HIV/AIDS and their families in Uganda" (NACWOLA 2000). Important objectives are to fight stigma attached to the disease and empower women and orphans. NACWOLA focuses on their economic rights in order to reduce dependency and vulnerability, and offer psychosocial support through counselling and home visits. Spreading the message of HIV/AIDS in the community is also one of their objectives (Ibid). The AIDS Information Centre (AIC) provides first and foremost an opportunity for people to get tested. In addition they offer post- and pre-test counselling where

[86] With the Local Government Act of 1997 Resistance Councils became Local Councils

they sensitise people on how to protect themselves and their partners. The post-test club offers education, awareness creation through entertainment and education, production and distribution of condoms and provision of IEC materials (AIC 2001: 08) There are also family planning services where clients receive information on family planning and are sensitised about ways to avoid contracting HIV (AIC 2001: 06).

Various religious groups, including Catholics, Protestants and the Islamic Medical Association Uganda (IMAU) have carried out programmes to educate their communities in prevention of HIV/AIDS. They also focus on how one can provide sympathetic care for the PLHAS as well as support affected families, especially widows and orphans (Kagimu et al. 1996: 04). Aids Widows Orphans Family Support (AWOFS) was founded in March 1991 to "alleviate the social and economic impact of AIDS on affected families" (AWOFS: leaflet). These programmes aim at behavioural change by providing health education and encourage positive living among HIV positive clients and encourage children of these clients to lead safe lives (Lubega 2002 [interview]). In addition the Federation of Uganda Employers early started the project "AIDS in the workplace" in various enterprises (Kagimu et al. 1996: 04).

In Masaka district civil society organisations have been involved in the response to the HIV/AIDS epidemic since the very beginning (MDLG 2002: 01). Civil society delivers information to people through counselling, home-care and training of volunteers (MDLG 1997; 2002). There is extensive collaboration between government agencies and NGOs in delivering AIDS services (MDLG 2002: 06). Kitovu Hospital early started a mobile AIDS home care programme in Masaka, which became a model for other hospitals (Kagimu et al. 1996: 04). Kitovu Mobile Home Care Services have been basically involved in home care for HIV/AIDS clients and counselling of PLHAs and support of orphans and families. Health education is also one of their components as they contribute to community capacity building and HIV/AIDS behavioural change (MDLG 1997: 03-05; 2002: 07-09). Informants also point at TASO as an agency with many activities in Masaka, which both inform the general public and offer care and support to PLHAs. World Vision has been important in rehabilitation and equipping of health care facilities. Furthermore, this INGO is central in training in AIDS prevention

of community health care workers (CHW) and village health committees and education and counselling of AIDS patients (Ibid). In addition, religious organisations have carried out HIV/AIDS activities. The Grassland Foundation has targeted Muslim communities, schools and religious leaders in their programmes (MDLG 1997: 04). And the Catholic organisation MADDO has provided AIDS-emergency facilities aimed at looking after AIDS patients and orphans including payment of school-fees for orphans and protection of their rights (Buwembo 2000 [interview]).

4.4 Resources

Extensive financial resources have been allocated for HIV/AIDS activities implemented in governmental and non-governmental organisations, research, institutions and religious groups (UAC 1997a: 15). The first NSP (1994-1998) was estimated at US$ 78.9 million for the government sector, and around US$ 500 including all non-governmental agencies, whereas the latest NSP (2000/1- 2005/6) was estimated at around US$ 181.5 millions[87] (UAC 1993b: 20; UAC 2000: 36)[88]. In year 2002 a *Resource Tracking Study*[89] was carried out by UAC to track financial resources for HIV/AIDS activities allocated by donors in *year 2001*. According to this study a total amount of US$ 43.71 million were allocated by donors in year 2001[90]. These funds were spent on; care and support (28 percent), prevention (19 percent), capacity building (16 percent), VCT services (12 percent), research (12 percent), adolescents (7 percent) and OVC[91] activities (4 percent). According to the WB the total amount of funds provided by other agencies than the WB is estimated to about US$16-17 millions per year (WB 2000: 18).

Since 1987, a number of multilateral, bilateral and private external support agencies have responded by supporting AIDS-related activities through financial and technical assistance[92] (Kagimu et al. 1996: 04). To get an overview of the external actors

[87] This does not include the cost of activities of NGOs (UAC 2000).

[88] Figures from the second NSP (1998-2002) are not available

[89] Appendix II for more information on the “Resource tracking study”.

[90] Figures are a result of their own estimates of their allocations to HIV/AIDS interventions.

[91] OVC: orphans and vulnerable children (UAC 2002)

[92] Already in 1986 international donors attended an international donor conference and pledged immediate support of HIV/AIDS programmes in Uganda (Kaleeba et al. 2000: 10).

channelling money for these activities is somewhat difficult as there is no single central channel for external resources (UAC 1993b: 19). The GOU estimated in 1996 that external support agencies has provided over 70 percent of the funding for AIDS related activities (Kagimu et al. 1996: 33). This money has largely been channelled through the Ministry of Health, the Aids Commission and directly to the NGOs (Ibid). Historically, resources have been centrally concentrated in Uganda (UAC 1993a: 47). However, since 1993 all projects have to be registered with the MOF and the UAC, and funding for district activities with the MOLG. The DACCs/ DHACs register funds for the districts' NGOs (UAC 1993b: 19).

Informants talk of extensive financial support from external donors and only limited financial assistance provided by the government. However, *local donors* have also contributed with financial resources. The Inventory of Agencies of 1997 reported that external donors have provided assistance to 64 percent of agencies who received support, while local donors supported the rest (UAC 1997b: 06). However, government has also provided financial resources to HIV/AIDS programmes primarily through their health budgets (included in the Primary Health care package), the UAC and the ACP. According to our informants government's financial resources are limited, and funds are largely provided by external donors. They claim civil society receives most financial resources from external donors directly or indirectly (through STIP; MAP). Only a few (e.g. TASO) receive direct government funding in addition to donor money. Looking at the allocations from 2001 we also observe that many of the donors work with civil society organisations as their implementing partners[93].

Multilateral and bilateral agencies have channelled a lot of resources to HIV/AIDS programmes. The 2001 "Resource Tracking Study" serves as an example of the allocations of financial resources. With reference to Appendix II we observe that besides Makerere University, the largest contributors to these programmes in year 2001 were large multilateral and bilateral donors such as USAID. WHO has financed the Aids Control Programme (in MOH) since its very beginning as they helped to set up a national plan to combat HIV/AIDS and offered technical and financial assistance

[93] Appendix 2 for further information on the "Resource Tracking Study, 2001"

(Kagimu et al. 1996: 04). In addition, the UAC Secretariat was initially funded by the donor agencies such as UNICEF, UNDP, USAID, WHO and IDA (WB 1994: 08). UNICEF has also provided funding to government AIDS control programmes (in the MOH and MOES) by offering support to AIDS education in schools and among out-of school youth (Kagimu et al. 1996: 04). Since 1992 UNDP has supported the establishment of 11 ACPs (Ibid). This organisation also funds community-based projects on AIDS education and counselling, care and education of orphans and care of PLHAs (WB 1994: 11). EU has provided funds and technical assistance to the National Blood Bank, while the smaller bilateral agencies such as DANIDA, SIDA have provided funds for different civil society activities (Kagimu et al. 1996: 04).

The World Bank has primarily channelled money through large loans to the GOU in the projects STIP and MAP[94]. These projects have provided for Uganda's fight against AIDS by channelling a large amount of financial resources to the National Strategic Frameworks, both to government agencies and civil society at all levels. The Sexually Transmitted Infections Project (STIP) was a project of US$ 73.4 launched by GOU in year 1994 and ended in 2000. 50 million US$ was a loan from the WB and the rest was funded by SIDA, KfW Germany, DFID and the GOU. STIP aimed at controlling and preventing HIV and other STDs, and through this project US$ 33.1 million were allocated to prevention, 22.4 million to mitigation and 10.7 million to capacity building (WB 1994: ii-iii). According to MOH this project has provided the main financial support to HIV/AIDS prevention and control in Uganda (STD/AIDS Programme 2000: 18). The main implementing agencies for this project were the MOH, NGOs and CBOs. STIP supported 400 NGOs and CBOs carrying out 30 percent of the activities (WB 1994: ii). Other government agencies such as MOES, MOGLSD also had activities supported by the project (AMREF 2001: 04).

The Multi-country AIDS program (MAP) was announced by the government in year 2000 to follow up STIP and finance US$ 50 millions of the Ugandan National Strategic Framework for HIV/AIDS activities 2000/1-2005/6 (WB 2000: 08). The project intended to support the Ugandan HIV/AIDS program, to scale it up and cover

[94] However, we will argue in chapter five that MAP and STIP projects are government money as they are loans which the GOU has to pay back.

some of the activities not funded from other sources (WB 2000: 08). MAP involves the following three components: 1. The Nationally coordinated programmes, coordinated by UAC and run by the line ministries, government agencies or contracted out to CSOs or private sector (US$ 25 million); 2. District Initiatives (DI): Activities directly carried out by district authorities, contracted out to civil society or private sectors to raise awareness, train human capacity, for activities in hospitals, IEC to workforce etc (US$ 10 million); 3. Community-led HIV/AIDS initiatives (CHAI) carried out by CSOs or contracted out by them to give home-based care, support to orphans and community-based IECs (US$ 10 million)[95] (WB 2000: 08-10).

In Masaka district informants claim that most financial resources for the district's HIV/AIDS programmes are donor funds channelled from central government. In general few funds come directly from donors to the local governments. Local governments also raise very little money themselves[96]. Informants claim the situation to be rather similar for the HIV/AIDS programme as large donor projects (STIP, MAP, DISH) have from the early 1990 to 2003 been channelled through central government. When STIP/MAP money is channelled to the districts, the partners distribute the money according to the district's work-plan (Musisi 2000 [interview]). To get an indication of the amount of money allocated for HIV/AIDS activities in Masaka district we can look at the allocations of the STIP project granted[97].

Government has contributed with financial resources through the ACP (in MOH), which especially in the early 1990s supported the strengthening of the District IEC campaigns and still provides the district with particularly technical support (Musisi 2002). As the district budgets for Primary Health Care (PHC), HIV/AIDS has to be one of the components[98]. This money is channelled from central government as

---

[95] The final US$ 5 million will be allocated to District Initiatives or Community Initiatives based on progress review and project needs (WB 2000: 10).

[96] According to the D.D.H.S in year 2001 central transfers contributed 79 percent of all revenues of the district while donor and NGO funds made up 18 percent. Only 3 percent were local revenues (Nnyanzi 2002 [interview]).

[97] From 1997-2000 allocation of funds from the Ministry of Health through the STIP project made up around 186,800,000 million Uganda Shillings= US$ 9,386.46 US dollars, some was delayed (Musisi 2002: [interview]).

[98] Money spent on PHC in the District 1996-1998: Year 1996/97: Ugandan Shillings: 232,523,000 equals US $ 11.683. 98. Year 1997/98: Uganda Shillings 232,523,00 was budgeted for but only 136,373,000= US$ 6.852.57 (58.6 percent) were received (Masaka District Council: 99: 31).

conditional grants to the districts. One of the goals for the PHC in Masaka District is to reduce HIV/AIDS/STDs/STI prevalence from 10 percent to 5 percent (MDLG 1999b: 65). However, informants claim the amount of PHC-money allocated on HIV/AIDS is very limited at all levels. Politicians prioritise other areas that are not as greatly funded by other sources and where needs are more urgent. According to informants the newly opened up ARV clinic is provided for with funds by American donors, who are personal friends of the District Chairman.

Civil society organisations claim they receive most financial resources directly from external donors in addition to those they receive through the STIP and MAP projects. International organisations such as the INGOs (e.g. World Vision) and USAID also bring in funds to assist NGOs in their work (Nnyanzi 2002: [interview]). Kitovu Mobile claims to receive most direct funds from external donors. These have changed over years, but presently they include CAFED, NOTIV, GOAL and CONCERN (Ssentonga 2002 [interview]). TASO, Masaka receives funds from their mother organisation at national level which is funded by e.g. USAID, DANIDA, EU, SIDA and CAFED. In addition, through CHAI projects (under MAP) external funds from central government are trickled down to communities under their supervision (Namusoke 2002 [interview]).

Human resources

A wide range of workers like peer educators, community health workers and community AIDS workers have been trained to extend knowledge on AIDS and prevention of the HIV infection (Kagimu et al. 1996: 06). In the *Inventory of Agencies, 2001,* 25.7 percent of the 717 agencies where involved with training, 8.7 percent train their own staff whereas 12.8 percent does training in the communities at large (AMREF 2001: 20-21). Informants point at government contributing to increased human resources. Hospitals, most NGOs, and some CBOs train both institution-based and community-based counsellors (AMREF 2001: 19) Together with civil society, the government has trained a wide range of health care service providers including peer educators in AIDS management (UAC 1997a: 18). In addition international organisations such as “Mildmay hospital of the UK and Medecins du Monde have also

been engaged in training counsellors (Kagimu et al. 1996: 21). Moreover, MOH and NGOs have produced training material for nursing care and guides for training counsellors. Donors also participate with some human capacity but they have provided most technical assistance to various NGOs (Kagimu et al. 1996: 31). In Masaka informants point at government and civil society who are training teachers in HIV/AIDS as well as medical staff and community counsellors. Various behavioural change agents and peer-educators have been trained in schools/ out-of schools and as community counsellors. Government contributes through their medical workers which sensitize people in clinics and schools. In addition, local leaders and religious leaders as well as community workers sensitise people about the HIV/AIDS epidemic.

4.5 Conclusion

The Ugandan HIV/AIDS programmes started out as fairly centralised government campaigns where the ACP channelled a lot of information from their offices. The aim was to make people aware of the disease. However, more and more grassroots interventions have been carried out with a stronger involvement of local governments and civil society, and more emphasis on changing Ugandan's sexual behaviours. Local communities and organisations, as well as district authorities have been given more authority to plan and implement their own programmes based on their needs. Civil society has held a very important position in the channelling of information about the epidemic and especially in the care for PLHAs. The cooperation between government and civil society has been extensive and was institutionalised through the creation of the Aids Commission (UAC) and the adoption of the Multisectoral Approach (MSAP). Financial resources have primarily been allocated by external donors. However, some financial and human resources have also been channelled from the Government's health sector: through the ACP, PHC and the large projects of STIP and MAP (primarily lent from the World Bank). In addition, resources to civil society have passed either directly or indirectly through government. Now we will seek to examine how we can analyse the effect of the different factors in order to explain the relative success of fighting HIV/AIDS in Uganda.

5 Explaining the Ugandan success!

While several theoretical contributions have highlighted the importance of strong and centralised institutions and political support for AIDS programmes to succeed, others underline the need for decentralisation and civil society to play an active role. In this chapter we will disentangle the routes to effective public sector health programmes in the south. Thereby, we look into how our informants consider the importance of various factors in explaining the relative success of fighting HIV/AIDS in Uganda.

Official statistics about the reduction in AIDS prevalence rates and changes in sexual behaviours, receive broad legitimacy and support amongst government officials. With some uncertainty concerning district figures such as for Masaka[99], national figures seem to have broad legitimacy. According to Dr. Baingana in the Ugandan AIDS Commission (2002 [interview]), the whole population is now aware of how the HIV virus is transmitted. While most respondents point at some gap between awareness and changes in sexual behaviour, they do confirm progress in both areas. And while civil society representatives are more sceptical about progress at the local level, they also agree to the Uganda "success story"[100].

Views may still differ when it comes to the explanations for the success. Informants underline the decrease in prevalence rates due to increased awareness, reduction of stigmatisation and discrimination as well as changed sexual behaviour. However, the question remains as to why the AIDS programmes have succeeded in Uganda. Is it the political focus and commitment at top national level, support from government officials or involvement of civil society that may be ruled out as the most crucial component in explaining the success? What seems to be most effective, centralisation or decentralisation of decision-making and delivery structures? Do structures have the most important impact or is impact rather seen as an effect of resource allocation? On this background I will look into which factors may explain the relative success of

[99] In Masaka there is no antenatal clinic and hence more problematic to collect information. Progress seem to have taken place, however, when we take into consideration that the number of deaths and burials has been reduced. According to the district medical officer, the population has also improved their clinical status.

[100] Informants in civil society organisations focus on the many challenges still present in fighting the HIV/AIDS epidemic in Uganda. Both TASO and Kitovu Mobile stress that the number of AIDS-patients is not getting down, rather up in Masaka district.

Ugandan HIV/AIDS programmes and how this corresponds to the theoretical approaches.

5.1 Political will and commitment

The political support of president Museveni is the factor most often emphasised internationally as explaining Uganda's success in the fight against AIDS. *All* the respondents agree that high level of political will and commitment has been amongst the most important reasons for the changes in people's awareness and behaviour. Most of our respondents argue that the even though not *one* policy on AIDS has been adopted, the first AIDS initiatives came from "the top" and with President Museveni playing a key role in driving the initiatives. Vis-à-vis other countries in the region, the President has held a leading role in the formulation and priority setting of campaigns and programmes.

Respondents describe how initial priorities and commitment in Uganda were played out in the establishments of institutions to initiate, control and coordinate the fight against HIV/AIDS. They also assert that this early and quick reaction has been carried through in the 90's and manifested itself through further escalation of interventions as well as in the consolidation and strengthening of institutions[101]. Thus, political will and establishment of institutions have led to information-sharing and coordination between major actors amongst civil society, donors and government. Many of the respondents at national level point at the importance of the AIDS Commission (UAC) under the President's Office as being the forum through which they cooperate and share information in a Multisectoral Approach (MSAP) involving all government sectors. While some informants underline the broader commitment and support also of parliamentarians, as they have addressed the issue of HIV/AIDS in various forums, it is first and foremost the will and commitment by the President that is emphasised by the respondents.

[101] Introduction of the multi-sectoral approach to expand the programmes and the establishment of the UAC under the President's Office in 1992 illustrate HIV/AIDS as having a high priority/ visibility, and confirms the political commitment of the GoU to fight HIV/AIDS. The National Strategic Frameworks which have been formulated and implemented since 1993, shows a planned response to the epidemic in Uganda involving many different stakeholders including the ones infected with the disease- the PLHAs (WB 2000: 21).

Museveni began talking to people around the country, sensitising them about the epidemic in the 1980s as he discovered a large amount of the Ugandan soldiers being HIV positive. Hence, he realised this was a serious issue which had to be tackled. According to our informants, the President contributed to the creation of an "environment of openness" in the country. By early addressing the issue he helped reducing the stigmatisation and discrimination attached to the disease. The government's "policy of openness" also mobilised other actors to become involved in the fight against the epidemic. Civil society organisations have been invited to join the struggle, and accepted as partners both formally through the MSAP and in the UAC and through more informal interaction. Respondents claim national political commitment has helped NGOs and CBOs to operate, participate from different angles and distribute HIV/AIDS information to the grassroots. In addition, informants point at Museveni's early personal commitment as essential in mobilising external donors as he was frank and early asked the international community for help (Hyde et al 2001). Two loans from the World Bank were for example granted through the recognition of the President's personal commitment to fight the epidemic (WB 1994; 2000) and were in turn channelled to local levels for information spreading.

Informants in Masaka emphasise the role of the President in bringing more openness around issues of AIDS. They claim Museveni's commitment has set the fight against the disease to be "a national priority issue", and a certain will from local level politicians to address HIV/AIDS out of "respect for the big man". Civil society describes how Museveni's commitment has given them new space to participate in political activities. The fight against HIV/AIDS has opened up for new forms and degree of collaboration with government officials. In addition, local level informants confirm the importance of the President and emphasise the general impact politicians in Uganda have on people's attitudes and beliefs. An important consequence of political commitment at local level is, according to our respondents, politicians' support to the district plans. In addition, they have channelled information to people about AIDS and mobilised target groups[102]. Furthermore, informants claim political

[102] For more on the involvement of local level politicians see section 5.5.

support has contributed to widespread collaboration between civil society and government. Various civil society organisations emphasise the importance of moral support by politicians and the support to operate also at local levels.

Yet, several respondents, and particularly national leaders themselves, argue that local level commitment is lower than that found amongst national politicians and leaders[103]. In Masaka, civil society organisations underline how local politicians "talk more than they act". While understanding the budget constraints of local governments, organisations still claim local politicians spend very limited district financial resources to AIDS programmes run by government or by civil society.

There seems to be indications that "political will and commitment" has played an important role in explaining the relative success of the Ugandan HIV/AIDS programmes. While there is little doubt that the AIDS catastrophe has also helped the President unite the people and avoid criticism for his zero-party regime, informants do believe his commitment is real and sincere, out of concern for the people. Suspicious voices may question the motives behind the President's AIDS focus and policies. However, the relative freedom given to civil society to operate in this area seems to indicate that he does not consider the issue to be a threat to his political leadership. In spite of limited political democracy, it seems as if the zero-party political system has managed to become a rather plural and open society in the area of HIV/AIDS.

5.2 Support of government officials

While all informants underline the role of Museveni in the area of AIDS policies, they are more mixed when it comes to the attitudes and commitment of government officials. A civil society informant explains how some government officials in the Health Department were rather negative to the early initiatives by the President. They were afraid information about the HIV/AIDS epidemic would have a negative effect on Uganda's foreign investments and tourism industry (Luwaga 2002 [interview]). Some government officials outside the Health Department also claim certain

[103] In general informants at national level seem to not have enough information on the involvement of politicians at grassroot level in Uganda and are somewhat indecisive in their answers on local level commitment. However, they believe they are not sufficiently committed, a problem which the UAC has addressed through a "political mobilization strategy".

bureaucrats today do not consider fighting HIV/AIDS as their responsibility (Ssonko 2002 [interview]; Nsubuga 2002 [interview]).

Nevertheless, all the national and local government officials that were interviewed express the importance of fighting HIV/AIDS, and believe they are both supportive and involved. In addition, officials in the MOH have spearheaded the policy of openness about the epidemic (UAC 1993a:12). All groups of respondents focus on how the government primarily through the AIDS Control Programme (ACP) in the MOH have carried out a multitude of interventions together with civil society from the very beginning of the response. These programmes have helped to raise awareness and change sexual behaviours. In Masaka most informants believe government officials do support the fight against the epidemic, even though some civil society informants explain how the officials are not as committed as *they* are. Informants emphasise how government's IEC activities have spread information through print media and radio contributing to awareness and behavioural changes[104].

At national level some civil society informants claim government officials are corrupt as they stick money into their own pockets. However, it is the delay in release of funds which is most often emphasised as a limitation to the successful implementation of HIV/AIDS programmes[105]. Also according to MOH "(…) there is generally a delay between commencement of project implementation and the initial disbursement of funds" (STD/AIDS Control Programme 2000: 19). Respondents in Masaka confirm the delay of funds at central level, which according to the DMO[106] hinders the decentralised HIV/AIDS programmes from becoming even more efficient (Musisi 2002 [interview]). Some civil society informants claim this delay is a result of lack of support among national bureaucrats more than a capacity problem. In Masaka informants believe government officials support the programmes, but acknowledge

[104] At both levels informants focus on the establishment of various FM stations around the countries, which has helped the government to spread information to all areas. This is due to the fact that while television reaches the urban population and newspapers only the literate urban areas, the radio reaches a much larger audience even the illiterate in remote areas (WB 1994: 16).

[105] In the "Inventory of Agencies of 2001", agencies involved with HIV/AIDS activities cited problems of the bureaucracy-delay of funds as causing an obstacle to implementing programs and hampering the progress (AMREF 2001: iii, 27).

[106] District Medical Officer: The person responsible for the District's HIV/AIDS activities and distribution of money for WB projects according to the District Plan.

"the government not being as efficient in channelling of money"[107]. Regardless of its causes, delays in transfers have had a certain negative effect on the degree of success of the HIV/AIDS programmes in Uganda.

Government and its administrative organs have created an enabling environment in which donor agencies, NGOs and CBOs can work unhindered (AMREF 2001: 21)[108]. Respondents express the importance of collaboration and trust between government and civil society as it increases resources for both parties and enhances the efficiency of fighting HIV/AIDS[109]. All groups of informants at both levels claim government is supportive to the work of civil society in combating AIDS. Government considers them as partners with more capacity and experience in areas such as counselling and caring. Hence, they bring in e.g. TASO and AIC to reach the grassroots of Uganda.

In Masaka informants describe how government officials support the involvement of civil society in their daily work. Respondents explain how this support gives civil society the opportunity to work within their fields of expertise and to access resources. For instance the district government provides civil society organisations like TASO with human resources such as medical personnel to follow up the medical needs of their clients- the People Living with HIV/AIDS (PLHAs) (Namusoke 2000 [interview]). The "partnership" with government also gives civil society the opportunity to access money through e.g. the STIP and MAP projects. However, civil society informants claim government officials at local level support civil society morally more than financially. They welcome the involvement of organisations and make it easy for them to establish themselves by e.g. offering them a building from which they can carry out their activities.

The possibility of a certain lack of support in the health department in the initiation of the programmes may strengthen previous interpretations that the President's will was "forced through". However, it seems as if most government officials do support the

[107] Still we must keep in mind that a certain *delay* in release of funds might also be a result of delays in the banking system, and general inefficiencies in bureaucracies at central level and not only lack of support.

[108] Also by looking into the NSPs we notice that government officials recognise the importance of the NGOs/CBOs in fighting the epidemic. In the last NSP more support to local NGOs/CBOs providing AIDS care and treatment is recognised (UAC 2000: 03).

[109] This cooperation will be further examined in section 5.4.

fight against the pandemic today. Informants claim this support is due to the fact that "all people have been affected", leading also most government officials to recognise the threat of the pandemic.

5.3 Resource allocation

Uganda's (…) "extensive level of funding has enabled a wide range of HIV prevention and mitigation activities to be developed and implemented" (Kagimu et al. 1996: 31). Informants at both levels explain how especially external donors' financial support has been essential in order to carry out HIV/AIDS interventions. They express how increased financial resources have helped both government and civil society to scale up their programmes and expand them to many areas of Uganda[110]. Civil society has also been able to start activities to reduce the vulnerability to become infected and to mitigate its impact. Informants in Masaka explain how increased financial resources have given actors more opportunities to reach out to people for instance by financing air-time at the local FM stations and distributing brochures and leaflets.

There is a strong tendency among informants at both levels to consider donors' financial contributions to the HIV/AIDS programmes as much more important than the government's. They point particularly at the financial contributions of the UN system, and the loans from the World Bank for government and civil society's implementation of various programmes[111]. Nevertheless, civil society informants at both levels assert that both multi-lateral and bilateral external donors collaborating directly with their organisations have contributed with most of *their* financial resources. Civil society informants, both in Masaka and at national level, point at government's allocation of resources to their HIV/AIDS programmes to be from limited to non-existing[112]. Our documentation indicates that donor resources are higher than the ones allocated by the GOU. *However,* the large loans of STIP and MAP, lent by the World Bank, have been taken up by the Government of Uganda. Hence, in line with assertions by the

[110] For instance organisations like TASO and AIC have been given the opportunity to go further into rural areas.

[111] The STI project has enabled many agencies, governmental, NGOs and CBOs to engage in the provision of IEC activities to promote awareness and avoidance of STIs and for training of health workers and counsellors (AMREF 2001: 18)

[112] We have to take into consideration that civil society might be very sceptical to the government, but also other documents confirm civil society primarily sponsored by external donors.

government officials these loans should be regarded as an expression of government's will rather than international priorities. This money is not charity and has to be paid back by the GOU with high interests.

Several informants claim government funding has played a major role since 1986 primarily for their own agencies to reach out to people with HIV/AIDS interventions[113]. Also in Masaka District some respondents as documents point at government activities primarily sponsored by central government, prior to the large projects of MAP, STIP and DISH (MDLG 1999: 03). Moreover, some government officials also claim more of the Primary Health Care (PHC) money was spent on HIV/AIDS at the time. Informants explain the importance of government's human capacity, through training of their own personnel such as doctors and nurses as well as teachers. In addition, civil society has trained government officials and vice versa, making use of each other's resources. Moreover, these actors have trained community members as counsellors, which is an enormous resource in passing of information to their villages.

All the respondents underline that they could have come even further with more resources made available for the HIV/AIDS programmes. Also all NSPs claim lack of resources is a main obstacle for further combating of the epidemic, and agencies both in 1997 and in 2001 pointed at lack of financial resources as the major constraint (UAC 1997b: 10; AMREF 2001: 29)[114]. Civil society informants focus on the need for financial resources in order to expand programmes to all areas of Uganda (including in the North and remote areas), and to limit the vulnerability of people to become infected. Informants at both levels also claim there is lack of *human resources* like counsellors and nurses to test people and follow up of the seropositives[115]. The review of AIDS activities in 1996 confirms a need for more counsellors (Kagimu et al. 1996: 12).

[113] This money has primarily gone through their own government agencies such as the ACP, MOH and the UAC as well as some money has been spent on HIV/AIDS in other departments (Education, agriculture, Local Government etc) (Hyde et al. 2001).

[114] The review of HIV/AIDS activities in 1996 confirmed shrinking donor funding and a need for more resources (Kagimu et al. 1996: iii).

[115] Insufficient trained personnel were stated by 25 percent of the respondents as a limit to their work, and inadequate capacity of CBOs was stated by 6.9 percent (AMREF 2001: 28).

In Masaka respondents assert how lack of human resources prevent LC structures from efficiently channelling information and services to the grass-roots, as there is need for house-to-house information due to high degree of illiteracy. Informants stress how organisations today lack financial resources and are hence run with voluntary unsustainable human resources. They also point at international donors, being the main contributors to the HIV/AIDS programmes, creating a problem of donor-dependency. Civil society organisations express concern of donor dependency, leaving them vulnerable to the international community's willingness to support their activities[116]. Organisations like TASO have developed a strong reputation and are heavily funded by many donors while others are more vulnerable (Kagimu et al. 1996: 34). According to some informants the support of the international community also seems to depend on the level of trust in the President of Uganda. Donor dependency implies that donors instead of agencies set the priorities for spending money, which can represent an obstacle to the efficiency of the programmes[117].

5.4 Involvement and support of civil society

All informants believe that involvement of civil society organisations in fighting AIDS has been one of the most important causes of raised awareness and behavioural changes among Ugandans, distinguishing their response from the ones in other African countries. Some informants point at early spontaneous initiatives to deal with the epidemic at grass root level, cooperating with the MOH. However, they also claim the involvement of civil society at national level and in Masaka in more "structured" forms to be a result of the President's invitation.

According to all informants civil society organisations in Uganda have been key actors to spread information about AIDS, offering counselling and care to the people in villages and communities. Through various often innovative means such as plays,

[116]Acknowledgments of the "Ugandan success story" can also affect their willingness to help positively as they see their contributions having an effect, but can also lead to "complacency" as they might get the impression of the HIV/AIDS epidemic already being combated (Nakabinge 2002 [interview])

[117] "The reliance on donors causes problems of sustainability of projects- if our donors pull out we don't have the resources to give services to people. Newly European Union introduced money that they wanted to be used on the Northern Districts, but now due to the war we can not go into these areas. At the same time we can not go into other areas because the donors have decided how the money should be spent. For example if a donor gives money to VCT we can not give a person a simple shot she/ he might need because this is not what the money is for" (Batte 2002 [interview]).

dance/ drama groups, peer-group support and seminars in communities, civil society has trained people in how to protect themselves and take care of their relatives. Several informants describe how people receive and accept the message of AIDS. They tend to trust more in the messages coming from civil society and trained community workers, which are closer to them. Civil society also has more capacity than the government to go out to the villages through outreach activities.

Overall, informants point especially at the importance of the involvement of the people infected with the disease (PLHAs) and their established organisations being decisive to fight AIDS in Uganda[118]. Together with the President's "openness policy" they have played a leading role to "open up" the Ugandan society, creating an environment in which channelling of information about the disease became possible. Informants explain how testimonies from PLHAs have helped to see them as victims, which has reduced the stigmatisation and discrimination of this group. Furthermore, people have tended to believe in the messages from the infected themselves, which has affected the behaviour of many Ugandans.

In Masaka PLHAs have played and continue to play a major role to get the message across through groups like TASO, NACWOLA and Kitovu Mobile. Informants at both levels consider the PLHAs involvement distinguishing their response from other African countries' where the government has not allowed this group to participate. Hence, in these countries there is a lot of stigmatisation attached to HIV/AIDS turning it into a "silent disease", spreading without too much attention by the government. According to several informants also involvement of Faith Based Organisations (FBOs) has influenced the population significantly. As religion and religious leaders are important for Ugandans, they have trusted the messages on HIV/AIDS coming from a variety of these organisations. In addition FBOs often have favourable structures already in place facilitating the spread of information throughout Uganda[119].

[118] A number of NGOs such as TASO and organisations of PLWA, have been formed and contributed to prevention, control and mitigation of the personal impact of HIV/AIDS, as well as promotion of positive living (STD/AIDS Programme 2000: 16).

[119] For instance in Namirembe Diocese, the Church of Uganda had already established youth groups, women's groups etc. through which they could spread information on HIV/AIDS (Moses 2002 [interview])

Informants believe civil society is important as their HIV/AIDS activities *support* the ones of the government. All groups of informants claim that the widespread support, trust and understanding between civil society and government officials have strengthened the response. Government officials at national and local levels bring in organisations where CSOs have "comparative advantages", and where government lacks capacity and resources. Informants claim these organisations are better at providing information to the grassroots; as they make use of means such as drama/songs. They also have more competence in offering care and counselling, and in addressing young people. For instance in Masaka government officials bring in the competence of various NGOs like TASO and Kitovu Mobile in e.g. schools to inform young people. In addition, CSOs often assist government in counselling and training, which gives the programmes more human capacity. Hence, involvement of civil society improves implementation capacity at district and community level (STD/AIDS Control Programme 2000: 19). Inclusion of civil society also brings more financial resources into the country through earmarked funds from external donors. In Masaka we witness how government increasing their financial resources by cooperating with NGO as they include civil society's activities in the government's budgets (Nnyanzi 2000: [interview]).

Moreover, informants explain that civil society has freedom to carry out their HIV/AIDS activities, as they have respect from the government and its officials. Nevertheless, some civil society informants claim it to be difficult to register as an organisation at the NGO board. Through institutions such as UAC and District Aids Committees there is also a certain control mechanism of civil society[120]. Many government officials consider this to be an advantage as it leads to less duplication of activities and more accountability and transparency[121]. However, civil society also receives money directly from donors at national and at local levels over which the government does not have as much control.

[120] As civil society participates in the formulation and implementation of NSPs and district plans, their activities are somewhat controlled as they have to account for the money being spent.

[121] Informants in Masaka district point at the D.D.H.S knowing at all times what they are doing as they have to account for their activities

Apparently the effect of the "involvement and support of civil society" has been extremely important both in initiating and implementing HIV/AIDS programmes in Uganda, and especially the organisations of PLHAs. However, why does civil society have the trust of government and a relative freedom in a country without political parties? Informants point at this freedom to be especially large regarding HIV/AIDS as this issue does not pose a threat to the President of Uganda, and as he has set this issue as a top priority to which he is sincerely committed.

5.5 Decentralisation

Informants at both levels point at differences in the degree of decentralisation of HIV/AIDS programmes throughout the response[122]. According to government informants, an early rather centralised response primarily initiated by the MOH had, a certain effect on raising the awareness of Ugandans. Nevertheless, respondents claim the needs of everybody were not taken into account and "normal people" did not decide as much as they do today. Some informants suggest the decentralisation process emerged when people's awareness should be transferred to further changes in sexual behaviours.

The main impression from the informants at both levels is that more local level control over the programmes has to a certain extent improved the channelling of information. In Masaka informants describe how the district has the responsibility for planning and implementation of these interventions. At both levels informants explain how increased local level decision-making has led to more local level "ownership" of the issue of HIV/AIDS, giving the districts an opportunity to identify and address their special needs[123]. Politicians in Masaka District claim local governments know better the needs in their districts than the national level authorities. And they now have the power to address these needs. Informants point at national level still establishing guidelines, policies as well as mobilising resources. Some government officials in

[122] In the 1980s and the beginning of the 1990s the government's response was more centralised as messages were mostly sent from central level's ACP, MOH which decided what the districts should do.

[123] Through an example set forward by the DMO in Masaka (Musisi 2000 [interview]) we realise how decentralisation reacts positively to local dynamics: The district has a problem with landing sites and fishermen's sexual activities, as they are fishing during the night and making love during the day which causes HIV to spread fast. This issue is today addressed by the district through specific programmes targeting this group.

Masaka claim the present guidelines from national levels hinder the districts' freedom to create efficient plans and implement their programmes.

Several informants explain how decentralisation of governance has led to increased commitment among local politicians. They seek to prove themselves as "good politicians" in order to be re-elected, and hence become more responsible to fight HIV/AIDS as it is a "national priority issue". In addition, informants primarily in Masaka, explain how local politicians through the decentralised system has mobilised and sensitised people at *all* levels, down to village level. Informants also look at the decentralised health institutions having brought HIV/AIDS information and treatment closer to people.

According to several informants at both levels more local level control of HIV/AIDS programmes has led to increased involvement of groups like civil society, and improved cooperation with the government. Local Government's Act provides for local councils to monitor and coordinate the NGOs within their jurisdiction area (Tumusiime et al. 2000: 11). According to several respondents a decentralised system of governance has led to more local level control over civil society's activities as districts supervise and collaborate with them. This leads to more transparency and better and more extensive coordination and integration of activities in the district[124]. Civil society organisations claim that the districts have a better overview of HIV/AIDS activities. This helps the districts and civil society to know where the capacity of NGOs is needed. Informants in Masaka claim there is more frequent information-sharing at lower levels than at central level, as they are directly communicating with each other weekly.

Some of our informants also point at decentralisation as a structure which makes mobilisation of human and financial resources easier. They describe how actors talk to the district council to get more resources without waiting for central government. In addition, local government structures are involved in planning and implementation of

[124] All activities including those from the NGOs and the private sector, have to be included in the District work plan (STD/AIDS control programme 2000: ix).

the budget through a "bottom-up" planning for e.g. PHC activities[125], making the health budget more adapted to local needs. However, informants claim HIV/AIDS programmes in the districts are primarily provided for with an extensive amount of donor-money passing through central government. Some informants claim that resource channelling from national level limits the efficient channelling of money since lack of support by central level government officials lead to delay of funds.

Informants explain how a decentralised approach with mobilisation of human resources at local level is efficient as districts train their own personnel and central authorities give assistance if needed. This training increases the chances of a sustainable response as it ensures competence at lower levels. Some national level government officials claim it to be easier for central level to direct funds and activities today as they use the already existing human resources at lower levels. Today central level (such as the UAC) contacts the district's HIV/AIDS focal person who works with the health team to implement programmes instead of using their own personnel.

There seems to be some positive results of "decentralisation", even though a centralised system might have played a role in the early years. When informants were asked to point at reasons for Uganda's progress, none spoke of decentralisation as the most important factor. However, when probed further most of them claimed that local level control has been important in the latter years.

5.6 Analysis and discussion of findings

On the basis of the interviews with the informants, there is little doubt that political will and commitment has been the most important factor in order to explain the relative success of Uganda in the fight against AIDS. Even though some informants point at sporadic initiatives being initiated by civil society, they point at the large strategic response in the implementation of HIV/AIDS programmes coming only after the President had taken the early initiatives. He invited civil society to join, and made the resources available. Although it is difficult to determine whether the political initiatives and programmes have come from the "top" or from the "bottom", political

[125] In Primary Health Care, HIV/AIDS activities has to be one of the components

will and commitment seems to be more important than the "involvement and support of civil society", even though they very soon became involved in the response. When informants were asked about the general reasons for the "Ugandan success-story", *all* of them expressed the importance of the President of Uganda, all the way down to the CBOs at the very grassroots in Masaka[126]. Hence, the importance of political will and commitment seems to be primarily due to the commitment of President Museveni and his "policy of openness".

Together with the People Living with HIV/AIDS (PLHAs), national politicians have contributed to the creation of "an environment of openness" about the disease in which stigmatisation was greatly reduced and programmes could be initiated by different actors. As Museveni announced the fight against HIV/AIDS as a "national priority issue", several other factors were triggered, such as the allocation of resources from external donors, mobilisation of civil society, and even some support of government officials. Political commitment has also had a certain effect on "decentralisation" as decisions of more local level control of HIV/AIDS activities have been made by the government and UAC. Even in Masaka informants pointed at the effect the President's openness to fight AIDS had on all actors to join the response from civil society to local politicians and government officials. In this "environment of openness" the Ugandans also became more open to receive and accept the messages on how to protect themselves and take care of the PLHAs. Nevertheless, the effect of the President's openness would probably have been less without the involvement of the People Living with HIV/AIDS themselves.

It is important to keep in mind that there have also been other factors besides political commitment leading to resource allocation to the Ugandan HIV/AIDS programmes especially to civil society, such as the trust of donors in these organisations[127]. Thus, political will and commitment can not take the entire credit for the extensive resource allocations to the fight against AIDS. In addition, we can not argue political

[126] They told about the importance of the President before I asked particularly of the role of "political commitment", which also increases the reliability of the information.

[127] For instance TASO is highly recognised internationally and with this reputation they raise donor resources primarily without the involvement of Ugandan government.

commitment to be the only reason for the involvement of civil society. Civil society announces their involvement to be a cause of real concern for the people of Uganda, However, it has mainly been through the political initiatives that they have been allowed to, and been given the resources to operate. In addition, political decisions initiated cooperation between government and civil society in order for the services to be better coordinated. In Masaka all groups of informants[128] explain how local politicians also support at least morally civil society and their activities, which makes it easier for them to operate. Thus, support to civil society seems to be one of the most important consequences of the support to fight AIDS among *local level politicians*.

From informants and documents we see how the openness and political commitment at national level also has continued, through establishment of institutions like UAC and by sustaining extensive cooperation between government and civil society. With increased financial resources from donors due to e.g. the President's commitment, HIV/AIDS programmes from all actors have been scaled up and efficiently implemented. From informants we have seen how politicians have also been important actors in spreading information to people at national level and to some degree also at local levels. In general we can not draw conclusions on a widespread involvement of politicians at *all* local levels or all districts, as we only have examined Masaka District. Nevertheless, informants in Masaka talk of at least some form of involvement of local level politicians from the early days, either through talking with their own village-members, or mobilising them to show up for events organised by other actors. When it comes to the personal involvement of Museveni, it is difficult to get the whole picture. However, information presented indicates that large presidential activity in fighting AIDS; from being personally responsible for spreading information to mobilisation of other actors. Thus, not only has political will and commitment, especially from the President and his government, initiated the fight against the epidemic, but has also contributed greatly to the relative success in *implementation* of the HIV/AIDS programmes up to now. Consequently, national level political will and commitment has had an important effect on all of the other factors.

[128] This includes informants of civil society which makes the information even more reliable and not only a result of "bragging" of the government"

Resource allocation

Contrary to the President's will to fight AIDS, the allocation of financial resources is not a necessity for *initiatives* to be taken. However, from the information reported we can draw the conclusion that extensive financial resource allocation has been essential in order for a variety of actors to *implement* and scale up their programmes within different areas of HIV/AIDS prevention[129]. From informants and documents we also realise the importance of *human* resources as one need human capacity in all agencies and at all levels in order to pass information on HIV/AIDS to people. Moreover, as informants regard a scarcity of both human and financial resources to prevent them from further progress in fighting AIDS. On this background, we recognise how resource allocation is also a necessary factor which should not to be taken for granted.

Despite the importance of resource allocation, this factor could be regarded as a consequence of political commitment and the involvement of civil society organisations. The President's early will to fight AIDS started the allocation of government and donor resources, and seems to also play a role for today. The money primarily lent from the World Bank by the GOU (STIP/MAP) is primarily a result of political commitment from the highest level of government. As pointed out above, external donors' trust in civil society has also contributed to their continued allocation of resources. In addition, human resources to these programmes are apparently a consequence of the extensive cooperation between government and civil society[130]. Therefore, it is questionable that resource allocation should be regarded as a separate factor. When asked about the general reasons for the Ugandan progress a grand majority of informants pointed at the "involvement of international donors" rather than resource allocation. We saw in chapter 4.4 that 70% of funds for HIV/AIDS activities came from donors before 1995. There might be other causes of the international donors' financial contributions (national interests in the donor countries etc). Nevertheless, political commitment and trust in civil society seems to explain *most* of

[129] We do not have the total overview of all financial resources allocated to the Ugandan HIV/AIDS programmes, but they seem to be extensive as they have covered different areas within prevention, care and mitigation of the epidemic as well as financial resources have been channelled to many different actors in order to carry out the programmes.

[130] The importance of this collaboration to increase human resources will be further examined in the following section.

the effect of financial resource allocations of international donors as well as the government's contributions.

Not only the actual existence of funds is important, but through which actors the resources have been channelled. Informants have described how resources have helped *all* actors contribute within their area of expertise and many different interventions targeting different groups. Resources in Uganda seem to have supported actors from the President's high level initiatives with involvement of national media, to the small grass-root organisations to educate families in how to take care of their sick relatives. And without the extensive interaction between government and civil society the channelling of resources, both human and financial would not have been as efficient. Hence, resources seem to have "backed up" the many initiatives allowing many different actors to participate within their area of competence. This leaves resource allocation as another force which has "pulled in the right direction".

The importance of civil society versus civil service?

From the information presented, we may conclude that the second most important factor in order to explain the relative success in fighting HIV/AIDS in Uganda has been the "involvement and support of civil society". Although their extensive involvement to a certain degree depends on the political commitment, *all* informants point at the involvement of civil society as an important factor for the progress in fighting AIDS. As documented previously (chapter 4.3), the early and extensive involvement of civil society played a vital role in passing information, fighting the stigma attached to the disease and caring for the ones infected. In order to create the previously discussed "environment of openness", the political initiatives had probably not been as influential if the People infected with the disease (PLHAs) were not included. From informants we have heard how the PLHAs "gave the epidemic a face", and without this involvement people might still not have believed in the messages sent out by various actors. Thus, many people might still be living "in denial" in Uganda, hiding its victims and not protecting themselves. This is still the situation in many other African countries.

Although initially, there were certain negative attitudes to give priority to AIDS in the health bureaucracy and government departments, such attitudes were not given much of a chance to influence the programmes. While this may to some extent be explained by the President being so decisive in initiating and driving these interventions, the role of civil society as a driving force also played its part in mobilising resources and placing the issue on the agenda. While it would be inaccurate to argue that civil servants played a destructive role in the longer term implementation of programmes, they are also not seen as an *equally* constructive driving force behind the mobilisation enrolling in the 90s.

Donors, civil society and government officials at national and local levels believe in the support of government officials in carrying out interventions especially in the MOH and MOES[131] since the beginning of the response. The role of government institutions, such as UAC, as coordinating mechanisms and information channels is seen as particularly important for the cooperation between these actors. In addition, these mechanisms also seem to be important as the response is multi-sectoral and also government sectors have to coordinate their response[132]. While the support of government officials may be more critical in the delivery of services at local level (as we saw in Masaka), it also seems to be stronger here.

All in all, a substantial amount of donor money (including STIP/MAP projects) is channelled through government. Thus, their support to the programmes is critical for their implementation. Delays in transfers of funds are highlighted by several sources. Some even suspect corruption. While no documentation has been found to this effect, the level of corruption is generally considered to be relatively high in Uganda. Delays may however be explained by delays in the banking system and weak infrastructure in Uganda. At the same time, all our respondents indicate that the support for, and commitment to the AIDS campaign seems to be much higher amongst local civil service, than amongst the national civil service. At local level, there are indications of less bureaucratic obstacles and more transparency than at the national level.

[131] See chapter four for more information on the HIV/AIDS activities of the MOH and the MOES.

[132] The importance of the MSAP is also mentioned by several informants: both for all government sectors and for private sector to be involved and cooperate.

It is difficult to put private and government initiatives up against each other as from interviews and documents we have seen how they have both played a role. The ACP, MOH is emphasised by all respondents to have played a leading role to e.g. raise awareness by the use of different media. However, the support of government officials looses some of its influence as we have witnessed that civil society has taken on many responsibilities. In a situation where government carried out all interventions this factor would of course be more important. Many programmes have also been carried out in cooperation between civil society and donors without real involvement of government. Nonetheless, what informants primarily focus on is the importance of their daily support to *civil society's HIV/AIDS programmes*. This appears to be the most important consequence of government officials' support. Both parties explain how this support is crucial in order for them to cooperate and use each others strengths in implementing efficient programmes. For civil society organisations in Masaka the support of government officials might even be more important in their daily work than that of local politicians. Thus, informants express the importance of this close cooperation whereas local level politicians' support seems to depend more on national level decisions and priorities.

In order to bring information to reach all the way to the grassroots, civil society organisations such as NGOs and CBOs as well as Faith based and Aids Support organisations were critical partners for the Ugandan government. Organisations took on several responsibilities in the fight against AIDS. They are often more trusted by the target groups, have more capacity and allocate both human and financial resources. Their initiatives also extended the areas of work in fighting the epidemic. Hence, support from and involvement of civil society seem to have been somewhat more important even than the role of government officials. It is important here to underline that it is also the extensive *cooperation*, without real conflicts, between government and civil society which is essential in explaining the HIV/AIDS programmes in Uganda. Nevertheless, we may still conclude from our informants that civil society's initiatives have had an even stronger impact than those of the civil service. Civil society has been critical in order for programmes to reach the grassroots with

information especially in care and counselling, as well as they have contributed to "open up" the Ugandan society.

Centralisation versus decentralisation?

From the information reported decentralisation seems to be relatively important in explaining Uganda's fight against AIDS. Resource allocation has been primarily a central responsibility from the start of the programmes up to now. However, as developing countries do not have much of an opportunity to raise their own financial resources at local level (through taxes etc.), funding to HIV/AIDS, like in other areas of public policy, becomes more of a national concern[133]. Hence, resource allocation, being a national responsibility can not be avoided, and thus should not be regarded as a sign of limited decentralisation. However, civil society has received funds outside of government structures since the very beginning, which limits the central control over resources. Today, district institutions seem to have *more* of a control over organisations' funds mechanisms, although not fully.

This relatively centralised resource allocation seems to be partly an advantage for these districts who struggle to raise their own resources. However, the delay of funds from central level is a disadvantage with this system, preventing resources from being more efficiently channelled. As documents and certain government officials and civil society informants at both levels talk of such delays, this information should be trusted at least for the district of Masaka and maybe also for other districts[134]. Further channelling of resources once received has become more of a local matter. This seems to have made more of a positive contribution as the structures and thus human capacity is already in place, and there is a better overview at local levels.

Informants and documents suggest that programmes have gone from more detailed control of national level, to local government having the responsibility for planning and implementation of their own activities within certain national policies and

[133] We have witnessed that in Masaka except for the DISH project most financial resources for government activities have apparently been allocated by central level through the STIP and MAP projects in addition to, especially in early years, the Aids Control Programme in MOH.

[134] We also saw in chapter 4.4 that the delay in funds also appears in other areas within health, which makes this information even more trustworthy.

guidelines. In the start of the response central level decided the nature of the HIV/AIDS programmes as well as national level was responsible for their implementation. Informants and documents, however, suggest positive results also from this early more centralised approach. This limits some of the effect of decentralisation. But maybe a certain awareness level had to be raised, before more local programmes could further try to influence people's sexual behaviour? However, there are still certain restraints to total local government control, which informants in Masaka claim limit the progress. On the basis of information reported we can draw certain conclusions of positive effects of *more* local level control and responsibilities. Many informants point at more autonomy to the districts and less control from central level having contributed to a possibility of "tailoring" the programmes according to the real needs of people in the districts[135].

More local government control seems to have a positive effect as it has supported the factors already stated to have played an important role. In Masaka we have witnessed that civil society has been involved from the very beginning to the response against the epidemic, which limited central government's control over local HIV/AIDS activities. And information reported suggests that more local government control and institutions have offered civil society even more of an opportunity to become involved, and collaborate with local government. Hence, more local level responsibilities seem to have supported the factor previously considered to be one of the most important: "involvement and support of civil society", and their cooperation with government officials. A decentralised decision-making combined with further collaboration between civil society and government has apparently made a great impact. In Masaka informants describe how more authority to local governments has contributed to further collaboration between actors and a better overview. This has resulted in more transparency and less duplication of activities both between civil society and government and between different government sectors [136]. More local government control therefore may have increased the availability of human resources to the

[135] At the time of more standard centralised programmes, the opportunity to address the different needs present in each district and adapt programmes were limited.

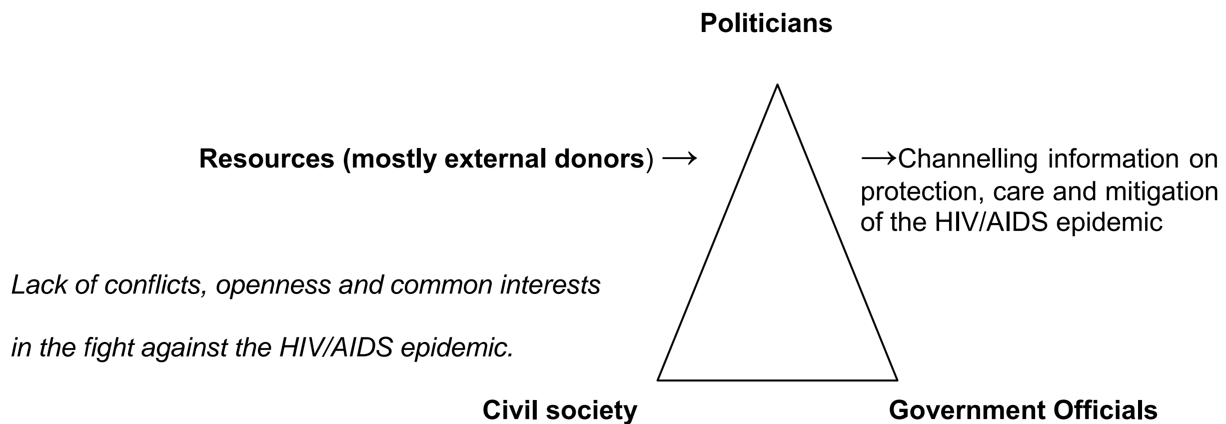
[136] As the Multisectoral approach is mentioned by several actors to have played an important role.

programmes. Also financial resources have increased as the organisations' finances to certain activities are included in district level budgets. We can not draw any clear conclusions of decentralisation in itself leads to more *political commitment* at local levels. However, there are indications for Masaka that a decentralised system has at least *facilitated* the involvement of local level politicians. We should, however, be careful in making these assumptions for all districts of Uganda as many informants question the amount of political commitment at local levels.

Efficient collaboration and common interests

In general one important reason for the relative success HIV/AIDS programmes in Uganda has been the peaceful and extensive cooperation between the various actors involved in fighting the epidemic: politicians, civil society, bureaucrats and donors. It seems that they all share a common goal: to fight the epidemic. Hence they support all contributing actors. The factors examined here more or less support this positive collaboration in "an environment of openness" were actors have all been asked and allowed to participate. This has made the cooperation successful. Many of the informants claim all Ugandans support the fight as all households in Uganda have been affected. As many have died people started to know about the cause, they wanted to participate in the fight. Another reason might be the power of the President turning the issue of AIDS into "a national priority issue". In a political system where the President is so powerful, everyone seems to accept the fight against the HIV/AIDS epidemic as a national priority.

Figure 3 Collaboration between the internal actors in HIV/AIDS programme [137]



5.7 Analysis and theoretical implications

The "top-down" approach claims that bureaucrats/ government officials are the most essential actors involved in formulation and implementation of programmes, while involvement of the informal "street-level bureaucrats" such as "civil society" is supported by the "bottom-up" approach (Sabatier 1986b). We have witnessed that in the initiation of the response to the epidemic political will and commitment has apparently played a more important role, than both the support and involvement of government officials and civil society. The pre-eminent role of politicians and their commitment in explaining the relative success in fighting HIV/AIDS support the "top-down" approach, which emphasises the need for politicians' support to the programmes with some focus on the political elite (Ibid).

The "top-down" approach is strengthened since the most organised initiatives to fight HIV/AIDS came "from above" even though no formal policies were adopted[138]. This speaks against the "bottom-up" which claim the "top-down" approach is not efficient when there is not one adopted policy (Sabatier 1986b). Hence, the "bottom-up" approach apparently underestimates the role of politicians both in initiation and implementation of programmes as they pay little or no attention to these formal actors. For instance, Elmore does not believe in actors who can influence each other's

[137] This figure is a follow up of figure 1 (in chapter 1) as to what can explain the efficient collaboration between the internal actors in the fight against the epidemic and how they channel information to the target groups.

[138] However, policies even not formally adopted by the Cabinet do function in practice and also informal policies do exist.

behaviours and policy-makers who can control policy implementation (Elmore 1982: 20 in Younis/Davidson 1990). In Uganda, contrarily, we have witnessed politicians who have had a large influence over the implementation of HIV/AIDS programmes.

Findings in Uganda support the "top-downers" Van Meter/ Van Horn (1975) and Mazmanian/ Sabatier (1983: 30-31) as they claim political commitment play an important role for resource allocation[139]. However, this approach fails to take into consideration that political commitment to a programme does not only lead to allocation of internal/ government resources, but also to external donor resources. The established connection between political will/commitment and *external* resource allocation, supports theories explaining successful programmes in developing countries and health programmes. For instance, the World Bank as well as development theorists such as Turner/ Hulme (1997 in Ingram 1990) and Rondinelli/ Montgommery (1991), focus on the necessity of political commitment for mobilisation of *donor* resources in addition to government resources.

Furthermore, findings from the Ugandan HIV/AIDS programmes fit perfectly with the theories of the World Bank on the need for strategies[140], in order to acquire donor money (WB 1994: 155). However, as the WB has been one of the most important agencies in channelling money to the programmes, this might be an example of "self-predetermination" rather than a confirmation of their theoretical approach. On the other hand, several other external donors have also channelled money to Uganda, many based on the NSPs, also prior to the STIP/ MAP projects, due to political will from the Government[141]. These findings strengthen the WB's theory. According to Grindle (1980) the political commitment should be noble in order to make a positive contribution. In the Ugandan HIV/AIDS programmes we have seen there is a possibility for a hidden agenda of the President's commitment: a need for donor money and acceptance by international community. However, here this appears to

[139] More information on resource allocation in the following section

[140] This is one of the measures through which political will and commitment is measured.

[141] With reference to section 4.4 and Appendix II

have had a positive contribution as the result has been extensive allocation of donor money to fight HIV/AIDS.

The apparent connection between political commitment and involvement of civil society and their cooperation with government is more or less missing from the "top-down" approach. Mazmanian/ Sabatier (1983: 30-31) claim that political commitment is an essential factor for early and efficient cooperation among various actors involved in programme implementation. Yet, this approach does not explicitly point at the importance of politicians to mobilise and involve *civil society*, which they claim are not important actors. And contrary to what "top-downers" expect, the political support has been more important for the involvement of civil society than for the involvement of government officials. Furthermore, the "bottom-up approach", which believes civil society organisations to be essential actors, seems to underestimate the importance of *political will* to mobilise these actors as they are rather seen to "mobilise" themselves[142]. In addition, they consider the ability of actors at one level to influence the behaviour of other actors to be limited (Elmore 1982).

Nevertheless, other theories might explain the connection between political commitment and mobilisation of civil society better than implementation theory. Development theorists like Rondinelli/ Montgommery (1991) point at the necessity of a stable political leadership at least to establish these coordinating mechanisms between private and public actors. Also Materu et al. (2000) claim real political commitment at national level support cooperation between government and civil society at local level, which is consistent with findings in Masaka district.

Despite the essential role of politicians and a somewhat strengthened "top-down" vis-à-vis the "bottom-up" approach, the "top-downers" *also* underestimate the role of the politicians and their commitment. This approach puts a stronger emphasis on the support of government officials than the politicians. In Uganda's fight against AIDS this political commitment has been proven far more important in initiation and implementation of public programmes than the government officials'. In addition, the

[142] Elmore (1982: 12 in Younis 1990) claims there is no possibility for policy makers to control the implementation or influence the other actors' behaviours.

"top-down" approach has overseen the importance of involving politicians as real actors in the response, to spread the messages, and not only to support the programmes. Even more importantly, the "top-down" approach does not place sufficient emphasis on the commitment by a country's leader, in this case the President's. Hence, implementation theory falls short in explaining the *extensive* importance of political commitment, which we witness in Uganda.

Development and health theorists speak *more* of the necessity of the political leadership. Some of the "development theorists" focus on the need for a "strong political elite" and consistent support from political leaders, in order for programmes to be successfully implemented (Rondinelli/ Montgommery 1991; Turner/ Hulme 1997 in Ingram 1990). In addition, health theorists like the World Bank (1993; 1994) and Cassels (1995) focus on the need for political commitment in order for health programmes, even HIV/AIDS programmes, to be *initiated,* presumptions which have certainly been confirmed here. The World Bank assumes that a country's leadership puts off dealing with the epidemic because sexuality is involved, political benefits are small and issues are controversial (WB 1994: 100). In Uganda, however, we have witnessed a President who did *not* put off dealing with the issue. Nevertheless, the issue of HIV/AIDS, even though not spoken much for at the time in Africa, had not been made controversial within Uganda. In countries like South Africa we see this situation very clearly: the issue *has* become politicised and controversial. In Uganda, the fight against AIDS has become an accepted issue for all groups in society, for all Ugandans, one in which they have to deal.

According to Grindle (1980) there has to be *real* commitment in order for political commitment to be a positive contributing factor. There might have been some political benefits to this decision, such as acceptance and resources from the international community. However, most people believe this to be a cause of real concern for Ugandans. Other information reported also suggests there is also real commitment. The President did not have to take up loans or speak about the issue if he was not sincerely concerned.

Even so, as we look at Uganda's fight against AIDS these theoretical approaches also seem to underestimate the *widespread* importance of a country's political leader, both in initiation and implementation of programmes. It is probably only the 1970s "statist" approach to development which plays sufficient emphasis on the importance of a country's political leader in order to affect the outcome of the programmes. Nevertheless, none of the theories employed can explain Museveni's widespread importance as a contributor to an "environment of openness" where implementation of HIV/AIDS programmes became possible. We also lack theories to understand how political commitment can contribute to "open up" a society and reduce stigmatisation attached to the disease for efficient channelling of information to people. When looking at the ability to transfer findings of the particular role of the President to other types of programmes, one must take into consideration that the fight against this pandemic is a very particular fight. Hence, a president's personal involvement in these programmes may not be *as* important for programmes in other areas where the issue in which to deal is being addressed openly. Nonetheless, the President's support to the programme and his creation of an "enabling environment" for all actors to become involved might very well have an influence also in other areas.

The political system

Various scholars emphasise the importance of a socio-economic stable context in order for programmes to be successfully implemented. For instance, development theories focus on the need for a stable and consistent leadership with abilities to develop structures to follow up their programmes (Rondinelli/Montgommery 1991; Turner/Hulme 1997 in Ingram 1990). In addition, Cassels (1995) considers political support to health programmes as fragile and the context as essential in order to obtain this support. In Uganda we have witnessed a stable political leadership, which has continuously addressed the fight against AIDS throughout the President's period, and which has manifested itself through the establishment of institutions. Institutions like the AIDS Commission (UAC), coordinates the country's Multisectoral Approach and all its actors. These are signs of "strong public institutions", which development theories like Rondinelli/ Montgommery (1991) consider to be a necessity for efficient

policy implementation. In Uganda a relatively stable socio-political environment has also contributed to the allocation of resources by donors. The President, which has proved himself committed to fight AIDS, has stayed in office up until today, and still donor and internal resources are granted based on Museveni's personal commitment.

Nevertheless, this rather stable political system is *not* an example of a democratic multi-party system, which Grindle (1980) stress to be a precondition for political commitment to play a *positive* role in the implementation of programmes. According to Grindle (1980) and Cleaves (1980), programmes implemented in an open democratic environment are better adapted as politicians and bureaucrats are more responsive, than if they are implemented in an authoritarian environment. It is therefore of particular interest that in a political regime which prohibit political parties, this factor has played a very important role. We can, however, not assert that the Ugandan political system is a *total* authoritarian system, as its leaders are very open to the involvement of private organisations in fighting HIV/AIDS, and thus might be more pluralistic at least in this area[143]. There is also a possibility that a political regime where the President has more power than under multi-party democracies can be efficient in order for his ideas to be carried through. In the fight against AIDS Museveni's ideas have benefited the whole population and gone in line with most other actors' interests. It could, however, be questioned what happens in a situation where the political leader's ideas are not in line with the people's needs and wishes.

Resource allocation

Findings on "resource allocation" support only to a certain degree implementation theory as they emphasise the need for bringing in the "existence of resources" as a separate factor. By looking at interviews and figures[144] we see that an *enormous* amount of money has been spent on HIV/AIDS activities in Uganda. There is no doubt that "resource allocation" has been important in explaining the Ugandan success. Without these financial resources plans by various actors on HIV/AIDS can not be carried out and programmes not scaled up. Hence, findings supports the "top-down"

[143] We will examine whether and why there is such freedom for organisations also in the next section.

[144] Go to section 4.4 and appendix II

approach such as Gunn (1980: 05 in Younis/ Davidson 1990) and Van Meter/ Van Horn (1975) who consider sufficient resources to be a necessity for programmes to be successfully implemented. Simultaneously, even though Elmore points at a certain need for resources to be granted primarily to organisations (1982), the "bottom-up" approach seems to underestimate the importance of resource mobilisation in order for *all* actors (also government officials) to carry out and scale up their programmes. However, as "resource allocation" in this case is more a consequence of other factors such as political will/ commitment and involvement of civil society, this factor should not be paid as much attention to as asserted by the "top-down" approach.

"Top-down" adherents such as Van Meter/ Van Horn (1975) describe how resources should be made available through government decisions and passed through government channels. Assertions of the availability of government resources are partly confirmed in these programmes as government has been active in providing human resources by educating personnel. In addition, government has made government resources available through channelling of financial resources through the Ministry of Health and the MAP/ STIP projects (by loaning money from the WB). However, these financial and human resources to fight AIDS where not granted through adopted policies, but are rather a result of collaboration between external donors and government[145].

Furthermore, the "top-down" approach does not emphasise the importance of external donor resources, which have been extremely important to fight AIDS, not only for the loans from the WB but also for other financial contributions. Hence, classic Western implementation theory is not *as* adaptive in environments where the state is poor, and external donors allocate much of the funds for public and private programmes. Again we have to go to development and health theory as they have adapted their theories more specifically to these circumstances. The WB's examination of health programmes and development theorists such as Materu et al. (2000: 33) and Rondinelli/ Montgommery (1991), all consider external agencies to be a necessity for programme implementation in developing countries, in combination with government

[145] Except for the UAC and the ACP, MOH where policies were adopted to establish these institutions and its human resources.

resources. These findings do not, however, support the early “neo-liberal” approach represented by World Bank in the 1980s, which believed the economic growth will “trickle down" to the health of the population, as most money was not spent from the government’s own revenues (Zwi/Mills 1995).

According to Grindle/ Cleaves (1980) a scarcity of resources in developing countries leads to more problematic implementation of policies. We see this situation very clearly in Uganda as the country has depended and continues to depend on donor’s will to support these programmes in order for HIV/AIDS information to reach out to people. This leaves the country very vulnerable. The solution to this “donor-dependency” might therefore be for external donors to make commitments to fight AIDS by supporting actors long-term. Moreover, in a poor country like Uganda the fight for resources is also more intense as resources are scarce. Hence, it is even more surprisingly that many actors have agreed on the prioritisation on the fight against AIDS. Of course this might be the consequence of a political system where the President has such a large power in setting country’s “priority-issues”. However, since all actors (including civil society) agree on the importance of fighting AIDS, this could also be the cause of “all Ugandans” having been affected by the epidemic.

In Uganda’s fight against AIDS we have seen that the extensive collaboration between civil society and government has been important at all levels to allocate, but most of all to *channel* resources[146]. Therefore, in line with Ugalde/ Jackson (1995), we must also take into consideration the importance of how resources are channelled, who controls them and how they are spent. The “bottom-up approach” considers resources should be channelled to organisations as they are closer to the target groups (Elmore 1982: 28), while “top-down” scholars focus primarily on the availability of resources for government (Van Meter/Van Horn 1975). Hence, both of these approaches seem to underestimate the need for *cooperation* between government and private actors for successful channelling of human and financial resources.

146 For more on the support of government officials see section 5.4.

As a consequence, findings from these programmes rather support development theorists and actors examining health programmes, like the WB and WHO. These actors consider public-private partnerships as important in order to raise and channel internal financial and human resources for HIV/AIDS programmes (WB 1994: 168-170; WHO 2000: 139). The "top-downers" Van Meter/ Van Horn (1975) as well as WHO, and to a certain degree the World Bank, emphasise the need for human resources. Findings of the importance of cooperation between government sectors and civil society for human resources primarily confirm the theories of the WHO. This organisation emphasises the need for such human resources, for skilled health personnel, which should be offered by the government, but otherwise mostly by the private sector (WHO 2000: 77). Findings of the importance of the UAC, DACCs/ DHACs and creation of common plans to fight AIDS also support Rondinelli/ Montgommery (1991). They point at the need for government to create effective structures and processes to mobilise and channel resources. In addition, as many civil society resources pass outside of government structures these findings support Ugalde/ Jackson (1995) who claim that people should have more control of the resources compared to the government.

The importance of civil society versus civil servants?

Findings from the Ugandan case strengthen the "top-down" approach as adherents see the need for *support* from both government officials and civil society. Nevertheless, this approach, contrary to the "bottom-up" approach, seems to underestimate the role of *civil society*. They have been key actors and one of the most important factors in order to explain the relative success. In addition, the "bottom-up approach" underestimates the role of government officials especially for the *involvement* of civil society, like they also did with the politicians. Hence, neither of the two approaches within classic implementation theory points at the importance of *cooperation* between government officials and civil society. Again we have to turn to development and health theories in order to understand the importance of this cooperation for successful programmes to be carried out in developing countries.

First of all we have seen the importance of civil society in passing of information to the grassroots, which are in line with the preconditions for successful implementation set by the "bottom-up" approach. Target groups have received information from what this approach called the "street-level bureaucrats" – the NGOs, community-workers, FBOs and CBOs. They are closer to the target-groups and can easier implement programmes to influence people's behaviours (Sabatier 1986a). Their influence follows the "bottom-up" adherents who claim organisations have greater possibilities of influencing people's behaviours as well as they have more skills from the grassroots (Sabatier 1986a; Wheatherly/Lipsky in Younis 1990). Simultaneously the "top-down" approach underestimates the local resources present in the informal groups such as civil society, as they have skills and competence of the problem which the government lacks (Elmore in Kjellberg/Reitan 1995: 155). By involving these groups in the response the programmes become more successful. The World Bank asserts that civil society, together with a decentralised approach, increases the involvement of community groups at all levels[147]. We also recognise presumptions by the Bank that these actors are more flexible than the government and use more creative methods to promote health education and information, through theatre, dance, films etc (WB 1994: 05). Development theorists also support the involvement of the private sector and civil society as they offer important services to the population (Rondinelli/Montgommery 1991) and can improve the quality of services (Van der Haag 1995 in Turner/Hulme 1997: 127).

Grindle (1980) and Cleaves (1980) believe civil society influences the programmes positively in an open, political system within a plural society. In these societies there are higher possibilities of organisations to be autonomous and responsive to people's needs, and for private organisations interests to support the ones of the government. Once again we see a certain contrast between these presumptions made by these authors and the Ugandan HIV/AIDS programmes. In this country which we can *not* call an open democratic society, there are between 700-1000 agencies involved with AIDS activities, and private organisations do support the public programmes. Hence,

[147] The connection between involvement and civil society and decentralisation will be further discussed in a later section.

there seems to be a certain level of pluralism benefiting these programmes despite Uganda being a zero-party system.

We have seen the "bottom-up" approach arguing that informal groups are more influential to pass on information to people (Sabatier 1986a; Wheatherly/Lipsky in Younis 1990. Nevertheless, in order to fully grasp the importance of People Living with Aids and their organisations to reduce the stigma and discrimination attached to the disease, we are in shortage of theoretical guidelines. Neither the "bottom-up" nor any of the other theoretical approaches talk of the importance of involvement of certain groups in order to "open-up" a society to become more susceptible to receive and accept the messages. This corresponds to the absence of theories we witnessed in order to understand the importance of the President's "openness-policy". Since there is often heavy stigmatisation attached to the AIDS epidemic, the programmes in question and the need for actors "to open up" might be particular in this case. One might, however, expect health theories to include this aspect, as also other diseases have some stigma attached to them, although not to a similar extent.

The "top-down" approach considers government officials' support to be one of the most important factors to carry out successful programmes (Ingram 1990)[148]. In Uganda we have seen that government officials have been involved, which according to Van Meter/Van Horn (1975) is evidence of support. Also government officials' support can be witnessed through government *institutions* to fight the epidemic[149]. These findings support "top-downers" like Mazmanian/ Sabatier (1985: 35) who assert that the creation of such agencies will increase the possibility of government commitment leading to prioritisation and visibility of the programmes[150]. However, apparently their support has not been as important as the "top-down" approach believes, as civil society has taken on responsibilities and not all information reported claim widespread support, at least at national level. But cooperation between

[148] For instance implementation scholars such as McLaughlin and Bardach focus on bureaucrats to be relevant actors with a major influence on the outcomes of the programmes (Bardach 1977: 43, McLaughlin 1978: 167-80 in Ingram 1990).

[149] From the establishment of the ACP, MOH to the establishment of the Multisectoral response and coordinating institutions like UAC and DACCs/ DHACs.

[150] The visibility of the fight against AIDS in Uganda can be witnessed through the creation of the UAC under the President's office.

government and civil society suggest that the public arena still has an important role to play unlike the arguments put forward by "neo-liberalism".

In addition, findings of lack of support among government officials through corrupt and delayed tendencies criticise the "top-down" approach and their emphasis on the need for support from government officials. Nevertheless, this does not support the "bottom-up approach" who claims the degree of the support of government officials to be *without* importance. On the contrary, findings support the sceptics to the involvement of government officials such as neo-liberalists and the WB as well as WHO (2000: 63) and Jain (1992) who claim bureaucracies are not efficient in health programmes as they often become tools for self-interest of the bureaucrats and are not responsive to people's needs. However, if all channelling of resources would have gone outside of the government system we would also face problems with overview of activities and placing the state on the sideline of activities, which various health theorists have warned against[151].

Cooperation between government officials and civil society

In the Ugandan HIV/AIDS interventions civil society *supports* the government programmes. This correspond to the "top-down" approach who points at the need for support of interest groups as for all other groups, but they ignore the involvement of civil society (Mazmanian/ Sabatier 1983: 30). However, in these programmes we have seen the importance of the *cooperation between government and civil society*. While, the "top-down approach" apparently omits that government support has to include support to the involvement of civil society, the "bottom-up" approach underestimates the need for support from government to the "street-level bureaucrats". However, in the fight against AIDS the actors depend on and compliment each other in order to increase capacity and carry out successful programmes.

We have to turn to development and health theories in order to fully understand the importance of both of these actors supporting each other. As government has included civil society in their HIV/AIDS programmes, these findings support development theorists such as Rondinelli/ Montgommery (1991). They emphasise the importance of

[151] WHO 2000; WB 1993.

the support from the bureaucracy in order to create conditions that allow NGOs to implement efficient programmes. Also Grindle (1980) considers the importance of public institutions to be responsive to people's needs and to understand the environment in which they operate and ensure responsiveness. Findings also support health theorists as the World Bank as they consider bureaucratic commitment to be essential for the involvement of local communities and non-governmental organisations in decision-making and implementation (WB 1994: 43). Edward/ Hulme's analyses of health programmes also point at the need for support from NGOs as they strengthen the capacity of the government through collaboration (in Lorgen: 1998).

We have observed that civil society has certain capacities in different areas with fighting HIV/AIDS of which the government seems to know how to make use of to improve the programmes' capacities[152]. These findings support Turner/Hulme (1997: 88) who consider increased resources and improved government's capacities to be a result of this cooperation. At local level the importance of cooperation and overview of the actors on a daily basis support Materu et al. They focus on local level and how cooperation between the two actors is important to avoid duplication of activities and conflicts and build trust between the two (Materu et al. 2000: 37). In Uganda we have also witnessed that these actors have the same interests of fighting HIV/AIDS leading to few conflicts between the two. These findings support Rondinelli/ Montgommery (1991) who claim cooperation between government and the civil society organisations can lead to successful programmes if they pursue the *same goals.*

In Uganda we have seen that despite the fact that many HIV/AIDS activities are in the hands of civil society, the government institutions have at least to some extent the overall control through various mechanisms. WHO (2000: 63) and Lorgen (1998) stress that the ultimate responsibility of health should lay within the government administration. Jain (1992) also considers bureaucracy to have emerged as the most important institution to plan, perform and deliver public goods. Findings of somewhat institutionalised HIV/AIDS programmes to a certain extent also support the statist

[152] Especially when it comes to care of PLHAs and VCT services, but also in areas they have innovative measures.

approaches and Ugalde/ Jackson (1995) and Zwi/ Mills (1995). They see a need for a strong state in order to administer and coordinate the programmes, and a certain control of the private sector to concentrate their resources on the right points and avoid duplication and fragmentation. On the other side, the "neo-liberalist" approach seems to undermine the need for an overview of the actors involved in the response through government institutions. WHO's assertions seem to be appropriate in order to describe the collaboration between government and civil society. The intention is "to achieve combined advantages of greater flexibility and innovation while maintaining overall control over strategic objectives and financial protection" (WHO 2000: 63).

Contrary to the wishes of the "bottom-up" approach, civil society is under a certain control from the government at national and local level as part of the cooperation between the two. However, in this case neither the "top-down" approach, wishing much control, nor the "bottom-up" approach believing in no control seems to be appropriate. It is rather the World Bank's and WHO's philosophy which is supported here: the government seems to provide the NGOs with an enabling legal environment for establishment and registration of their activities without unnecessary regulation of their activities (WB 1994: 125). We have seen indications that civil society organisations are controlled but are still given freedom to implement innovative HIV/AIDS programmes (WB 1994: 05). The extensive cooperation in various institutions support WHO which points at a need for information- sharing and dialogue between public and private sector to get an overview of the activities of NGOs, and to coordinate and regulate them (WHO 2000: 128).

Centralisation versus Decentralisation?

Whether or not the public programmes should be under local or central level control (decentralised or centralised) is one of questions most clearly distinguishing the two approaches within implementation theories. Indications from this research primarily support the "bottom-up" theory, although some central level control probably played a role early in the response. Assertions in the HIV/AIDS programmes of a positive effect of more autonomy to local authorities to "tailor the programmes to local needs" correspond to claims by adherents of the "bottom-up" approach. Elmore claims

decentralisation leads to adaptation of programmes to people's own needs and increases the possibility for programmes to influence changes in behaviour (in Kjellberg/Reitan 1995: 155). Simultaneously, this is a critique of the "top-down" approach who claims strong central control of the programmes is necessary in order to secure successful outcomes. Findings also support development theorists such as Turner/Hulme (1997: 114) which argue that decentralisation can better meet the needs of the target groups, as opposed to times in Uganda when central level set the priorities regardless of local needs. This seems especially to be the case in Uganda as decentralisation is combined with involvement of civil society, spoken for by various theoretical approaches.

According to the "top-downers" Van Meter/ Van Horn (1975), a variety of actors involved in a programme decrease the chances of successful outcomes. On the contrary, in Uganda more local level control over the programmes and district coordination committees has contributed to the increased involvement of government sectors, but especially to the close collaboration with civil society. This has a clear positive effect on the programmes which support the "bottom-up" approach. Elmore explains how decentralisation contributes to more knowledge and competence at local level through strengthening of the involvement of non-governmental actors (Elmore 1980 in Kjellberg/Reitan 1995: 53). In Masaka this is exactly what we have witnessed: local level control has contributed to more involvement of civil society, and more capacity in order to reach out to people with information about HIV/AIDS. Findings from the district also support development theorists like Materu et al. and health theorists like the World Bank, which both claim decentralisation leads to more efficient cooperation and coordination between the government and civil society (WB 1994: 117-118; Materu et al. 2000: 18). The HIV/AIDS programmes also appear as good examples of Turner/Hulme's precondition for when to decentralise a program: when there is need for flexibility, innovation and responsiveness, for more participatory measures including civil society[153] (1997: 108). Thus, there are indications that a decentralised system of governance is efficient when it supports the

[153] As we witnessed in a previous section the inclusion of civil society has contributed to innovative and flexible programmes to reach down to people with HIV/AIDS initiatives.

factors which tend to strengthen the programmes, such as the collaboration between the state and civil society. In addition. decentralisation may also have contributed to more responsible and committed local politicians[154]. None of the theories examined can, however, explain this connection.

Nevertheless, in the Ugandan HIV/AIDS programmes there is not a total absence of control from central level which the “bottom-up” approach prefers. Hence, these findings rather support Grindle (1980) who point at a certain control of district and its actors to be important if one should have successful decentralised programmes[155]. However, as this lack of autonomy for government officials seem to somewhat limit freedom and thereby effectiveness of the programmes, this might strengthen the need for further decentralisation and further control of “local government”. However, due to early positive results we can conclude that also a more central control, spoken for by the “top-downers”, has had a certain positive effect. But we should keep in mind that also in the early years of the response the situation was not like the “top-downers” preferred with overall central control as civil society was involved.

Materu et al. (2000: 13) state that decentralisation can increase also the possibility of efficient allocation and channelling of financial resources. This is only to some extent supported in this case. Contrary to what the “bottom-up” approach expect, and consistent with the “top-down” approach there has been central level control in allocation of resources, which can be an advantage for the programmes within poor countries. Hence, the “bottom-up” approach claiming a need for local government to allocate resources does not seem to be adapted to developing countries. As we saw in Masaka, chances of raising their own resources through local taxes appear rather limited, and few donors today wish to give direct support to only a single district within a country[156]. These findings are supported by Materu et al. who claim that in a developing country with a weak revenue base there is limited possibility for local

[154] However, these findings should not be generalised to all of Uganda as several informants questions local politicians’ commitment to fight AIDS.

[155] Districts HIV/AIDS plans should also be approved by central authorities before the money is granted.

[156] In Masaka we have, however, seen one example of a Chairman’s own political initiatives raising money to an ARV clinic, which has had drastic consequences for provision of ARVs. This appears however to be an exception and based on personal friendship in the US, and not organisational cooperation through which most money is passed to the HIV/AIDS programmes in Uganda.

governments to raise their own revenues through e.g. taxes (Materu et al. 2000: 15). In developing countries national level political commitment can contribute to resource allocation from external donors to local levels. Hence, some central control over resource allocations seems to go hand in hand with the "top-down" approach. However, financial delays of central government show how national level control over allocation of resources can also be an obstacle to an efficient implementation of programmes in line with the "bottom-up" approach. To avoid such delays from central government the best solution might be more decentralised financial resource allocation by which donors could deliver money directly to the District Government. In Masaka informants claimed that lack of local resources and national level control limit their freedom to address local needs. However, unless they are able to raise their own district resources a certain level of control from national level might be needed.

We have, however, seen how a decentralised system facilitates *channelling* of funds as the structures are already in place and improves the availability of human resources. These findings support "bottom-up" and health theorists like the World Bank, which claim decentralisation can create better institutional arrangements and improve the channelling of financial and human resources (WB 1994: 04). Once the money is allocated to the districts, it is their responsibilities to spend them according to their own plans and to the actors responsible for carrying out the interventions. In a previous section we also witnessed that a more decentralised system of governance contributes to raise human resources, as many people at all levels could be mobilised in fighting the epidemic such as politicians, government officials and civil society.

6 Summary and Conclusion

This master thesis has put its focus on a major security threat: the HIV/AIDS pandemic, and has sought to understand why Uganda as the only country in Southern Africa, has managed to turn the trend and greatly reduce the number of infected. We have examined the HIV/AIDS programmes and witnessed that they have involved a wide variety of actors both from public and private sector. External donors have greatly financed these activities, but government has also contributed, for instance by lending money from the World Bank. From starting out as fairly centralised programmes, the programmes increasingly became more decentralised involving more of civil society.

The factors which can explain Uganda's relative success in fighting AIDS have contributed in a concerted action of "an environment of openness" about the disease. The most important factor is "political will and commitment" primarily from the President of Uganda. Museveni early addressed this issue and "opened up" the Ugandan society, creating an environment for actors like civil society to become involved. The President thus spearheaded the cooperation between government and civil society through various forums at all levels. The President's commitment also triggered mobilisation of resources from external and internal donors. Even in Masaka we have witnessed the consequences of the President's commitment through openness and facilitation of activities from different actors like local level politicians, government officials and civil society.

"Resource allocation" has been important for *all* actors to carry out programmes in different areas. However, this factor seems to be largely the cause of other factors such as political commitment and involvement of civil society. In addition, also *channelling* of resources seems to play a role. Channelling of resources has supported the cooperation between the government and civil society, which have contributed to most human resources. However, this factor should not be taken for granted in a country depending on external donors.

"Involvement and support of civil society" appears to be the second most important factor. The creation of the "environment of openness" would not have been possible without the inclusion of People Living with HIV/AIDS themselves and their organisations. They have held testimonies and given the "epidemic a face", which has increased the target groups reliance in information on the issue. Civil society in general through NGOs, FBOs and CBOs has also been the government's most important partner in fighting HIV/AIDS. Their involvement has been extremely important to distribute information to the grassroots. People trust them. Moreover, they have more capacity and knowledge and use more innovative measures to reach people at all levels. However, involvement of civil society has been even more important as they have supported government interventions. Thus, "support of government officials" at national and district level can be observed through the support to, and collaboration with, civil society. This collaboration has been extremely important, increasing both human and financial resources, to reach more people with information and services in relation to HIV/AIDS. However, "support from government officials" looses some effect as there are indications of *some* lack of support at national level creating certain obstacles through especially delay of funds.

"Decentralisation" appears to have had a certain effect as more local level responsibility has supported other important factors. In this connection we will emphasise the collaboration between government and civil society and to some extent also local political support. In addition, districts now have more of an opportunity to "tailor" the programmes according to local needs. However, programmes still have to follow certain national guidelines, and programmes also had an effect when they where more under national level control.

Findings from the Ugandan HIV/AIDS programmes in general support the "top-down" more than the "bottom-up" approach since many actors have supported the programmes and formal actors, especially the politicians, have played such an important role. As initiatives came primarily "from above" this supports the "top-down" approach. However, this approach seems to pay too much attention to formal actors such as government officials and their "control", and too little attention to the

freedom of e.g. civil society organisations to contribute with their capacities. As "bottom-up" initiatives were early taken and civil society has been a *decisive partner* for the Ugandan government, contributions of the "bottom-up" approach are also very important. The involvement of these "street-level bureaucrats" has provided the programmes with innovative and flexible measures spoken for by the "bottom-up" approach. In combination with more local level control over the programmes, this seems to have been decisive.

Classic implementation theory does not, however, seem to grasp the importance of the *cooperation* between government and civil society. Hence, we need to supplement this theory by development and health theoretical approaches in order to further understand the Ugandan case. And thereby also to grasp the challenges of health service and delivery structures in developing countries. Development and health theories place more of an emphasis on the role of politicians and point at the importance of the *collaboration* between public and private sector to increase financial and human resources. Contrary to the implementation theory which only focuses on internal money, these theories also point at the need for external resources. This collaboration supports the WB (1993; 1994) and WHO (2000) more than either of the implementation theories. Civil society is somewhat controlled, but still given freedom and flexibility to fight AIDS. However, none of the theoretical approaches examined can help us understand the *widespread* importance of the President's commitment, the importance of the "environment of openness" and the involvement of People Living with HIV/AIDS.

For other countries struggling to fight the epidemic the country's political leadership must take a primary role in combating AIDS to involve the PLHAs and reduce stigmatisation of the disease. The worst enemy for fighting HIV/AIDS in African countries is silence and stigmatisation. Unless people start talking about the disease, thus making the disease "acceptable", the issue of AIDS can not be dealt with. The political leadership must also encourage and "open up" for involvement from all actors who can participate in the response, especially civil society and international donors should be accepted as partners.

If these initiatives will lead to the decrease in the HIV/AIDS epidemic also in other countries might depend on the country's political system and the amount of power of the President to set "national priorities". In addition, we must keep in mind that at the time of the annunciation of Uganda's HIV/AIDS programmes the donors had their eyes set on Uganda as the country had a very violent history. There might have been good-will among the international society for a new path in Ugandan history. Maybe it was easier for the President to receive extensive resources as he showed early signs of cooperation with the West, by adopting WB policies and announcing the fight against HIV/AIDS? This was a clear contrast to the previous leaders of Uganda and donors quickly responded to the requests.

Whether similar initiatives will lead to similar outcomes can also be a matter of timing. Today more political leaders have already taken a stand to this issue, and do not have the same opportunities as Museveni to announce this fight at the takeover of a regime. In the mid-80s few African leaders had started to address the issue of AIDS, and the President's initiative was highly appreciated at the international level. Today, however, more countries have started to address the issue of AIDS also in African countries. Consequently countries which today initiate their responses do not appear "as unique" as Uganda, and maybe the international community is not as "generous" in allocating money to the HIV/AIDS programmes as they once were.

Appendix I Abbreviations

AWOFS	Aids Widows Orphans Family Support
AIDS	Acquired Infection Deficiency Syndrome
ASO	Aids Support Organisation
CBO	Community Based Organisation
CHW	Community Health Worker
CSO	Civil society organisation
GOU	Government of Uganda
HIV	Human Immunodeficiency Virus
IMAU	Islamic Medical Association Uganda
IEC	Information, education and communication
LRA	Lords Resistance Army
INGO	International Nongovernmental Organisation
MAP	Multi-country Aids Project
MDLG	Masaka District Local Government
MOES	Ministry of Education and Sports
MOFPED	Ministry of Finance, Planning and Economic Development
MOGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
MSAP	Multisectoral Approach
NACWOLA	National Community of Women Living with AIDS
NRM/A	National Resistance Movement/Army
NSP/F	National Strategic Plan/ Framework
NGO	Non-Governmental Organisation
OWAU	Orphans and Women of Aids Uganda
PEAP	Poverty Eradication Action Program
PAF	Poverty Alleviation Funds
PHC	Primary Health Care
PLHAs	People Living with HIV/AIDS
STIP	Sexually Transmitted Infections Project
TASO	The Aids Support Organisation
UAC	Uganda AIDS Commission
UNAIDS	United Nations Joint Program on AIDS
UNDP	United Nation Development Program
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WDR	World Development Report
WHR	World Health Report

Appendix II Resource allocations from donors, year 2001[157] (US$ millions).

Agency	Implement. Partner	Prevent-Ion	Care Support	VCT	Capacity Building	Adol.	IGAs	Research	Advo-cacy	OVC	TOTAL
USAID	TASO, JSI, CCP, FBC, NGOs	2,799	5,590	2,437	3,447	0,150		0,475	0, 130		**15,028**
MAKERERE UNIVERSITY	Rubaga Hosp,MUK	0,500			0,100			2,650			**3,250**
EU	AAU, TASO, Straight Talk, AIC, PEARL	1,041	0,748	0,247	0,245	0,943					**3,223**
World Bank	Publ./private, NGOs,comm....	0,333	0,333	0,333,	0,333	0,333	0,333	0,333	0,333	0,333	**3,000**
WHO	MOH	0,092	0,340	0,037	0,053	0,522					**1,044**
DFID	TASO,MOH Straight Talk Mildmay	0,232	1,508	0,232							**1,972**
AVS	MOH, COWA, Kitgum distr..	0,050	0,134		0,877	0,290				0,698	**2,049**
CDC	AIC, TASO, AIM,UVRI..		0,483	1,680							**2,163**
MRC/UVRI	TASO, EU, WELCOME							1,499			**1,499**
FRENCH EMBASSY	UNICEF, MU, Med. de Monde, UNFPA		0,476								**0,476**
JAPANESE EMBASSY	UAC, CPAR, AMREF	0,577									**0,577**
MILDMAY CENTRE	MoH, NGOs hospitals etc.		0,837							0,102	**0,940**
DANIDA	TASO, RAIN Kitovu, OCBO	0,107	0,282							0,023	**0,412**
SIDA	Naguru TC	0,150	0,500			0,050					**0,700**
NORAD	FUE, UWESO	0,016								0,090	**0,106**
WFP	World Vision Feed the Child.	0,248	0,248		0,248					0,248	**0,992**
UNICEF	MOH, NGOs	0,237			0,187			0,019			**0,411**
UNFPA	MOH, Norad WHO, UNICEF, districts,	0,200		0,100		0,263			0,038		**0,600**
UNAIDS	Unaso, IMAU Unicef, ATGWU	0,333			0,590			0,315	0,053		**1,290**
AMREF	KCC, MOH, MOES		0,030		0,145	0,135					**0,310**
Save the Children, DK	FOCA, GUSCO HAR, CPA		0,040			0,044				0,070	**0,154**
AYA	MOH, MOES POPSEC				0,500						**0,500**
EMBASSY OF IRELAND	Districts, NGOs, CBOs	0,221	0,089		0,089						**0,398**
GOAL UGANDA	UYDEL, Meting Point, MMM, AWOFS		0,032		0,151	0,053	0,010	0,034		0,035	**0,315**
FEED THE CHILDREN	AMREF, KCC, DISH, MOES, MOH, MLGSD,	0,080				0,135				0,095	**0,310**
UNHCR	Dictricts OPM, AHA, IRC,etc.	0,117		0,010							**0,127**
ACORD	NCOs, UNHCR Comic Relief	0,638	0,411		0,114						**0,116**
HOSPICE UGANDA	MOH		0,111		0,076						**0,187**
TOTAL[158]		**8,289**	**12,160**	**5,076**	**7,159**	**2,932**	**0,367**	**5,325**	**0.596**	**1,805**	**43,709**

[157] The table is a summary of the 35 agencies responding to the study: where agencies allocating over 100.00 dollars are present.

[158] These figures are a result of the whole table, all agencies included, not only the ones represented in this table.

Appendix III Interview Material

Each interview lasted between 30-90 minutes depending on how much time the respondents had available. Extensive notes were taken during the interviews and the notes were completed soon after the interviews were finished in order to maximise accuracy. Altogether 36 interviews were conducted, of which two thirds were with national representatives of government and civil society organisations, donors and academics and the rest amongst local level representatives in Masaka. Respondents were asked questions about the organisation, focus and priorities of the HIV/AIDS programmes in Uganda with a focus on the following:

1. Has there been success, progress in the fight against AIDS in Uganda?
2. Are people aware, have they changed their sexual behaviours, decrease in prevalence rates?
3. What are the reasons for this progress?
4. Actors: Who where the most important to pass on information to people?
5. Politicians: what role have they played? Have politicians been committed?
6. Resources: where do they come from-to the government? What impact have they had on the programmes?
7. Decentralisation: what is decided by local and national level. Has decentralisation contributed?
8. Civil society: has contributed?
9. The informants contributions: how have they spread information or channelled resources?
10. The informants' cooperation with others (especially the cooperation between government and civil society): through what channels and has it been efficient?
11. Through what channels do you receive your financial resources?
12. What are the obstacles for further improvement of the HIV/AIDS situation in Uganda? What are the obstacles the informants face in their daily work?

Informants:

Dan Wamanya Ahimbisibwe. Programme Manager Specialist. USAID

Beatrice Ajambo. Account assistant. NACWOLA

Susan Ajok: Project coordinator, Straight Talk

Vincent Bagire. HIV/AIDS Focal Point, Uganda Catholic Secretariat, project administrator

Kasheeka Emmanuel Baingana. Director, Planning and Monitoring, Uganda AIDS Commission

Jane Batte. Public Relations Officer, Aids Information Center

Vincent Bagire. Catholic Secretariat

Sam Igaga Ibanda. Assistant Resident Representative. UNDP

Jantine Jacobi. Country Programme Advisor. UNAIDS, Kampala.

Swizen Kyomuhendo. Lecturer and Consultant in Research and Training, Dept.of Social Work and Social Administration

Beatrice Lumbega. Director, AWOFS

Henry Luwaga. TB specialist, AIM

Dr. Elizabeth Madraa. ACP Coordinator, MOH

Motavu Moses. Namirembe Diocese.

Edward Mukiibi. Information scientist, TASO

Stella Neema. Research fellow/ Medical Anthropologist-Makerere Institute of Social Research

Kayongo Nsereko. President/ Chief Executive Director of OWAU

Ysuf Nsubuga. Commissioner for Secondary Education/ HIV AIDS co-ordinator, MOES

Deo Nyanzi. Information and Documentation Officer, UNASO: Uganda Network of AIDS service organizations

Dr. Hafswa Kyambadde. IMAU

Rosemary N. Ssenabulya. Leader Federation of Uganda Employers

J.J. Sonko.S. Head of Human Resources Mangagment, Deputy ACP Manager, MOLG

Benon Webare. Programme Support Services Manager. Save the children Norway

Rosemary Mwesifwa, Documentalist/ Librarian, UAC

Dina Kakande. Health educator, Department of Health. Masaka District

John Kazabwe. Community Health Worker, TASO Masaka

Matia M. Lukumbwa. Health Educator, Masaka District

Jamil Miwanda Deputy Chairman, Masaka Distric

Dr. Stuart Musisi. District Medical Officer, HIV/AIDS Focal Person, Masaka District

Joseph Kazotzi Muyomba. Secretary health and environment, Masaka district

Stephen Nakabinge. Customer-relations service coordinator, World Vision

Teresa Namisangov. District Health Visitor.

Deodata Namusoke. Manager, TASO. Masaka

Dr.Joseph Nnyanzi. District Director of Health Services, Masaka District

John Kyosimba Onanya, District Promotion Officer. UNDP, Masaka

Robina Ssentongo. Programme Director, Kitovu Mobile

Appendix IV Bibliography

Asuumwe-Okiror et al. (1997): "Change in sexual behaviour and decline in HIV infection among young pregnant women in urban Uganda". *AIDS* 11: 1757-1756

African Medical and Research Foundation (AMREF-UGANDA): *Inventory of Agencies with HIV/AIDS Activities and HIV/AIDS Interventions in Uganda 2001. A review of actors, interventions, achievements and constraints relating to the HIV/AIDS challenge in Uganda.* Kampala.

Aids Women Orphans Family Support (AWOFS) : *AWOFS.* Leaflet. Kampala.

Cassels, A (1995): "Health Sector Reform: key issues in less developed countries*". Journal of International Development.* May-Jun; 7(3): 329-47.

Chazan, Naomi et al. (1999): *Politics and Society in Contemporary Africa.* 3rd Edition. Lynne Rienner Publishers, USA.

Cleaves, P.S (1980): "Implementation and Apathy: Political Power and Policy Design", chpt. 11 in Grindle, M.S: *Politics and Policy Implementation in the Third World.* Princeton University Press: Princeton, New Jersey.

Damgaard, H: "AIDS- kontinentet Afrika-Uganda". *Udvikling: Vol.* 2/2000.

Epstein, H (2001): "The Truth about AIDS". *The New York Review of Books.* July 5.

Elmore, Richard F. (1982): "Backward Mapping: Implementation Research and Policy Decisions", chpt. 2 in Williams (ed): *Studying implementation: methodological and administrative issues*. Chatham House series on change in American politics. Chatham, NJ.

Fylkesnes, Knut et al. (2001): "*Declining HIV prevalence and risk behaviours in Zambia: evidence from surveillance and population based surveys". AIDS* 15: *907-916.*

Golola, Moses L. (October, 2001): "Decentralization, Local Bureaucracies and Service Delivery in Uganda" [online]. Discussion Paper. United Nations University, WIDER. Available by FTP: http://www.wider.unu.edu/publications/dps/dp2001-115.pdf

Grindle, Merilee S (1980): " Policy content and context in implementation" chapter 1 in Grindle (ed) *Politics and Policy Implementation in the Third World.* Princeton, New Jercey: Princeton University Press.

Hansen, Bernt Holger/ Twaddle, Michael (1991): *Changing Uganda-the dilemmas of structural adjustment & revolutionary change.* London: James Currey.

Hansen, Bernt Holger/Twaddle, Michael (1998): *Developing Uganda.* Oxford: James Currey.

Harboe, Jørgen (2000): " AIDS- de fattiges nye svøpe". *Udvikling 2/2000*

Hermele, Kenneth (1989): *Landanalys; Uganda*. Stockholm: SIDA.

Human Rights Watch (1999): *Hostile to Democracy: The Movement System and Political Repression in Uganda.* New York, report 2394.

Hyde et al. (2001): *HIV/AIDS and the Education Sector*. Final Draft. Kampala.

Hyden, Goran (1998): "The challenges of constitutionalizing politics in Uganda, chpt 7. in Twaddle/ Hansen (ed): *Developing Uganda.* Eastern African Studies. Ohio: University Press

Ingram, Helen (1990): Implementation: "A review and Suggested Framework", chpt 18 in Lynn, N.B/ Wildavsky,A: *Public Administration. The state of the discipline.* Chatham NJ: Chatham House.

Jain, R.B (1992): " Bureaucracy, public policy and socio-economic development: a conceptual perspective", chpt.2 in Ashmeron, H.K et al. (ed): *Bureaucracy and development policies in the third world.* Amsterdam: University Press.

Kagimu, M./ Marum, E., et al (1996): *The review of AIDS prevention and Control Activities in Uganda. November 1996.* Entebbe: Health Education Printing Unit, Ministry of Health.

Kaleeba, Nooerine et al. (2000): *Open Secret. People facing up to HIV and AIDS in Uganda.* Strategies for Hope series no.15. London: Actionaid.

Kamali, Anatoli et al (2000): "Seven year trends in HIV-1 infection rates, and changes in sexual behaviour, among adults in rural Uganda". *AIDS* 14*:* 427-434.

Killian, Albert H.D et al (1999): "Reductions in risk behaviour provide the most consistent explanation for declining HIV-1 prevalence in Uganda". *AIDS* 13*:* 391-398.

Kjellberg, Francesco/ Banik, Dan (1995): *The paradox of Pollution Control: Regulations and Administration in a South Indian State.* Department of Political Science. Faculty of Social Sciences. University of Oslo. Research Report no.2/2000.

Kjellberg, Francesco./ Reitan. Marit (1995): *Studiet av offentlig politikk: en innføring.* Oslo: TANO. 2.opplag

Leggett, Ian (2001): *Uganda. An Oxfam Country Profile.* Oxfam UK 2001 and Fountain Publishers Ltd, Kampala.

Legum, Colin (ed.) (1987): Africa Contemporary Record, Volume XXV 1985-1986: Annual Surveys and Documents.

Lorgen, C.D (1998): “Dancing with the state: the role of NGOs in Health care and Health policy”. *Journal of International Development* 10, 323-339.

Lubwama. P.C (1990): “Mobilisation of rural women for Development” in Abidi Syed A.H (ed.): *Ugandan Women in Development.* African Development Series No.1 Foundation for African Development. Kampala.

Lyons, Marinez (1998): “AIDS and development in Uganda” chapter fourteen in Hansen/ Twaddle (ed): *Developing Uganda. Eastern African Studies.* Ohio: University Press

Materu et al (2000): *Decentralised Cooperation and Joint Action: Building Partnerships between Local Government and Civil society in Africa*. Policy Management Report 10. European Centre for Policy Management. Maastricht.

Masaka District Local Government (2002): *Workplan for HIV/AIDS Control Programme 2002-2003.* Directorate of Health services-by DHAC. Masaka.

Masaka District Local Government, District Medical Department (1999a): *Workplan for control of STI/HIV/AIDS 1999/2000.* Masaka.

Masaka District Local Government (1999b): *District Development Plan 1999/2000-2001/2002. Vol.1*. Masaka.

Masaka District Local Government (1997): *STI Programme Masaka District 1997/1998.* Masaka.

Mazmanian, D.A/ Sabatier, P.A (1983): *Implementation and Public Policy.* Scott, Foresman and Company. Bind Nr. 1 public policy analysis and management series. Glenview. Ilinois.

Ministry of Local Government (2000): *HIV/AIDS plan for the Ministry of Local Government (2000/1-2005/*6). AIDS Control Program Desk/ Personnel Division. September. Kampala.

Ministry of Health (2000): *Health Sector Strategic Plan 2000/1-2005/6.* Kampala.

Mugaju, J.B (1996): *An analytical review of Uganda’s Decade of Reforms 1986-1996*. Kampala: Fountain Publishers.

Musisi, Stuart (2002): *Masaka District HIV/AIDS interventions.* Unpublished.

Mygyeni, Mary R. (1998): *Towards Empowerment of women: a critique of NRM policies and programmes,* chpt. nine in Hansen, Bernt H./Twaddle, Michael: *Developing Uganda*. Oxford., James Currey

National Community of Women Living with AIDS (NACWOLA) (2002): *NACWOLA.* Leaflet. Kampala. Available at URL: http// www. designerswithoutborders.org/nacwola.html

Ntozi, James P.M. et al: (2000): “Has AIDS awareness changed sexual behaviour in Uganda?”, chapter 4 in Caldwell et al: *Towards the Containment of the AIDS Epidemic: Social and behavioural Research.* Canberra: The Australian National University

Ofcansky, Thomas P (1996): *Uganda. Tarnished Pearl of Africa*. Colorado, USA, Westview Press Inc. A division of Harper Collins Publishers Inc.

Okware, Sam et al. (2001): “Fighting HIV/AIDS: is success possible?”, in *Bulletin of the World Health Organization* 2001, 79: 1113-1120.

Parkhurst, Justin O. (2002): “The Ugandan Success Story? Evidence and claims of HIV-1 prevention”, *Lancet.* Volume 360, July 6: 78-80.

Poverty trends in Uganda 1992 to 1996, discussion paper no.2”, august 1998. Ministry of Finance planning and Economic Development, Kampala.

Pressman, L.J/ Wildavsky, A (1973): *Implementation- how great expectation in Washington are dashed in Oakland.* London: University of California Press.

Rondinelli, D.A/ Montgommery, J.D (1991): “Methods and Problems of Analyzing Administration in Developing Countries: Development Administration as a Conceptual Framework”, chpt 3. in Elsenhaus, H and Fuhr, H (ed): *Administration and Industrial Development.* New Dehli. National Book Organisation.

Rwomushana (1999): *A Study of the Multisectoral response to the Aids epidemic in Uganda. C*onference paper: 10-15 May. Safari Park Hotel, Nairobi.

Sabatier, Paul A. (1986a): “What can we learn from Implementation Research?” , chpt. 15 in Kaufman et al (ed): *Guidance Control, and Evaluation in the public sector*. Berlin. NY

Sabatier, Paul A (1986b): “Top-down and Bottom-Up Approaches to Implementation Research: A Critical Analysis and Suggested Synthesis”. *International Public Policy* 6, I: 21-48

STD/AIDS Control Programme (2003). *HIV/AIDS Surveillance Report, 2003.* Ministry of Health. Kampala.

STD/AIDS Control Programme (2001). *HIV/AIDS Surveillance Report, 2000*. Ministry of Health. Kampala.

STD/AIDS Control Programme (2000): *Expanded STD/HIV/AIDS Response Project: a proposal to sustain HIV/AIDS achievements, widen the health sector response and confront new challenges 2001-2006.* Kampala

STD/AIDS Control Programme (1997). *HIV/AIDS Surveillance Report, 1997.* Ministry of Health. Kampala.

Thagaard, Tove(1998): *Systematikk og innlevelse- en innføring I kvalitative metode.* Fagbokforlaget.

The Aids Support Organisation (TASO)/ World Health Organisation (WHO) (1995): *TASO Uganda-the inside story. Participatory evaluation of HIV/AIDS counselling, medical and social services 1993-1994.* Kampala/ Geneva.

The Aids Support Organisation (TASO) (1997): *TASO 10th Anniversary compendium: Memories and hopes, ten years of facing the challenges of HIV/AIDS.* Kampala.

The Economist Intelligence Unit (1992): *Uganda Country profile 1992-1993.* London.

The Economist Intelligence Unit (2002): *Uganda Country profile 2002*. London.

Tumusiime, P. et al. (2000): *Report on the study of the role of local governments in health development: the Uganda Situation (part of a multi-country study)*.

Turner.M/ Hulme. D (1997): *Governance, Administration and development. Making the state work*. Westhartford, Conneticut: Kumarian Press.

Ugalde, A./ Jackson, J.T (1995): "The World Bank and International Health Policy: a critical review". *Journal of International Development.*Vol.7, no.3, 525-541

Uganda AIDS Commission (1997): *Inventory of Agencies 1997.* Kampala: Uganda AIDS Commission.

Uganda AIDS Commission (1993a): *AIDS Control in Uganda: The Multi-Sectoral Approach.* Kampala: Uganda AIDS Commission.

Uganda AIDS Commission (1993b): *Uganda National Operational Plan for HIV/AIDS Prevention, Care and Support (1994-1998).* Kampala: Uganda AIDS Commission.

Uganda AIDS Commission (1997): *National Strategic Framework: 1998-2002.* Kampala: Uganda AIDS Commission.

Uganda AIDS Commission (2000): *National Strategic Framework: 2001/2-2005/6.* Kampala: Uganda AIDS Commission.

Uganda AIDS Commission Secretariat (2002): *Guideline for District HIV/AIDS Coordination. Draft as of 24th July 2002*. Kampala

Uganda Demographic and Health Survey 1995. Kampala, Ministry of Finance and Economic planning, 1996

Uganda Poverty Status Report 1999 (the challenges of implementing the Poverty Eradication Action Plan)”. Ministry of Finance planning and Economic Development, Kampala.

Uganda Bureau of Statistics (2001): *Statistical Abstracts, June 2001.* Entebbe

UNAIDS (1998): *A measure of success in Uganda: The value of monitoring both HIV prevalence and sexual behaviour.* UNAIDS case study. Best practice collection.

UNAIDS (2000): *Report on the Global HIV/AIDS Epidemic.* Geneva: UNAIDS

UNAIDS (2002): *Report on the Global AIDS Epidemic Update*. Geneva: UNAIDS

UNAIDS (2003): *AIDS Epidemic Update, December 2003*. Geneva: UNAIDS

UNDP (1990): *Human Development Report 1990.* Oxford University Press: New York and Oxford.

UNDP (2002): *Human Development Report 2002: Deepening democracy in a fragmented world.* New York and Oxford: Oxford University Press.

UNDP (2003). *Human Development Report 2003: Millennium Development Goals: A compact among nations to end human poverty*. New York and Oxford: Oxford University Press.

Van Meter, D.S /Van Horn, C.E (1975): ”The Policy Implementation Process-a conceptual Framework”. *Administration and Society, Vol.6 no.4.* Sage Publications, Inc.

World Health Organisation (2000): *World Health Report 2000: Health systems: improving performances.* Geneva

World Health Organization/ AFRO (26.02.04): *Uganda-Health System*, [online] URL: http://www.afro.who.int/uganda/healthsytems.html

World Bank (1994): Development in Practice: *Better Health in Africa, Experience and Lessons Learned.* Washington DC: The World Bank.

World Bank (1993): *World Development Report 1993: Investing in Health*. Oxford University Press: Oxford.

World Bank (1994): *Staff Appraisal Report. Republic of Uganda. Sexually Transmitted Infections Project.* March 9, 1994. Report NO. 12630-UG

World Bank (2000): *Project Appraisal Document on a proposed credit in the amount of SDR 37.3 million (US$ 47.5 million equivalent) to the Republic of Uganda for an HIV/AIDS control project.* Report NO: 21350-UG

Yin, Robert K. (1982): “Studying the Implementation of Public Programs”, chapter 3 in Williams, Walter et al.(ed): *Studying implementation: methodological and administrative issues*. Chatham House series on change in American politics. Chatham, NJ.

Yin (1994): *Case study research design and methods.* Second Edition. Applied Social Research Methods Series Volume 5. London: Sage Publications.

Younis, T/Davidson, I (1990): “The Study of Implementation”, Chapter 1 in Younis (ed): *Implementation of Public Policy.* Aldershot, Dartmouth.

Zwi, B. Anthony/Mills, Anne (1995): “Health Policy in less developed countries : past trends and future directions“ *Journal of International Development* Vol.7, No 3, 299-328