ST. FRANCIS HEALTH CARE SERVICES
P.O. BOX 2210 JINJA
ANNUAL REPORT JANUARY - DECEMBER 2003

1. Name of Organization:

ST FRANCIS HEALTH CARE SERVICES

2. Project to which this report relates

HIV PREVENTION AND AIDS CARE

3. Telephone No (if available): Fax and /or E:mail address (if available)

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4. Report Preparer: Position:

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5. Type of Report (Annual, bi-annual, quarterly etc):

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FROM JANUARY – DECEMBER 2003

7. Date of Report: Signature:

22nd January 2004.	***Faustine Ngarambe***

8. EXECUTIVE SUMMARY

This annual report covers January - December. 2003. It highlights activities, undertaken during the implementation and shows clearly the outcomes of our effort to strive to achieve our long-term objectives.

St. Francis Health Care Services received a grant from our main funder Elton John AIDS Foundation to implement the activities aiming at HIV prevention and care for those infected and affected. During the implementation of the activities that are contained in our workplan aimed at achieving the following goals:

1. To reduce HIV prevalence by 25% by the year 2005/6
2. To mitigate the health and social- economic effects of HIV/AIDS at the individual, household and community level.
3. Strengthening management of HIV prevention and care.

a) In our desire and effort to reduce HIV prevalence by 25%, we conducted activities that aim at promoting behaviour change (abstinence, faithfulness and safer sex among sexually active population particularly young people aged 15-24 years.

   Awareness and sensitization were taken to schools, aiming at educating young people about the vulnerability of young people to HIV infection.
   Three secondary schools were visited by St. Francis Shadow Idol club, that was trained as peer educators; plays, songs, poems, and film shows were performed in these schools; 1,800 students attended, and VCT was provided. Out of 159 students only 1 student was HIV- sero positive representing 1.6% in 3 randomly selected schools; IEC materials distributed were 300 straight talk and young talk magazines.

   Sensitization and awareness also was taken to 22 communities by PHA drama group aiming at promoting VCT which is a means towards behaviour change, and reduction of stigma and discrimination. The theme used in these community shows; " live and let live", the slogan for the World AIDS Campaign 2003-2004, the campaign focuses on reducing/eliminating stigma and discrimination associated with HIV/AIDS. The result of this saw 1636 people testing for HIV from January to December 2003 and 785 new clients who had lived in Isolation for years registered for ongoing Medical and Counselling Support; an indication of reduced stigma and discrimination.

   The number of non HIV/AIDS (OPD) patients increased due to reduced stigma and discrimination, this can be seen in monthly attendance i.e. an average of 174 per month from 90 per month as of December 2002. The amount of money collected from OPD has also increased by 50%. The situation is therefore being assessed for commercial viability.

   Radio spot and radio talk shows were used to provide information to the populace. The information aired was proper use of condoms, caring for the HIV/AIDS clients, the importance of VCT and where to access the services. As a result of these 1636 people accessed VCT, 785 new clients registered for Medical and Counselling Support and 50,000 condoms were distributed to the populace.

b) To Mitigate the social-economic efforts of HIV/AIDS at the individual household level; The organization has promoted social support and medical care to clients and their families. Our clientele has also had access to Counselling and Medical care and health education.

- 16,680 Counselling sessions were conducted both at the static centre and in clients homes.
- 1000 clients were visited in their homes and opportunistic infections managed at home by the medical and Counselling teams.
- 108 clients who already had established IGA's, were boosted with piglets and goats to improve on their household income. A fully-fledged IGA component will be implemented in next six months of implementation.
- The other component in mitigating of social impact of HIV/AIDS was orphaned and vulnerable children (OVC) support. In the event of implementation of this component, a registration exercise for all orphans was carried out. The number planned for earlier was less than what was found on ground. We found out that, the most vulnerable children were in Secondary schools. These had either had dropped out or were on and off in school. In view of this our Board made it a priority to increase the number to be supported.
- 137 students were supported in senior secondary school instead of the 50 earlier planned for.
- 695 Pupils were supported in primary schools this aims at supplementing the Universal Primary Education already supported by Government.

Shadow Idol programme for orphans and vulnerable children was started.
- The average of 366 children attended these activities per month. This was born out of a need to help orphans and vulnerable children to envision their aspirations for the future. Categories of professionals came and talked to the children i.e. a Lawyer, a Doctor, an Engineer, a teacher, did talk to the children. During these activities, the children participated actively in reproductive health and life skills discussions. Youth friendly services are offered at the centre e.g. Counselling for STD and treatment. Children meet at the Centre twice a week during holidays and once a week during school days.

c) Strengthening the capacity to manage and implement the HIV /AIDS Programme was done by training 2 Counsellors in Child Counselling for 3 weeks; a course that was partly funded by Regional Training Network (RATN) and Elton John AIDS Foundation.
1 Counsellor was also trained in care and Management of People Living with HIV/AIDS.
One of the Medical Officers completed his Masters of science in Health Services Management.
1 Counselor obtained a diploma in Care and Management of PHA's run by Mildmay International tailored by Manchester University UK sponsored by Center for Disease Control (CDC).
The Programme Coordinator underwent a one-week in organizational development sponsored by Firelight Foundation USA; our partner in supporting orphans and vulnerable children.

Collaboration and Networking.

We have continued to collaborate and Network with other civil society organizations both in Mukono and Jinja Districts.
Jinja District and Mukono are the source of educational materials and technical support. They supplied condom, T.B drugs and reagents. Mukono District Directorate of Health Services also provides VCT kits. We hosted visitors and University students who came to learn about our work and experiences in HIV/AIDS activities.

St. Francis held its annual general meeting with 90 members in attendance. The meeting was held on 17 December 2003.
The New Board members were elected:
Mr. Morris Seru - Chairman – Public Health Specialist
Mrs. Maria Kafuko – Vice chairperson- A long term serving social worker
Mr. Faustine Ngarambe – secretary- Programme Coordinator
Mr Steven Nkulaije – Hon. Treasurer – A senior finance manager
Mr. Dismas Mbabazi – member – A researcher and PhD Candidate
Rev. Fr. Peter Mubiru – member – Parish Priest and Lecturer
Mr. Peter Mugerwa – Client representative males
Mrs. Anne Lunyolo – Client representative females

Acknowledgement
Many thanks to the following for their financial and material support;

- Elton John AIDS Foundation for the financial support.
- Irish Embassy in Uganda
- Firelight foundation.
- Holy Cross Sisters
- Holy Cross Mission Centre.
- Mukono and Jinja Districts.

9. DESCRIPTION OF PROJECT.

a) Background:
St. Francis Health Care Services undertakes the HIV/AIDS activities in Njeru Town Council, Wakisi Sub-County, parts of Nyenga and Najjembe Sub-Counties. We however, due to historical reasons also operate in Jinja Municipality and its environs. Few clients from other neighbouring Districts also come to our centre for services.

We are carrying out treatment of opportunistic infections and other diseases of people living with AIDS (PHA) after either having had Voluntary Counselling and Testing at our Centre (VCT) or having been referred from other organizations. Treatment also takes place at outreach sites and individual homes. Depending on the degree of morbidity of the clients some bed-ridden clients and difficult cases are referred to Jinja and Nyenga hospitals or to other specialized clinics/hospitals in Kampala. By the end of the year there were 3,200 clients registered with our organization for on-going support and treatment.
The organization has formed a PHA drama and youth groups for behavioural change communications (BCC) targeting their respective peers i.e. Sexually active adults and youths especially at school and out of school. Radio talks, spots and Jingoes were developed and aired over the radio to communicate to the general public about the dangers of the scourge.

The other activity among others is Voluntary Counselling and Testing (VCT) which targets those who want to know their sero-status for one reason or another and those who respond to our

communications through drama and radio. Response was good as evidenced by the 1636 people who reported for VCT by the end of the year.

The increase in PHA and non-PHA's attending our clinic and outreach sites, coupled with increase in VCT attendees means stigma and discrimination is slowly eroding. In the meantime the distribution of condoms continues with our Community Counselling Aides reporting more demand for them. Of course, this does not negate abstinence and "Zero grazing" by married couples. The age of first encounter for sex is also reported to have increased to 18 years. The majority of our clients who registered with us early 1999 are still going strong and still come for our services; indicating prolonged healthy lives.

Our OVC project has attracted very many applicants. Although the widows may be living in our catchment area, some of their children are scattered among relatives far way. They therefore miss out on our assistance since we can not visit their schools. However, the numbers seeking the support is far beyond our means.

During the year 2003, out patients (not HIV positive) were more than new HIV clients who sought our medical services at the centre in the ratio of 4:1. This in effect demonstrates that there is reduction of stigma, discrimination and denial (SDD) among the community against HIV/AIDS infected and affected people.

CURRENT STATUS AND PROGRESS.

Objective .1

Planned Activities	**Successful indicators**	**Comments**
1. Develop IEC materials. 1000 papers in English 1000 posters in Local Language.	IEC materials were not developed MOH declined, they want uniform messages developed by MOH.	Not done because Ministry of Health advised that individual organization messages could conflict with theirs.
2. Conduct mobile AIDS video shows and drama activities	1,340 Females, 1,175 males and 1,115 children attended in different places	Video shows and drama plays are very vital in education about HIV/AIDS/STDs.
3. Distribute I.E.C materials to schools and community.	Only 300 Straight talk copies from straight talk were distributed to schools	Straight talk foundation provided Young talk and straight talk copies.
4. Sensitize the community on the dangers of early sex, infidelity, unprotected sex, drugs and alcohol abuse in relation to HIV/AIDS	Done with No. 2 above.	Used drama plays and songs. Response was good
5. Develop radio spots and organize talk shows with phone in asking questions.	2 Radio spots were developed one in English and one in Lusoga a local language; 2 talk shows were hosted on two FM radio stations	Radio communication reaches many people. People called to ask questions.
6. Conduct advocacy seminars for AIDS education in schools	3 Secondary schools were sensitized 1,800 children attended.	Straight talk is very popular with young people.
7. Distribute AIDS education manuals/materials to schools; to be produced from Ministry of Education/Straight talk Foundation	Non procured from Ministry of Health	Distributed straight talk News letters to school and youth clubs
8. Refresh trained trainers in AIDS education and counselling.	2 Counsellors were trained in child counselling. 1 counsellor trained in care for PHA by Mild May International tailored by Manchester University.	Their skills were enhanced.
9. Train Community based distribution agents (CBO's) on condom distribution practices and establish condom distribution networks in the rural areas.	36 distribution centres for condoms established CCA's participation.	Demand is increasing.
10. Procure Condoms	50,000 condoms were procured.	Condoms were procured from District Directorate of Health stores in Jinja and Mukono
11. Advocate for appropriate condom education	Continuously done by CCA's	Demonstrated during video shows and drama plays

		using green bananas and expired condoms.
12. Distribute Condoms to all outlets from the Centre	Distributed 50,000 condoms	Clients and other people were given condoms after counselling
13. Conduct community sensitization and education on correct use of female condoms.	Response was lukewarm.	The Ministry of Health has not yet done enough marketing.
14. Conduct sensitization using drama on VCT.	PHA drama group sensitized the population in 4 communities and 3 schools.	There is high demand for VCT services from the community.
15. Conduct VCT in community outreaches	1636 people tested voluntarily	55% encouraged by friends. 32% got courage from mobilization. 13% heard from radio
16. Conduct a baseline survey to establish the incidence of violation and abuse of the rights of children, youth and women	Heard a lot about the abuses during the OVC mobilization and registration.	Formal survey next six months.
17. Sensitize community opinion leaders on the rights of children, youth and women.	Had many discussions with opinion leaders.	Sensitization next six months.
18. Distribute policy and list of rights of children.		Mobilization of OVC took most of the time as it need much time to verify genuine orphans and vulnerable children.

Objective 2;

OVC Planned Activities	**Successful indicators**	**Comments**
19. Sensitization of the community on the objectives of the project	36 communities were sensitized about the OVC programme	OVC programme was very much appreciated by the beneficiaries.
20. Register all HIV/AIDS orphans to establish their conditions, location and general family environments	1,200 orphans were identified and registered	It was tiresome exercise in verifying the genuine orphans due to big numbers and distances.
21. Select beneficiaries who must be needy orphans for school sponsorship: 600 Primary and 50 Secondary schools.	Primary 695 pupils and 137 senior secondary students were selected	1,200 applied for primary and 250 students for secondary education. Most of those not selected are out of school now.
22. Re-assess school needs of selected orphans.	In progress	This exercise has excited the community

		Number seeking OVC support are un manageable.
23. Identify schools for partnerships	33 Secondary Schools. 90 Primary Schools	Some schools don't have bank accounts, we paid cash.
24. Ensure OVC's are placed in schools	Orphans identified are progressing in schools.	There are more children in dire need of education.
25. Provide orphans and vulnerable children support	Fees paid and treatment offered free of charge.	Treatment of mostly malaria.
26. Sensitize OVC 's and their caregivers	OVC's are sensitized in a home based care programme.	Messages of care giving to OVC's composed in drama songs.
27. Identify beneficiaries	1500 applications received.	total to date is about 1,500 applications.
28. Provide medical care to 1200 OVC's.	150 children treated for various diseases.	Provide free medical treatment to the HIV infection and non-infected
29. Sensitization of the community on the importance of Child Counselling.	Used drama	Sensitization done using drama plays and songs.
30.Training of child counselling	2 Counsellors were trained by RATN for 3 weeks	One male and one female were trained.
31. Training of teachers in counselling skills		Will do retraining for replacement of teachers who have left our catchment area.
32. Facilitate trained counsellors to provide counselling services to OVC.	The two children counsellors were trained for three weeks by Regional Training Network (RATN)	We need a child centre to handle children in a friendly manner.
33. Sensitization of the community on the family law focusing on the rights of children and widows.		Next 6 months
34. Sensitization of the community leaders on their role, responsibility and limitations in the family succession law.		Next 6 months
35. Facilitate beneficiaries to seek a conclusive end to success on wrangles both within and outside the community (including seeking legal and welfare department services)	20 client cases handled at various times. 20 clients referred and recommended to access their deceased husband/wife NSSF funds.	Many widows still face discrimination. Some have no fixed abode.
36. Community sensitization about out of schools OVC's training vocational skills.		Registration of OVC in schools consumed all our time; OVC out of school to be revisited in the next quarter.
37. Identification of 200 OVC's for the vocational skills training.		As above.
38. Identification of local artisans to	One Government Institution willing to	Trades in Motor Vehicle

provide the training.	do the training.	repair plumbing. Electrical installations
39. Facilitate the beneficiaries to select their desired trades		To be done next quarter
40. Equip selected local artisans with training tools		do
41. Provision of 200 OVC's with vocational training of their preferred choices.		do
42. Identification of 200 needy HIV/AIDS affected families to be provided with IGA's.	Many applications received.	More IGA' s to be given next six months.
43. Training of project staff and IGA beneficiaries in Micro project planning management and resource mobilization.		To be done next six months.
44.Provide up to 200 HIV/AIDS affected families with IGA's seed money	108 families benefited	They like goat raring, poultry, piggery etc.
45. Monitoring the project	Schools are constantly visited to check on OVC attendance	Data pertaining to OVC's collected and analysed.
46. Evaluation of the project.		At the end of funding year.

Objective 3:

Planned Activities	Successful indicators	Comments
47. Provide information and education on symptoms of STDs, prevention and management in the context of HIV using video shows		A video shown called Silent Epidemic depicting most of the STD's is available has been shown at the end of every drama activity.
48. Conduct visits to inform and educate students on STDs, prevention and management in the context of HIV/AIDS.		Done during the aforesaid visits.

Objective 4.

Planned Activities	Successful indicators	Comments
49. Sensitize LC's and Civic leaders on PMTCT interventions		To be done next six months.
50. Conduct community sensitization on PMTCT, positive living using drama and video shows	Seminar for midwives conducted by a woman's group and nevirapine given for administration	Messages composed in all drama plays and talks after video shows.
51. Conduct VCT to willing expectant mothers.	Five mothers had VCT	Reports of whether children born are HIV free not available.
52. Refer HIV sero -positive mothers	Five were referred to private midwives	To recruit and enrolled

to hospitals /private midwives for safe delivery management.		/registered midwife 2004.
53. Sensitize religious and community leaders on the care, social support and spiritual counselling needs of PHA's	Messages delivered every Sunday/Friday by individual staff members in attendance.	Our organization encourages members to religious masses and talk about HIV/AIDS issues.
54. Provision of care, counselling, social and spiritual support to PHA's		Religious leaders provide support at their own will.
55. Distribute food to the needy clients at the centre and outreach sites		already done
56. Conduct monthly meetings with community counselling aides	Once every month	Provides opportunity to discuss problems encountered in the field and solutions proposed
57. Conduct mobile AIDS care services and counselling outreach sites and homes.	Four visits per week catering for 3200 clients in the four sub-counties in Mukono district and some parts of Jinja district.	Home visits and outreach very popular because some clients lack transport fares to the centre.
58. Carry out continuous supervision and monitoring of outreaches and home community care providers.	60 CCAs monitored and supervised by the centre. Monthly reports received from them.	Eases tracking of HIV/AIDS inputs
59. Procure appropriate drugs for opportunistic infections, laboratory equipment, chemicals and reagents for relevant tests.	Source drugs from Joint medical store. Nine and a half million Uganda shillings worth of Drugs/supplies per quarter. This is expected to increase by 15-20 % per year following a similar rate of increase in the number of clients.	Need to acquire other diagnostic and operating equipment (for minor procedures e.g. incision and drainage, biopsy etc) as soon as possible.
60. Refer clients from home to health units, hospitals and other centres that offer specialized palliative care.		Difficult cases are referred at any time using our ambulatory services.

Objective 5:

Planned Activities	Successful indicators	Comments
61. Review and support SACC, PACC, VACC to effectively implement their coordination roles and functions.	Held 6 meetings with CCA's	The SACC, PACC will be rearranged by Uganda AIDS Commission
62. Train St. Francis staff in planning, monitoring and evaluation of HIV/AIDS activities in the communities.	The training will be undertaken next six months	OVC programme took all the time
63. Seek partnerships with businesses etc. within and outside	We have sought partnership with WFP and Pic-fare Group of Companies	-Considering food support. - Construction of

our area of operation.		counselling centre

64. Hold annual stress management for staff		Done in December 2003
65. Hold annual clients get together at the centre.		Held AGM instead
66. Hire outside programme evaluators.	To be conducted in September 2004	

St. Francis Health Care Services Strategic Framework for HIV/AIDS Activities Oct. 2003-March 2004

GOAL 1: TO REDUCE HIV PREVERENCE BY 25% BY THE YEAR 2005/6

Objective 1: To promote behaviour change (abstinence, faithfulness and safer sex) among sexually active population particularly young people aged 15-24.

Outcome: By the year 2005/2006 atleast 90% of the sexually active population shall have access to information, education and services (condoms, voluntary counselling and testing, and follow-up required to reduce the vulnerability to HIV Infections.

Strategies	Activities	Indicators	Means of verification	Recommendations
Strategy 1: Promote IEC on HIV/AIDS for sexual behaviour change.	a) Develop IEC messages inappropriate form for the different categories of the population.	a) No. of IEC materials disseminated for a and audiences reached through various IEC activities.	a) IEC impact assessment	Access to various media (print, radio) is another consideration. Traditional/Cultural systems can be vehicle, IEC messages. PHA's should be involved.
	b) Conduct Mobile AIDS Video shows and Drama activities.	b) % of Men, Women, Youths and Children having access to information required to reduce HIV Infection. c) Number of Community AIDS Education films and theatre conducted per Su-County/Schools	b) Records indicating schedule of Community AIDS Education films shows and plays. c) Interviews/Surveys.	The mobile film shows should aim at providing correct AIDS information and reminding people that AIDS still causes a big danger to the community.

	c) Distribute IEC materials to schools and the community.	No. of IEC materials distributed.		
	d) Sensitize the public on the dangers of early sex, infidelity and unprotected sex and drug substances /alcohol abuse in relation to HIV/AIDS.	a) Number of community sensitization conducted. b) % Sexually active persons reporting abstinence, faithfulness and condom use.	a) Interview key community members. b) Household surveys	There is need to review laws governing drinking hours and the age limit for alcohol consumption.
	e) Develop radio spots and organize talk shows.	Number of Jingoes developed and aired.	- Recorded jingoes - Schedules of jingo to be aired.	FM radio stations attract many people.

Strategies	Activities	Indicators	Means of verification	Recommendations
Strategy 2. Promote AIDS education and counselling in schools e.g. Primary, Secondary and other Institutions.	a) Conduct advocacy seminars for AID education and counselling in schools.	Number of advocacy seminars with heads of education Institutions held.	Advocacy seminars Reports available.	School children should be encouraged to discuss their sexual health including HIV/AIDS.
	b) Distribute AIDS education manuals and materials to schools. These will be procured from the Ministry of Health and St. Francis Health Care Services.	a) Number of AIDS education and counselling materials produced and distributed. b) Proportion of schools having access to AIDS education materials.	a) AIDS education and counselling manuals /materials for schools available.	
	c) Refresh trained trainers in AIDS education and counselling.	a) Number of trained refreshed in AIDS education and counselling b) Number of staff trained as AIDS counsellors.	a) Records indicating the specific issues addressed in training and lists of attendance.	All schools should have atleast two leaders trained in HIV/AIDS education and counselling.
Strategy 3. Increase condom accessibility with particular emphasis	a) Procure condoms	a) Number of condoms procured and distributed each quarter.	Report indicating number of condoms procured.	

to rural areas.	b) Advocate for appropriate condom education.	a) Number of advocacy seminars conducted on appropriate condom education.	a) Report indicating the specific advocacy issues addressed and attendance lists.	This is important for purposes of insuring parties involved the condom distribution and promotion provide the appropriate information to the community.
	c) Distribute condoms to all outlets from the centre.	a) Proportion of sexual activity partners having access to condoms.	a) Records indicating no. of condoms distributed and taken by different target group each quarter.	Given the high poverty levels government should ensure that the price of condom is heavily sub-subsidized particularly in rural areas.
	d) Conduct community sensitization and education on correct use of female condom (Femdom)	a) % of women reporting consisted and correct use of female condom (Femdom)	Condom use surveys.	Given that the concept of female controlled barriers in HIV prevention is new in Uganda, there is need to especially sensitized women about the advantages and disadvantages of using them.
	f) Conduct sensitization using drama on VCT.	% men, women, youths in under served areas that report having had HIV VCT.	Records indicating VCT clients by categories of population.	VCT is a means to behaviour change.
Strategy 4. Promote HIV voluntary counelling and testing (VCT) services to the community.	a) Conduct VCT in community outreaches.	Records indicating the clients accessing VCT services through out reach activities.	Reports: -Monthly - Quarterly - And annual .	

Objective 3: To reduce sexually transmitted infections by 25% by the year 2005/6
Outcome: To have reduced STI prevalence by ¼ in the various age groups by the year 2005/6

Strategies	Activities	Indicators	Means of verification	Recommendations
Strategy 1. Integrate STD prevention and treatment into voluntary counselling and testing.	a) Provide information and education on symptoms of STD's, prevention and management in the community in the context of HIV using video shows.	a. % of new clients reporting STD's. b. no. of shows. c. Estimated attendance.	a. Reports and No. of clients treated for STD's.	

	b) Conduct school visits to inform and educate students on symptoms of STD's their prevention and management in the context of HIV infections using drama & video shows.	a. No. of schools visited. b. No. of students accessing VCT and STD treatment.	a. Service records indicating the information given questions asked and misconceptions cleared. b. No. of students accessing treatment.	

Objective 4: To reduce the current 15-25% incidence /risk of mother to child transmission by 1/3 by the year 2005/6

Outcome: To have reduced MTCT of HIV by 10-17% by the year 2005/6.

Strategies	Activities	Indicators	Means of verification	Recommendations
Strategy 1. Initiate implementation of PMTCT	a) Sensitize LC's and Civic leaders, on PMTCT and interventions.	No. of seminars held. No. of participants.	PMTCT advocacy report.	PMTCT is the only hope to save children.
	b) Conduct community sensitization on PMTCT of HIV and positive living using drama & video shows.	No. of seminars Drama shows	Reports	
Strategy 2 Strengthen sensitization and awareness on PMTCT to reduce pregnancies and facilitate informed decision making among HIV positive and discordant couples.	a. Conduct VCT to willing expectant mothers.			
	b. Refer HIV sero-positive mothers to hospitals and private midwives.	No. of mothers who accessed Neverapine	Reports	

GOAL II: TO MITIGATE THE HEALTH AND SOCIAL-ECONOMIC EFFECTS OF HIV/AIDS AT THE INDIVIDUAL, HOUSE HOLD AND COMMUNTY.

Objective 1: To promote AIDS care social support and protection of rights of PHA's that affected individuals and families.

Outcome: By the year 2005/6, at least 80% will have access to HIV/AIDS counselling, care, social support and other essential package services including health education and food.

Strategies	Activities	Indicators	Means of verification	Recommendations
Strategy 1: Integrate AIDS care, social support and spiritual counselling religious institutions to address stigma and discrimination during World AIDS campaign.	a. Sensitize religious and community leaders on the care, social support and spiritual counselling needs of PHA's.	a. No. of seminars per parish conducted. b. No. of schools and community leaders sensitized.		
	b. Provision of care, counselling, social and spiritual support to PHA's.	Proportions of persons having access to AIDS care, social support and spiritual counselling of cultural and community agents.		
	c. Provide food to clients at the day care centre/outreaches.	Records of food distributed.		
Strategy 2.: Strengthen palliative care and treatment of opportunistic infections of PHA's.	a. Conduct monthly.. for community AIDS counsellors.	No. of community counsellors that attend.	Records indicating issues addressed and trainers.	
	b. Conduct mobile AIDS care services and counselling in outreaches and PHA's homes.	a. No. of PHA's families, individuals having access to mobile care and counselling.	a. Service records indicating issues handled. b. Survey on impact of home care and support on health of PHA's.	
	c. Carry out continuous supervision and monitoring of outreach and home community care providers.	a. No. of supervision and field visits carried out each month etc. b. % PHA's reporting improved quality in delivering of AIDS care counselling services.	a. Records on SW, lessons leant and gaps. b. Survey on quality of home AIDS care and counselling for PHAs.	

	d. Procure appropriate drugs for opportunistic infections, laboratory equipment and reagents.	a. Quantities of drugs, equipment and reagents. b. Type of diseases treated and tested. c. No. of clients treated.	a. Records of drugs and diseases treated. b. List of equipment and reagents.	
	e. Refer clients from home to health unit, hospitals and other centres that offer specialized palliative care.	No. of PHAs referred	Records indicating referrals and specific problems that necessitated them.	

GOAL III : STRENGTHENING MANAGEMENT OF HIV PREVENTION AND CARE.
Objective 1: To enhance the community participation and ownership of HIV/AIDS programs
Outcome: By 2005/6 communities will access/provide support and funds to assess and better manage/sustain the programs.

Strategies	**Activities**	**Indicators**	**Means of verification**	**Recommendations**
Strategy 1. Strengthen planning, coordination and monitoring of HIV/AIDS activities at the community levels	a. Review and support SACC, PACC, VACC to effectively implement their coordination roles and functions.	Function HIV/AIDS coordination mechanism	a. Minutes of meetings. b. Plans c. Records	
	b. Train St. Francis staff in planing monitoring and evaluation of HIV/AIDS activities in the communities.	No. of people trained	Records indicating people trained.	Training will improve on M &E skills.
Strategy 2: Adopt a programmatic approach to partnerships with other partners.	a. Seek partnerships with business etc. Within and out of our area of operation.	a. Acknowledgements Government international organization.	a. Responses b. Visits received of inquiries and responses.	
	b. Hold annual stress management for staff.	No. of staff attending	Report.	
Strategy 3: Stakeholders in planning & implementation of HIV/AIDS activities.	a. Hold annual clients get together at the centre.	List of clients attending		
Strategy 4: Do evaluation of the programme.	Hire outside evaluators.		Reports made to stakeholders.	

MEDICAL SUPPORT JANUARY - DECEMBER 2003

Introduction

St. Francis Health Care Services is a day care center dealing mainly with HIV/AIDS Patients but also cares for non-HIV/AIDS patients. It is now located on Owen Road plot No. 5 Njeru Town Council, Mukono District. It operates mainly in Buikwe North sub-health District (Mukono District) and Jinja District. However clients are at times referred to us from neighbouring Districts e.g. Kamuli, Iganga and Kayunga.

From January - December 2003, the total number of new sero-positive clients was 785. Of these, children were 87, female adults were 396 and male were 225. Thus the centre now caters for about 3200 clients.
The following activities are carried out at the center:

- There are two official clinic days (Tuesday & Thursday) in a week during which clients get counseled and treated according to the ailments they present with. However the work load during the week these days is heavy enough to warrant Monday to Friday clinic days.
- On Mondays, Wednesday, Thursday and Friday are out reach days. These are conducted by the Medical team and the counselors. The beneficiaries of these are the bedridden clients and the HIV/AIDS orphans and vulnerable children. Places visited are as follows: Buziika, Kiryowa, Bukaya, Njeru south aids initiative programme (NSAIP), NSACI in Buziika B, Mbiiko, Nakibiizi, Naminya, Konko, Walukuba, Wairaka, Bugembe, Jinja town, Kirugu, Mpumudde, Kalagala and Kitigoma. The medical team comprises of the following: 2 medical Doctors, 2 medical assistant, 3 nurses, 1 nursing assistant and 2 volunteers people living with HIV/AIDS who help at the reception.

Table 1:

Clinical spectrum of adult HIV/AIDS clients attending St Francis health care services/month January - December 2003.

Condition	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Skin Rash (A)	51	72	105	97	53	77	59	50	48	61	62	60
Diarrhea (B)	28	40	87	102	70	73	62	60	34	89	41	58
Ear Problem ©	0	0	0	2	1	2	0	0	6	0	8	12
Fever (D)	99	150	173	134	137	149	154	155	179	282	196	165
Abdominal pain (E)	31	50	79	59	75	79	73	70	76	76	37	42
General malaise (F)	19	40	57	49	74	79	67	65	45	44	28	36
Oral thrush/sores (G)	24	30	57	88	84	59	91	88	66	63	43	95
Loss of appetite (H)	19	38	64	68	80	79	62	67	65	51	49	49

Herpes zoster (I)	0	1	12	3	6	2	2	10	9	7	6	12
Joint pains (J)	43	52	57	37	60	73	63	60	62	54	37	37
Painful urinating (K)	1	0	0	0	0	0	0	0	7	4	3	12
Cough (L)	98	122	137	109	100	139	128	152	204	205	179	112
STDs (M)	8	12	25	20	26	25	30	35	6	3	4	5
Headache (N)	53	90	96	100	100	113	130	125	118	131	116	95
Chest pain (O)	20	32	41	50	70	74	45	40	74	83	68	52
Insomnia (P)	0	0	19	31	52	43	20	20	16	8	5	13
Nausea (Q)	17	30	20	32	20	17	15	10	8	7	10	20
ANAL sores ®	0	0	12	4	15	20	35	23	2	2	5	14
Vomiting (S)	18	32	58	48	75	83	63	60	52	51	29	43
Dizziness (T)	0	0	1	17	2	3	2	0	7	7	15	13
Swollen limbs (U)	7	20	3	0	0	0	4	0	1	2	2	7
Palpitations (V)	11	30	30	33	75	72	74	12	4	50	29	30
TB (W)	8	4	1	5	3	3	2	1	2	2	4	3
Itching eyes (X)	3	1	4	3	20	1	0	0	2	7	4	18
Karposi's sarcoma (Y)	1	0	0	0	0	0	0	0	0	2	1	4
Varginal candida (Z)	23	28	26	15	40	42	50	34	8	29	8	17
Abcess/boils (AA)	16	28	17	25	47	14	25	20	13	10	10	10
Confusion/tremors (AB)	0	0	0	0	0	2	1	0	0	1	0	0
Paraesthesias (AC)	13	20	23	27	48	49	55	44	10	8	5	5
Genital herpes (AD)	18	22	17	8	24	14	10	4	1	8	2	3
Herpes labialis (AE)	0	1	0	0	0	2	3	2	0	0	0	2

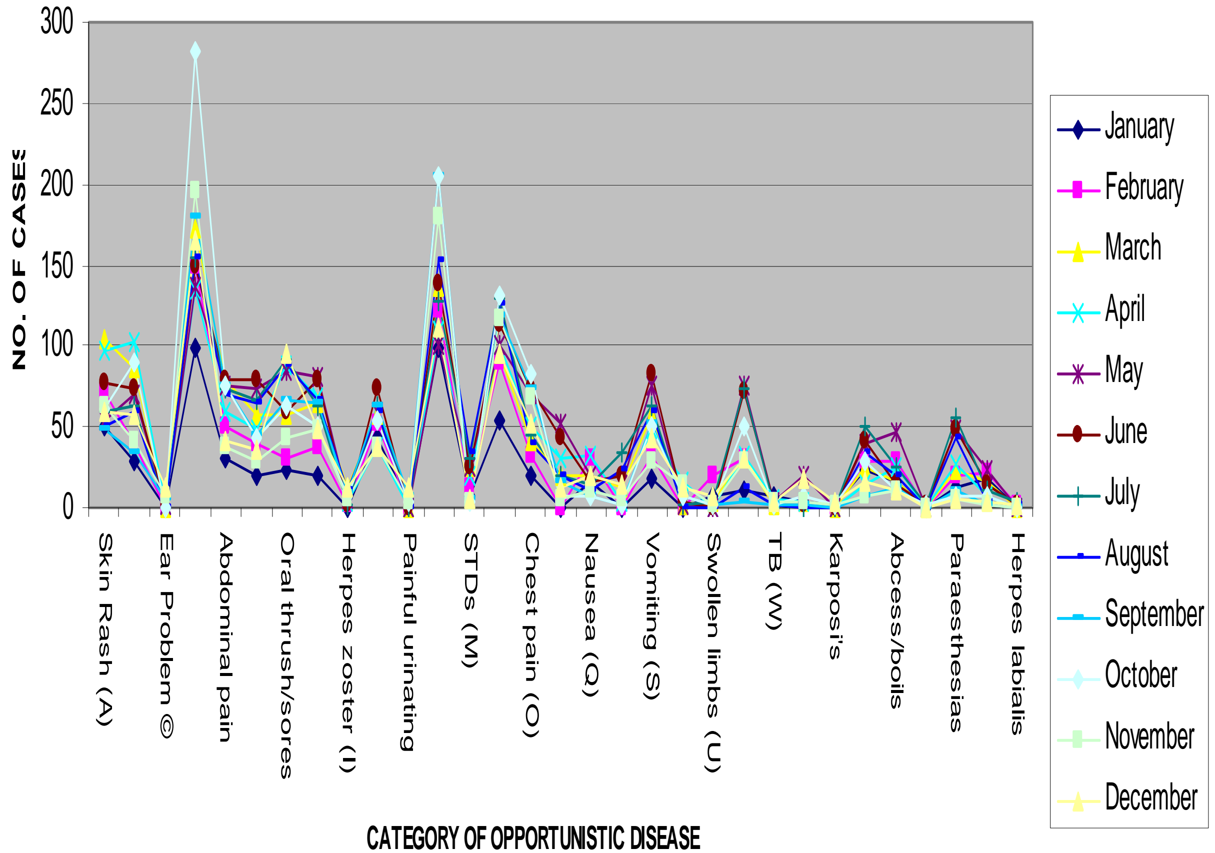
The commonest conditions were noted to be fever, cough, and headache. Graph 1 below shows the clinical spectrum by month during January to December 2003. The following can be deduced from this graph; the most prevalent conditions i.e. fever, cough and headache among others, occurred mainly during June to September. The above months i.e. June to September lay within the 3rd funding period from Elton John AIDS foundation. During these months all medical activities at the centre were in full gear (especially during the period April – July) thus the apparent increase in all the complaints from the patients during these months.

Graph 2 below shows total cases/condition/month April to September 2003. From this graph the following were noted; In general the total number of complaints per condition reported during the six months has more than doubled compared to the last reporting period January – December 2002. This can be attributed to the increased number of patients being seen by the centre partly due to the new premises that are

more accessible to the clients financially and in terms of distance; and also due to the drama & VCT activities that have continued to contribute to further reduction in the community stigma.

<u>GRAPH 1:</u>

CLINICAL SPECTRUM OF HIV/AIDS PATIENTS AT ST FRANCIS HEALTH CARE SERVICES, JANUARY - DECEMBER 2003.



GRAPH 2:

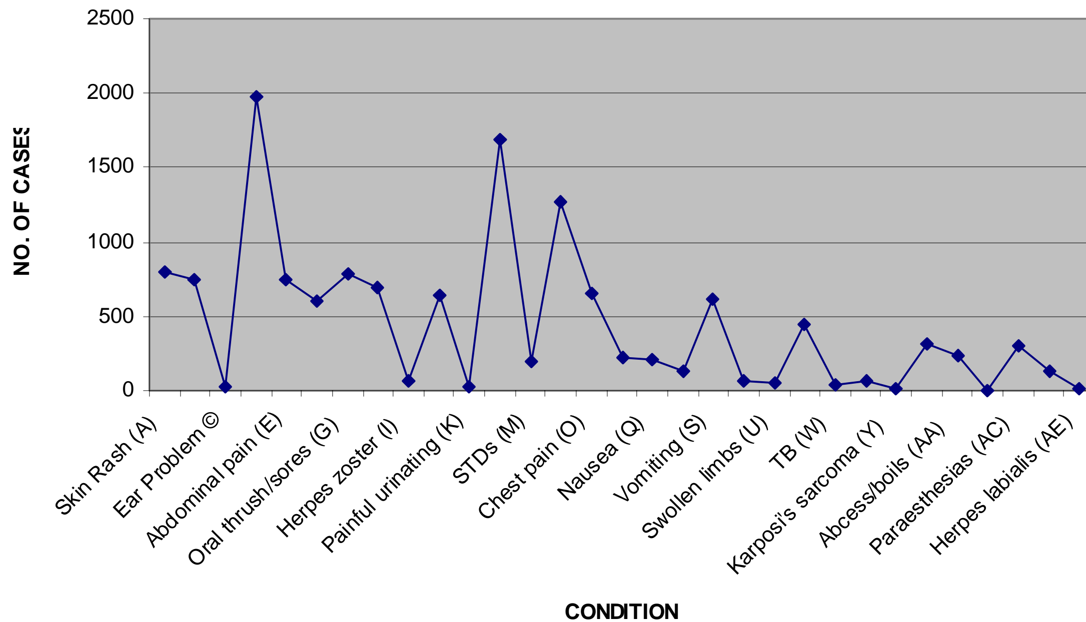


Table 2:

Clinical spectrum of HIV/AIDS children attending St Francis health care services/month January – December 2003.

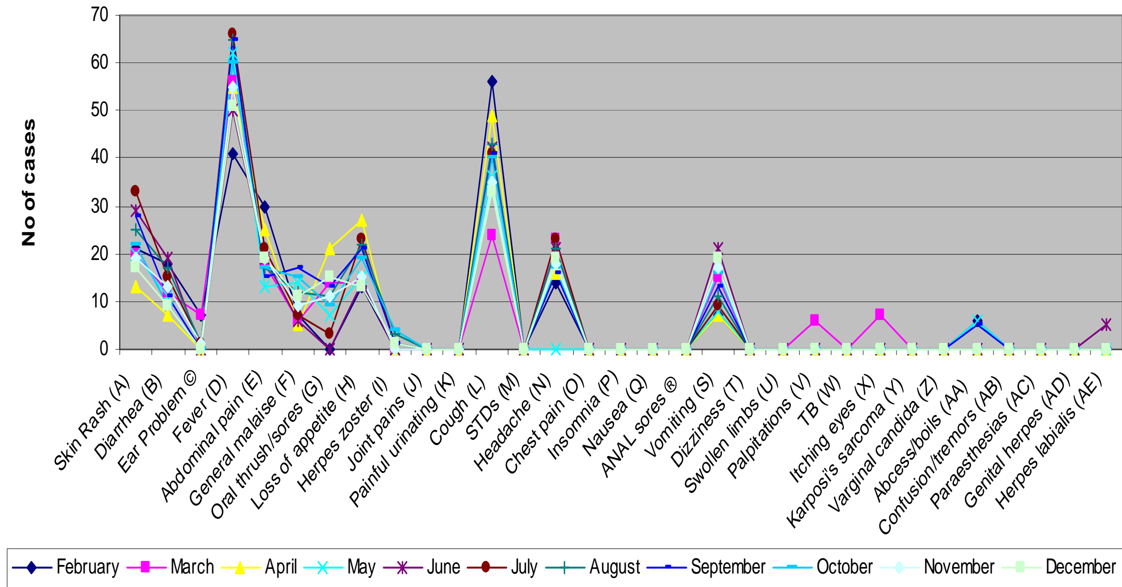
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Skin Rash (A)	21	20	13	20	29	33	25	28	22	19	17
Diarrhea (B)	18	12	7	11	19	15	17	11	9	13	9
Ear Problem ©	7	7	0	0	0	1	1	0	0	1	0
Fever (D)	41	56	55	62	50	66	65	65	60	55	51
Abdominal pain (E)	30	18	25	13	19	21	17	15	17	19	19
General malaise (F)	7	6	5	14	6	7	12	17	15	9	11
Oral thrush/sores (G)	0	14	21	7	0	3	11	13	9	11	15
Loss of appetite (H)	13	14	27	15	14	23	22	21	19	15	13
Herpes zoster (I)	0	0	0	0	0	1	3	1	4	0	1
Joint pains (J)	0	0	0	0	0	0	0	0	0	0	0

Painful urinating (K)	0	0	0	0	0	0	0	0	0	0	0
Cough (L)	56	24	49	36	42	41	43	41	40	35	33
STDs (M)	0	0	0	0	0	0	0	0	0	0	0
Headache (N)	14	23	16	0	21	23	21	16	17	18	19
Chest pain (O)	0	0	0	0	0	0	0	0	0	0	0
Insomnia (P)	0	0	0	0	0	0	0	0	0	0	0
Nausea (Q)	0	0	0	0	0	0	0	0	0	0	0
ANAL sores ®	0	0	0	0	0	0	0	0	0	0	0
Vomiting (S)	7	15	7	8	21	9	11	13	16	17	19
Dizziness (T)	0	0	0	0	0	0	0	0	0	0	0
Swollen limbs (U)	0	0	0	0	0	0	0	0	0	0	0
Palpitations (V)	0	6	0	0	0	0	0	0	0	0	0
TB (W)	0	0	0	0	0	0	0	0	0	0	0
Itching eyes (X)	0	7	0	0	0	0	0	0	0	0	0
Karposi's sarcoma (Y)	0	0	0	0	0	0	0	0	0	0	0
Varginal candida (Z)	0	0	0	0	0	0	0	0	0	0	0
Abcess/boils (AA)	6	0	0	6	0	0	0	5	0	0	0
Confusion/tremors (AB)	0	0	0	0	0	0	0	0	0	0	0
Paraesthesias (AC)	0	0	0	0	0	0	0	0	0	0	0
Genital herpes (AD)	0	0	0	0	0	0	0	0	0	0	0
Herpes labialis (AE)	0	0	0	0	5	0	0	0	0	0	0

Table 2 above shows that the general trend in the clinical spectrum of HIV/AIDS children is comparable to that of the adult HIV/AIDS clients. The other main complaints on top of those also seen in the adult clients were as follows; loss of appetite, abdominal pain and vomiting. These were also evident in more or less the same magnitude through out all the months.
Please see also Graph 3 and 4 below.

Graph 3:

Clinical spectrum of HIV/AIDS children at St Francis health care services per month January - December 2003



Graph 4:

Clinical spectrum of HIV/AIDS children attending St Francis health care services for the period Apr - Sept 2003

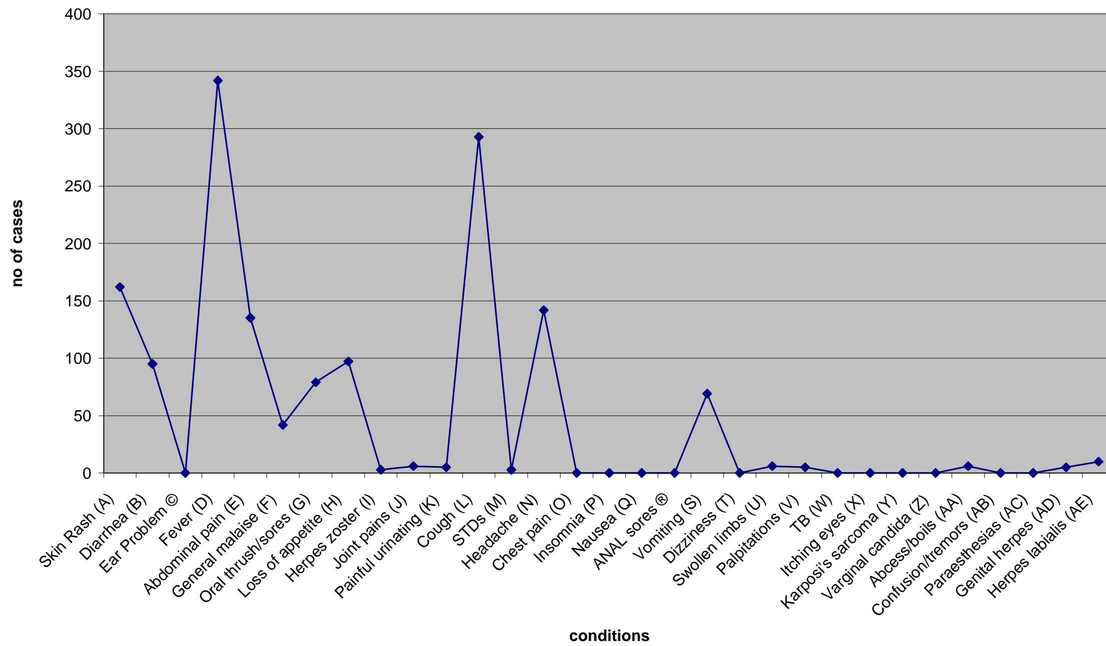


TABLE 3:

New out patients (not HIV positive) by age/sex per month treated by the centre January – December 2003.

	Children		Adult		
Month	Male-ch	Female-ch	Male-ad	Female-ad	**total**
January	38	44	34	44	**204**
February	25	23	57	78	**261**
March	43	34	42	84	**287**
April	30	38	31	61	**221**
May	33	39	34	51	**208**
June	24	34	31	32	**153**
July	39	18	39	49	**194**
August	45	35	55	65	**265**
September	29	45	94	104	**376**
October	24	31	102	137	**294**
November	42	30	84	86	**242**
December	31	40	55	62	**188**

Table 3 above shows the non-HIV positive patients who sought medical services at St Francis health care services in the period January - December 2003. There was a general drop at first followed by an increase in the number of adult non HIV/AIDS patients who attended the OPD at the centre between the months of March and October 2003. However the number of children attending was stable. It was noticed that the adult female patients attended more than their male counterparts. Despite this apparent drop in the number of out patients over the months, the total OPD attendance was better than that recorded in the last reporting period January – December 2002. This may be attributed to the following;

- Decreased stigma in the populace where by they no longer mind being treated together with HIV/AIDS patients.
- Good medical & lab services for the non-HIV patients accessing our clinic. The new premises are spacious and also offering entertainment on top of the above during the waiting period prior to receiving service.
- Widespread publicity & sensitization talks conducted over time in the community by the medical and drama group during VCT outreaches and also through radio adverts about the benefits of VCT. See graph 5 below:

GRAPH 5:

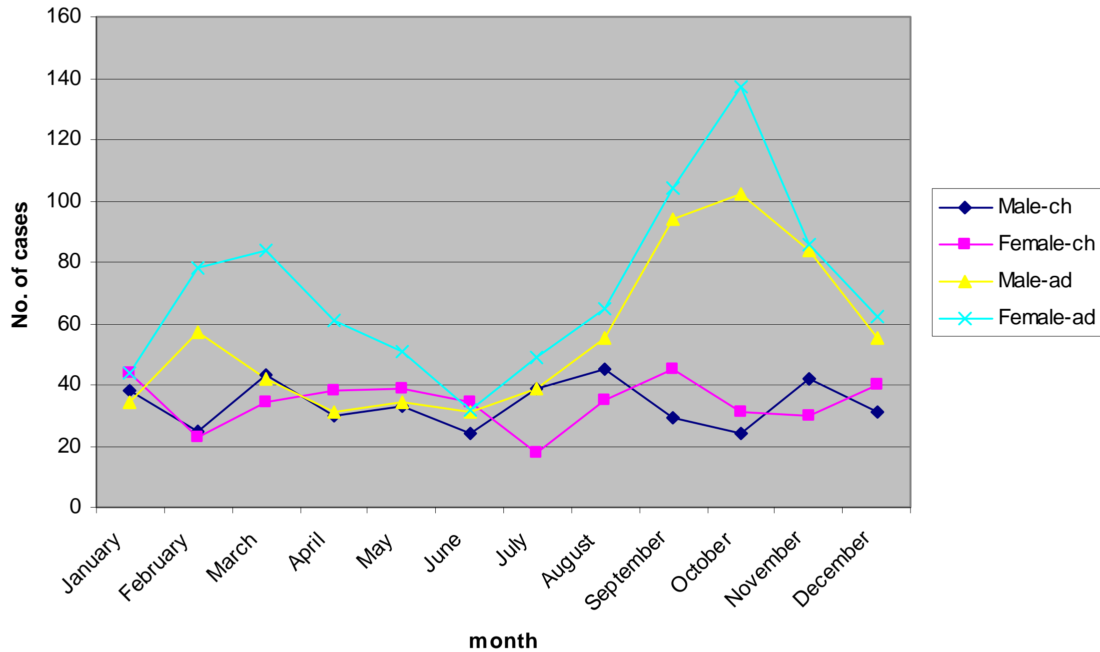


TABLE 4:

Reported AIDS patients by AGE and GENDER January – December 2003.

Month	child female	child male	Adult female	Adult male	total
January	14	15	175	68	**272**
February	27	23	187	50	**287**
March	26	12	242	100	**380**
April	24	20	245	105	**394**
May	30	34	305	145	**514**
June	29	21	280	176	**506**
July	26	32	459	227	**971**
August	25	23	463	179	**869**
September	22	17	330	169	**707**
October	18	18	339	175	**550**
November	23	15	290	175	**503**
December	31	23	228	112	**394**

Table 4 above shows that during the period January – September 2003, the number of adult AIDS cases seeking our services showed a sustained increase until figures comparable to those of the last reporting period were attained. This was then followed by a decline between September and December. Though the numbers of the female and male adult AIDS clients showed increase over the months, the figures of the children with AIDS were stable but fewer than the former. This is further illustrated in Graph 6 below;

GRAPH 6:

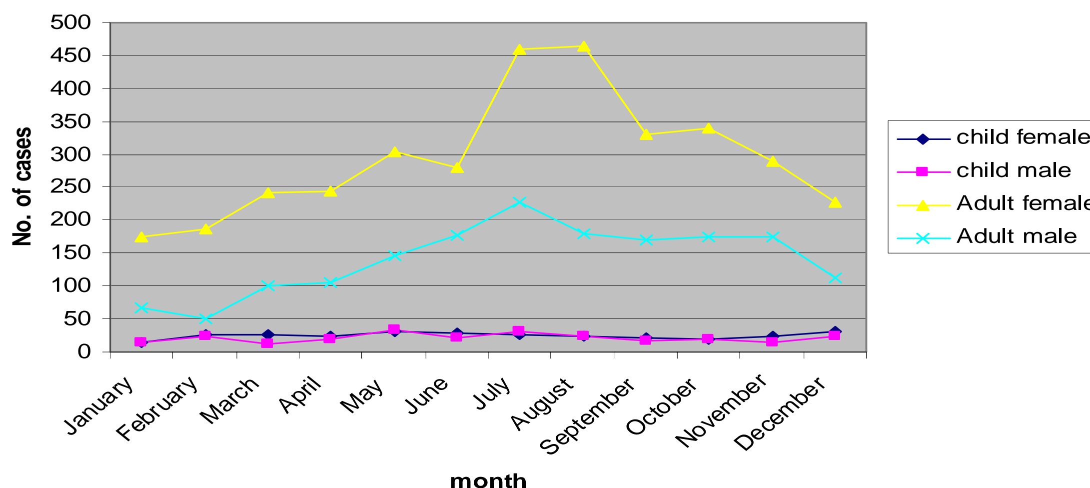


TABLE 5:

Reported new HIV positive cases by age and gender/month January – December 2003.

month	children		adults		Total
	Female	male	female	male	
January	5	3	42	23	73
February	5	2	24	11	42
March	2	4	23	10	39
April	4	3	13	11	31
May	2	4	26	16	48
June	6	5	44	21	76
July	5	7	44	38	132
August	5	2	43	24	98
September	2	2	32	15	66
October	0	5	47	21	73
November	1	2	31	16	50
December	5	6	27	19	57

Table 5 above shows that the number of new adult HIV/AIDS cases seeking our services has been fluctuating with the least number being seen in April 2003. However the number of both male and female new HIV clients showed a drop after July and August respectively. This could be attributed to the fact that the first trounche of the current Elton John AIDS foundation funding ended in July and the next release was scheduled in November 2003. Therefore during August and September the centre's programmes were running at half strength due to the financial constraint experienced during these two months. The number of new HIV positive children was stable all through the six months.
This is further illustrated in Graph 7 below.

GRAPH 7:

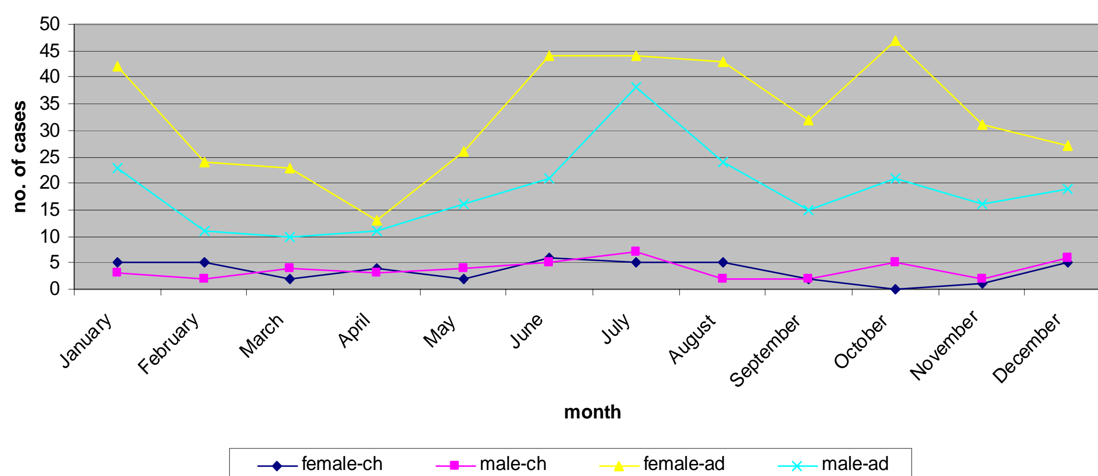


TABLE 6:

Comparison of six randomly selected clinical spectrums of new & old HIV/AIDS cases expressed as a percentage of the total new or old HIV/AIDS cases.

	February		March		April		May		June	
condition	new pt	old pt	new pt	old pt	new pt	old pt	new pt	old pt	new pt	old pt
skin rash	38.4	4	47.6	1.8	71.8	4.8	77.4	4.6	41.7	4
diarrhea	54.8	3.3	28.6	3.2	71.8	3.2	51.6	3.2	50	3.2
fever	104.1	8.7	162	12.8	133.3	11.2	103.3	8.5	108.3	12
oral thrush	49.3	4.7	28.6	4.8	0	4	77.4	6.2	16.7	5.6
cough	71.3	11.4	95.2	13.6	92.3	8.8	116.1	5.4	91.7	5.6
headache	16.4	6	66.7	7.2	41	4.8	29	5.4	0	6.4

In this section data from February – June 2003 was utilized in order to show that the new HIV/AIDS clients still reported more complaints of opportunistic infections than old HIV/AIDS clients even when the centre had little or no funding (February & March).
Table 6 above shows the comparison between six randomly selected clinical spectrum cases of new and old HIV/AIDS cases expressed as a % of the total new or old HIV/AIDS cases monthly February to June 2003. From this table and the corresponding graph 8 below, it can be noted that the old/continuing clients have markedly fewer complaints of opportunistic infections (O.Is) as

compared to the new clients (in this particular case less than 1 month). In short graph 8 and table 6 serve to show that continuing treatment at the center/home visit outreaches markedly helps to decrease opportunistic infections. This is true so long as one doesn't come in extremely advanced stages of AIDS e.g. cryptococcal meningitis, extensive Karposis sarcoma etc. Another important point to note is that clients who attend on going counseling and thus live positively have fewer complaints of O.Is as compared to those who are erratic in their treatment seeking behaviour and/or do not live positively. Please note Graph 8 below.

GRAPH 8:

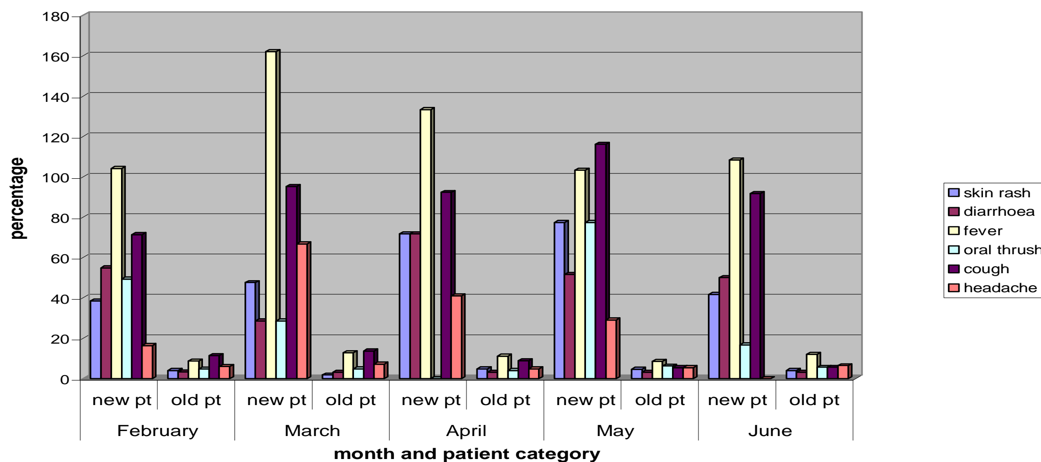


TABLE 7:

Comparison of six randomly selected clinical spectrums of new & old HIV/AIDS cases expressed as a percentage of the total new or old HIV/AIDS cases over the period February – June 2003

Condition	% reported in new cases	% reported in old cases
Skin rash	51.5	4
Diarrhea	51.5	3.2
Fever	120	10.6
Oral thrush	32.6	5
Cough	94.4	9
Headache	29.2	5.5

Just as in the previous case, Table 6 above goes on to show the comparison between six randomly selected clinical spectrum cases of new and old HIV/AIDS cases expressed as an average % of the total new or old HIV/AIDS cases between February and June 2003. From this table and the corresponding graph 9 below, it can be noted that the old/continuing clients have markedly fewer

complaints of opportunistic infections (O.Is) as compared to the new clients (in this particular case less than 4 months). In short graph 9 and table 7 serve to show that continuing treatment at the center/home visit outreaches markedly helps to decrease opportunistic infections. Please note Graph 9 below.

GRAPH 9:

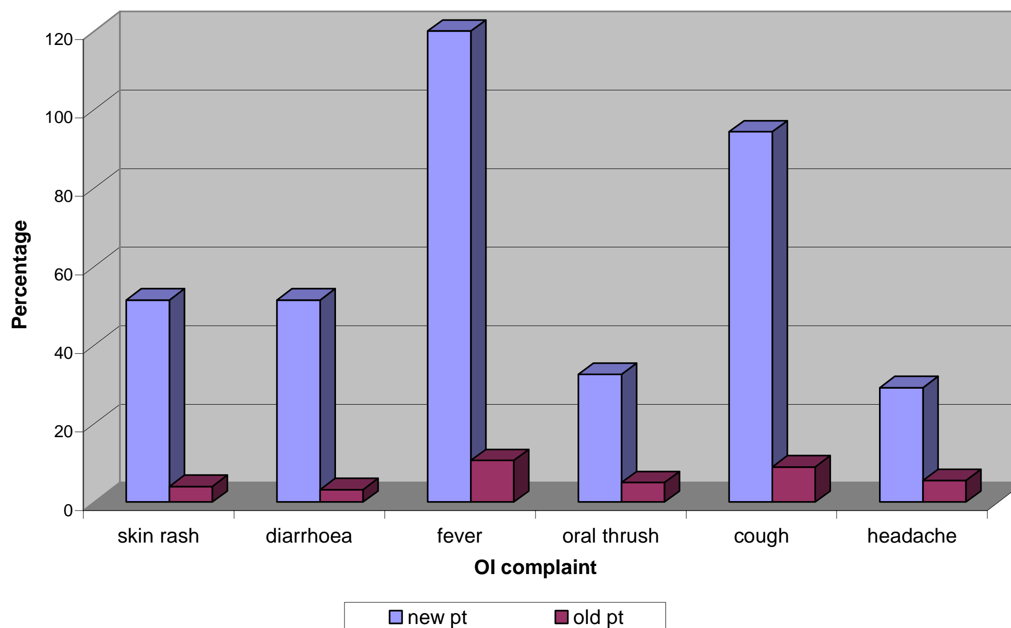


Table 8:
TB diagnostic/treatment outcomes in St Francis health care services versus those recommended by the National Tb & leprosy programme for the period 1st January 2002 – 31st January 2003.

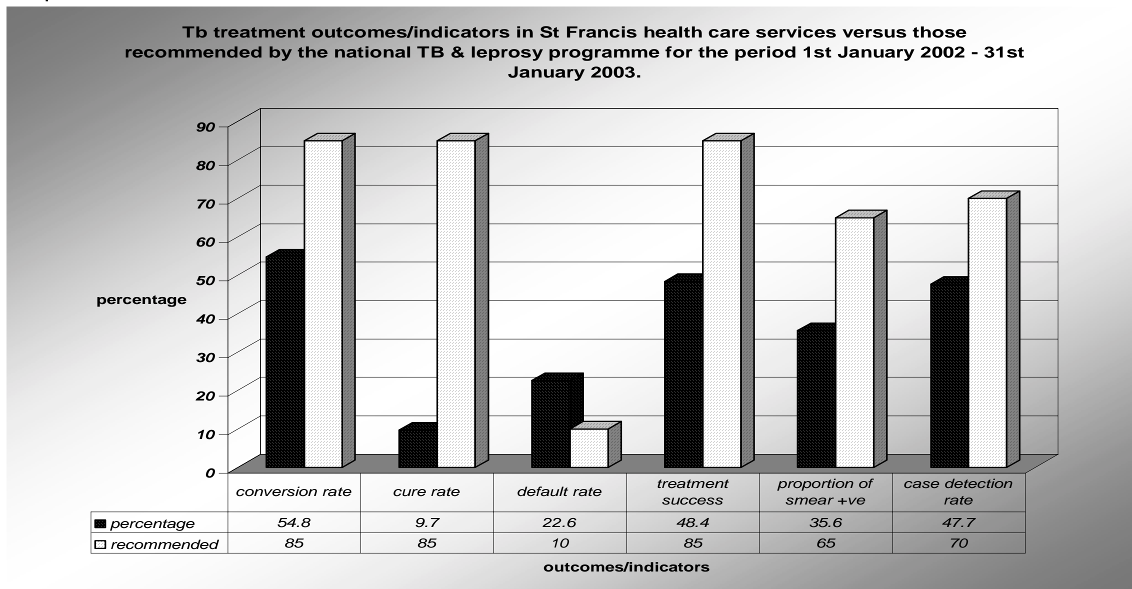
TB diagnostic/treatment outcome	Percentage	Recommended (%)
conversion rate	54.8 (n =31)	85
cure rate	9.7 (n = 31)	85
default rate	22.6 (n = 31)	10
treatment success	48.4 (n = 31)	85
proportion of smear positive	35.6 (n = 87)	65
case detection rate	47.7	70

Tb diagnosis and treatment at St Francis health care services has been on going with the blessing of the District Tb and Leprosy supervisor since January 2002. Table 8 above shows Tb diagnosis and treatment outcomes for the period 1st January 2002 to 31st January 2003 this was because all these should have completed their eight months treatment by 30th

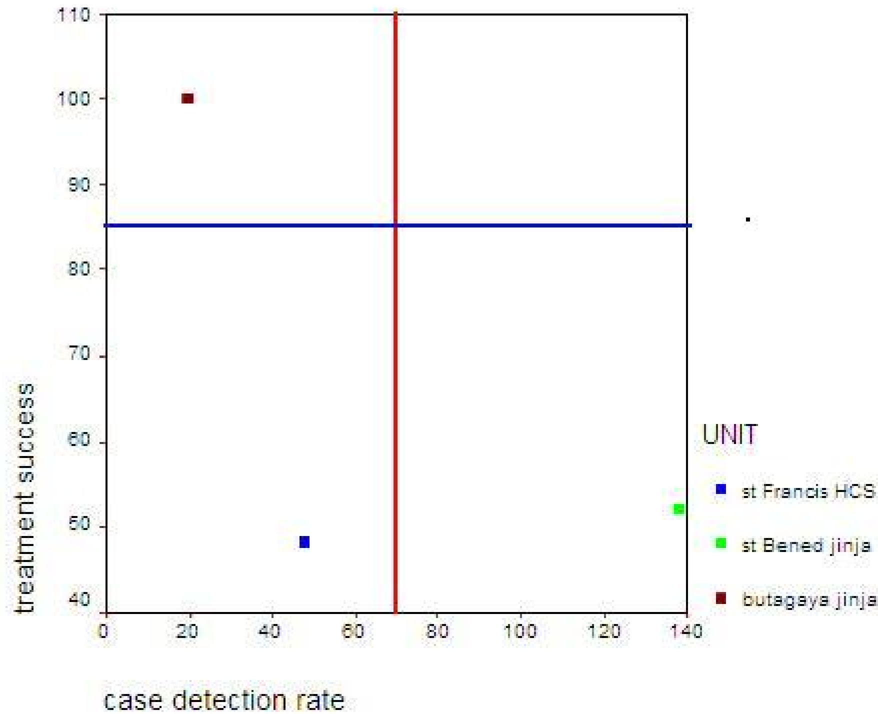
September 2003. This evaluation involved only the pulmonary sputum smear positive Tb cases this is because they have a vast potential to spread the ailment further if not detected early and if not successfully treated (cured). There were 31 smear positive cases out of the total 87 being managed for Tb i.e. pulmonary sputum smear positive, negative and extra pulmonary Tb cases.

From table 8 above and graph 10 below all the parameters evaluated were well below the recommended. The cure rate was particularly low because of all the cases completing the eight months Tb treatment with short course chemotherapy very few had their sputum smear tested at end of eight months treatment. The default rate is very high because patient follow up is minimal (once a month when patient comes for more Tb drugs from the centre). The case detection rate was based on the population of the official catchment area of the centres' TB services. This is Njeru town council with a projected population of 52,000 people, and at sputum smear positive projection of 125 cases per 100,000 persons in the community of the catchment area (Zonal Tb and leprosy supervisor). The centre has not yet registered any treatment failure among the pulmonary sputum smear positive Tb patients.

Graph 10:



Graph 11:
Correlation of the treatment success against case detection rate of pulmonary sputum smear positive Tb patients at St Francis health care services Njeru, Mukono District.



Graph 11 above shows the correlation between treatment success (the sum of cure and completion rates i.e. those without the sputum smear test at eight months of treatment) and case detection rate of St Francis health care services Tb treatment centre. The two Tb treatment units from Jinja District serve as reference points to show how far the Tb services at the centre have reached versus the recommended by national Tb and leprosy programme and WHO[1].

Moving clockwise and starting in the bottom left quadrant that stands for both low case detection and treatment success. Beginning Tb treatment units should at least begin in this quadrant. They should then advance to the top left quadrant that stands for low case detection but high treatment success in the cases detected. There after Tb treatment units should strive to move towards the top right quadrant that represents both high treatment success and case detection rate. This is the target for every Tb treatment unit in the world. The bottom right quadrant that stands for high case detection but low treatment success should be avoided at all costs by all Tb treatment units since this encourages increase in the number of Tb treatment defaulters and hence treatment failures. This situation can lead to development of multi drug resistant Tb if not checked early[2].

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[1] Kazibwe F. Appraisal of the community based directly observed treatment of TB with short course chemotherapy (CB-DOTS) in Butembe and Kagoma HSDs, Jinja District; unpublished Masters dissertation, Uganda martyrs university September 2003.

[2] World Health Organization. *Global Tuberculosis Programme. Global Tuberculosis control. WHO Report 1998. Geneva, Switzerland, WHO/TB/98-237*

From the graph 11 above it is clear that Tb services at the centre are still faced with both low case detection and low treatment success. There is thus need to improve on patient follow up and also increase on the Tb treatment sensitization drives during the outreaches and at the centre.

SUMMARY OF RECOMMENDATIONS

- There is an urgent need for all the medical personnel to become computer literate. This will stream line the data entry and analysis. This will also help in keeping track of the large amounts of medical data currently available at the centre so that future evaluation studies and research can be accomplished more accurately.
- the medical personnel need to be facilitated to attend the available short courses on HIV/AIDS in order to stay up to date with the current management and thus offer our clients with the best possible treatment at all times.
- The number of medical personnel needs to be increased to meet the increasing patient load. Currently the 2 part-time Doctors, 2 clinical officers, 3 nurses, 1 nursing assistant and 2 PLWAs volunteers care for about 3000 registered clients. The quality of care is thus being impaired every time the clients increase without a similar proportionate increase in the number of health workers.
- There is need to achieve stability in the financial resources of the centre. This will help the medical department consolidate on its successes in HIV/AIDS patient care it has so far achieved. Otherwise this irregularity in financial resources corrodes client confidence in the centre's ability to care for them, leads to rapid progression into AIDS and death for those who solely depend on the centre's medical services.
- There is need to improve on the Tb treatment services at the centre in order to achieve high TB treatment success in all the detected Tb cases. The medical department through the Mukono district Tb and leprosy supervisor should consider implementing community based directly observed treatment of Tb with short course chemotherapy (CB-DOTS). The latter has been shown to be highly effective in achieving both high case detection and treatment success, if well implemented.

COUNSELLING DEPARTMENT

Five counselors man the department. They do the counseling, home visiting and sensitization of the community about HIV/AIDS scourge.

TRAINING AND CAPACITY BUILDING

St. Francis Counselling department has so far undertaken various trainings to update on its efficiency and effectiveness.

Mrs. Akiiki Faith completed a course in Care and Management. Sponsored by CDC at Mildmay International, tailored by Manchester University UK.

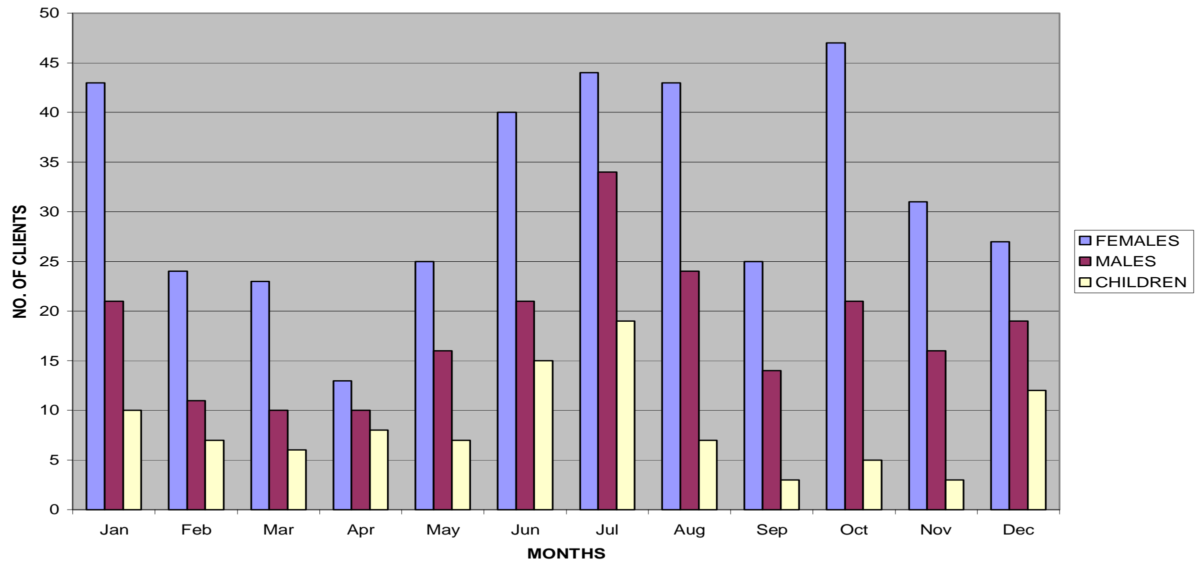
Asiimwe Medias has also trained in palliative care of people living with HIV/AIDS sponsored by Center for Disease Control (C.D.C) at Mildmay and has also acquired a Certificate in child counselling sponsored by St. Francis Health Care Services and Regional Training Network (RATN) at TASO.

Tenywa Paul Kafuko has also acquired a Certificate in child counselling sponsored by St. Francis Health Care Services and Regional Training Network (RATN).

Mbabazi Olive has also acquired a Certificate in HIV/AIDS counselling sponsored by St. Francis Health Care Services at TASO.

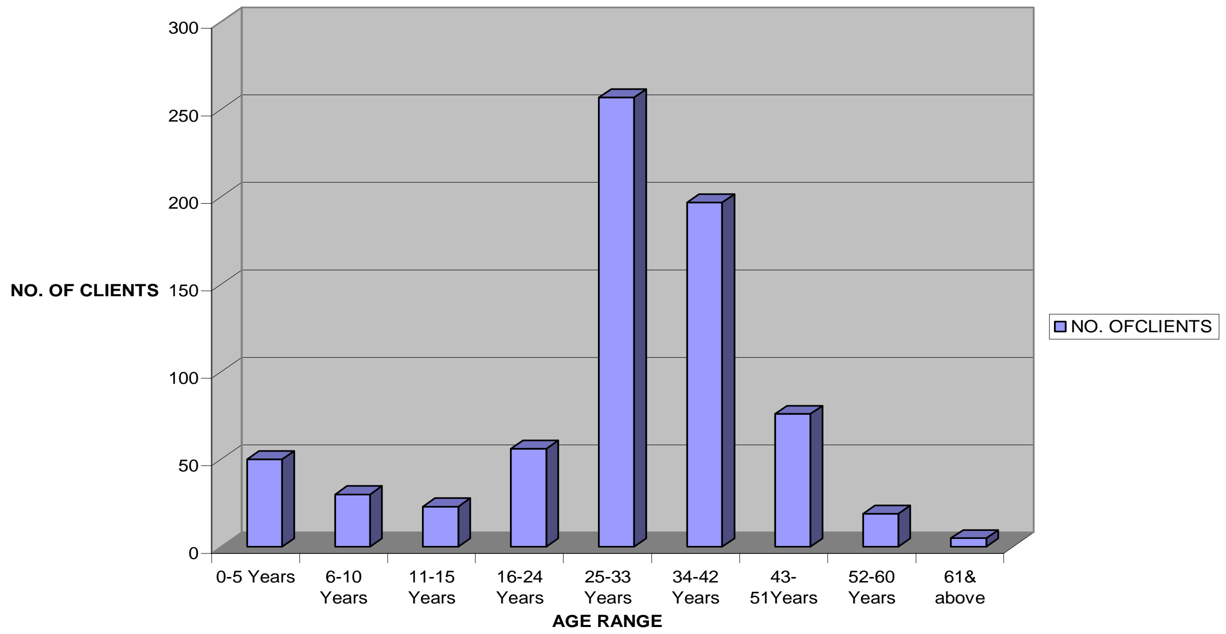
Kisembo John has also acquired a certificate in psychosocial and spiritual care in HIV/AIDS at Mildmay International sponsored by CDC (Centre for Disease Control)U.aviour.

GRAPH 1



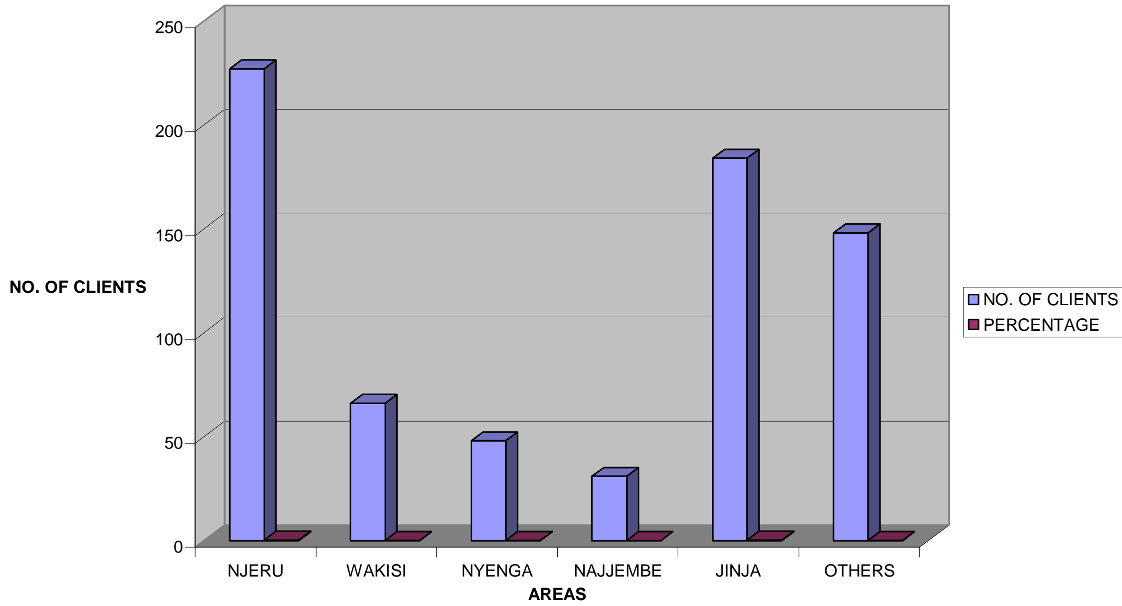
Graph 1 above shows the monthly distribution of the total 704 clients registered between Jan and Dec. 2003. Of these 385 were females, 217 were males and 102 were children. The number of clients in 2003 decreased compared to the number registered in 2002 over the same period. This was due to the reduced sensitization and health education talks which we conducted during this period.

Graph 2



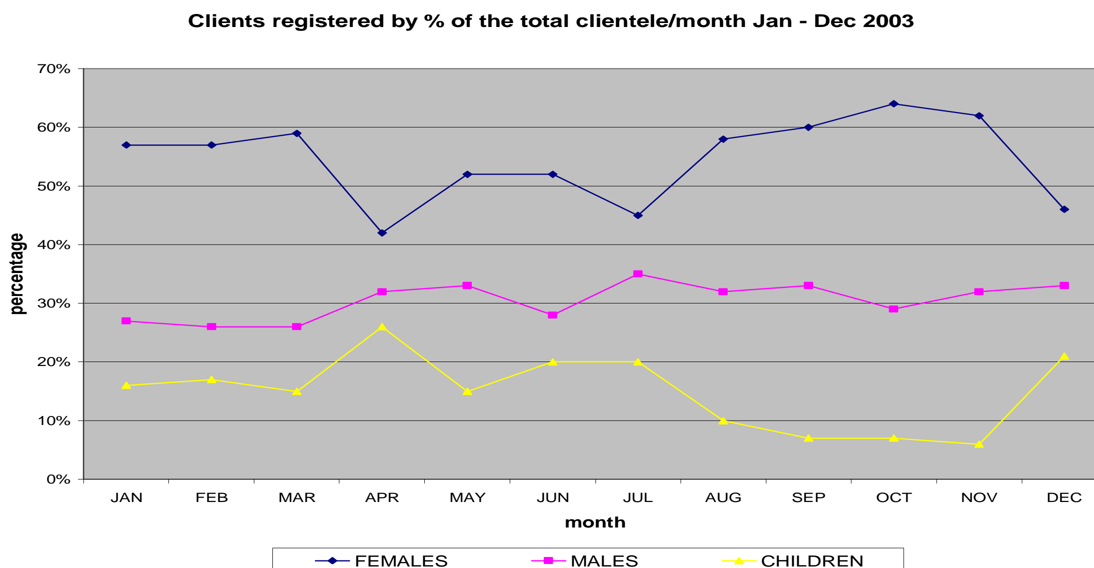
Graph 2 above illustrates that the clients most infected are those between the age ranges of 25-33 and 34-42 years. It can be noted that these are the most sexually active age ranges. Graph 2 also indicates that the majority of the children who were registered for medical treatment and ongoing support are between the age range of 0-5 years.

Graph 3



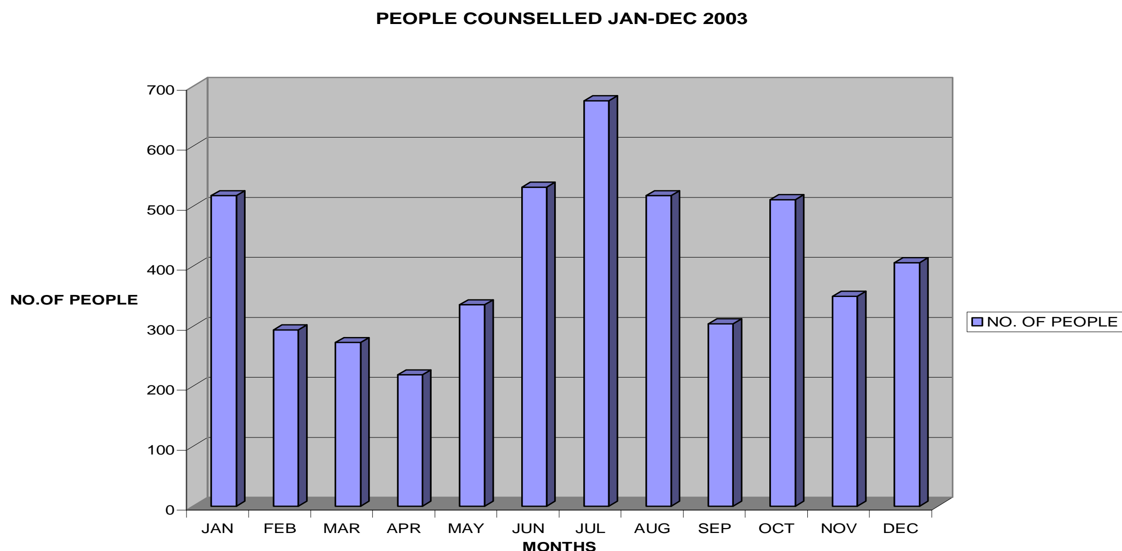
Graph 3 above shows that the majority of the clients are from Njeru and Jinja. This could be attributed to our proximity and effective sensitization of the drama group to the two areas. The large number of clients received from other areas outside the normal catchment area can be attributed to the centres' VCT messages aired over the radio in Jinja municipality.

Graph 4



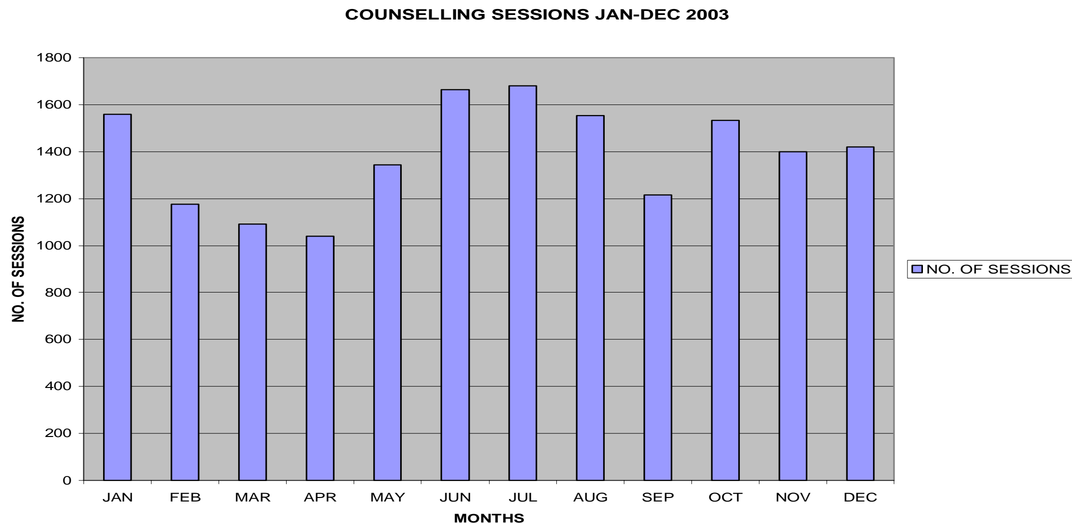
Graph 4 above shows that female clients made up the biggest percentage of the registered clients. Some of the children who are registered were orphaned by HIV/AIDS and are brought by their caretakers/mothers seeking treatment for various ailments and were recommended by the doctor/counselor for medical surveillance.

Graph 5



According to the graph 5 above, the number of people counseled increased from May to December. This was due to the sensitization programs we carried out with our drama group during this period.

Graph 6



A total number of 16680 counselling sessions were conducted between Jan and Dec. 2003. These sessions consisted of pre-test, post –test and on going counseling. Graph 6 above depicts the monthly variations in 2003.

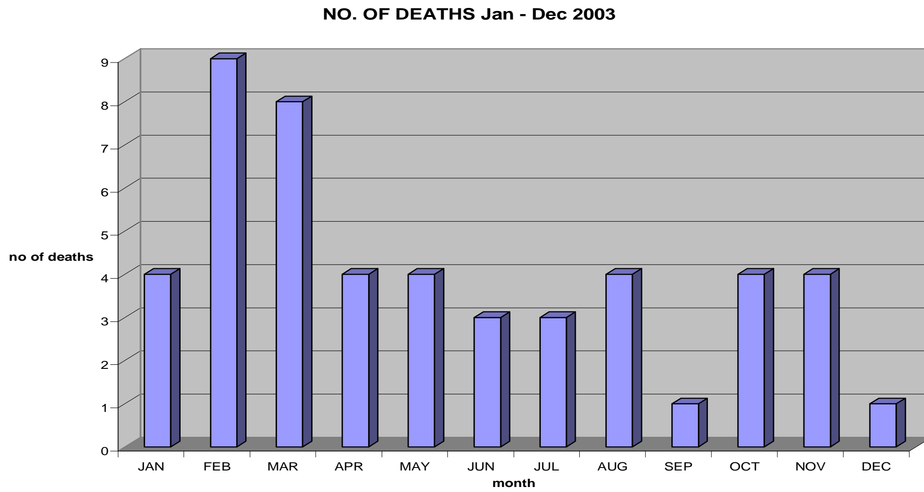
HOME VISITS JAN- DEC 2003

A total number of 192 home visits were made between January and December. These home visits were made to people who were terminally ill and could not come to the center for the services, and others who expressed the need to be visited at their homes.

HEALTH EDUCATION TALKS JAN-DEC 2003

A number of health education talks were conducted at our out-reach centers. These talks were about the importance of good hygiene, balanced diet, proper condom use and early medical seeking behaviour in respect of HIV/AIDS management.

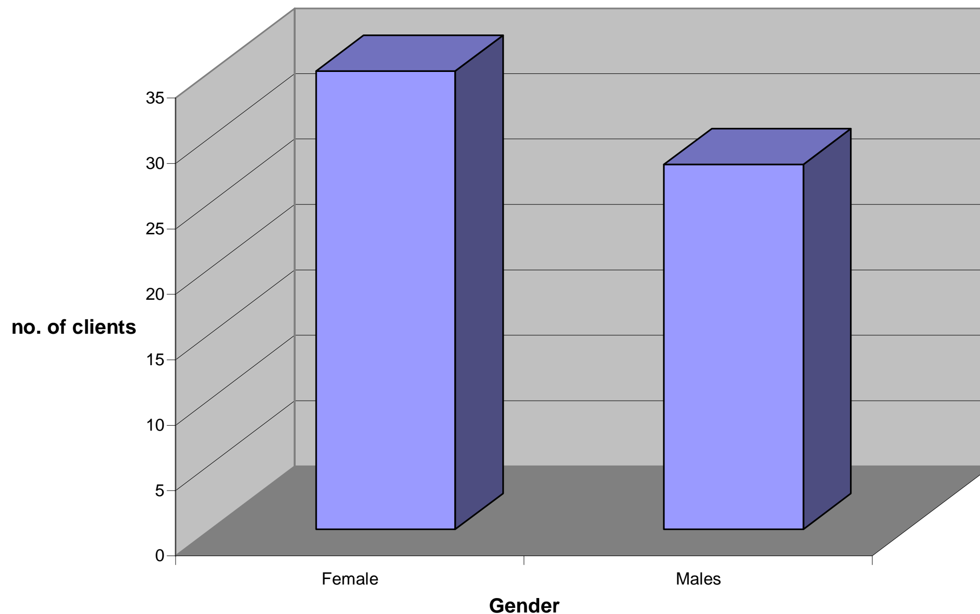
Graph 7



Graph 7 shows that during the year 2003 the number of deaths recorded among the registered clients was generally low (an average of five clients/month). This could be attributed to the positive services being rendered by the centre.

VOLUNTARY COUNSELLING AND TESTING (VCT) JANUARY TO DECEMBER 2003

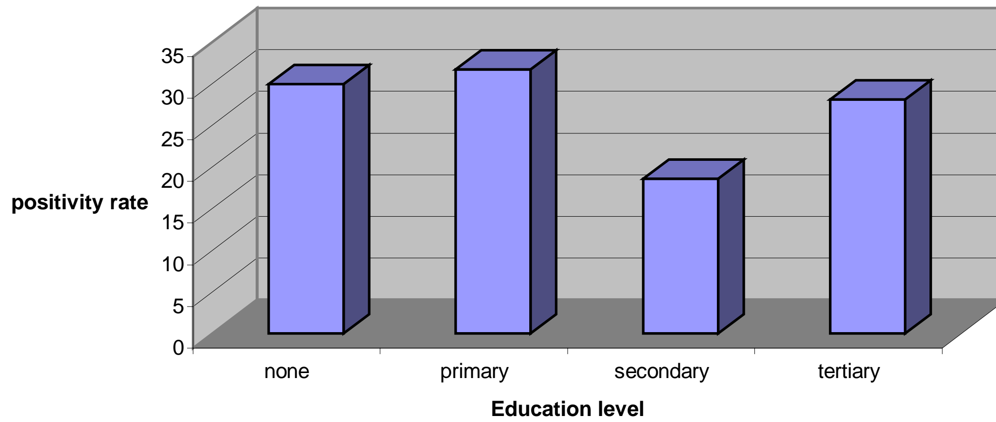
Graph 1



The above graph 1 shows the HIV positivity rate of people seeking voluntary counseling and testing at St Francis health care services during the period Januaryl to December 2003. From the graph 34.9 % (n = 886) of the female and 27.8 % (n = 750) of the male clients who sought VCT services at the centre were HIV positive. The above includes both VCT at the centre and during outreach visits.

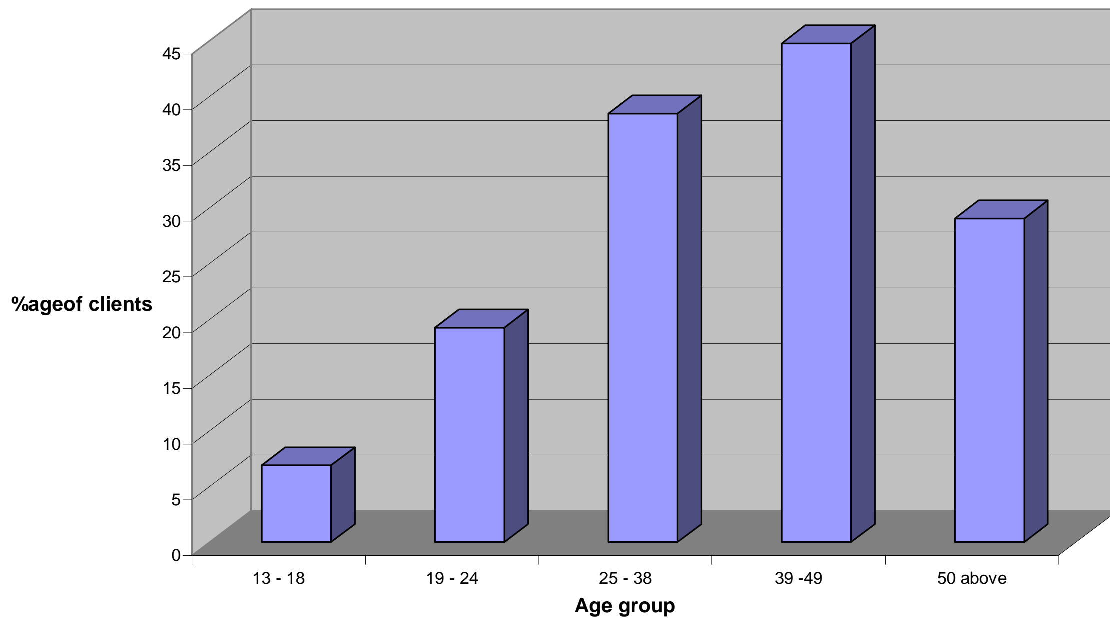
The graph 2 below shows the HIV positivity rate by education level among clients attending VCT at ST Francis health care services during the period April to September 2003. This period of six months was selected to represent the whole year (January – December 2003).
From the graph 29.9% (n = 134) of those with no formal education, 31.7% (n = 356) of clients with primary level, 18.6% (n = 442) of those with secondary level and 28.1% (n = 64) of the clients with tertiary level were found to be HIV positive after undertaking VCT at the centre. From the above we note that the clients with secondary education had a positivity rate at least half that posted by clients with primary or no formal educational education. However clients with tertiary education had a much higher positivity rate than those with secondary education. Despite this however, clients with secondary and tertiary education were noted to have a lower positivity rate than those with primary or no formal education at all. In summary formal education empowers the individual to protect him or herself from HIV infection.

Graph 2



The following graph 3 below shows the HIV positivity rate by age group for the period January - December 2003.

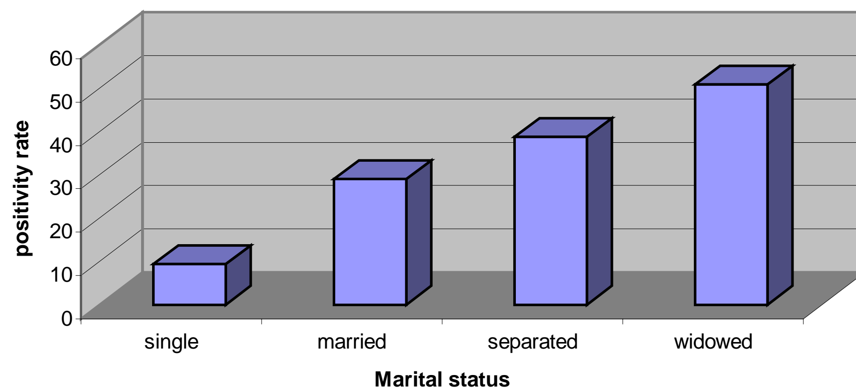
Graph 3



From the graph 3 above we note that the positivity rate of the 19 – 24 age group (19.2% where n = 322) is more than three times that of the 13 – 18 age group (6.8% where n = 203). This trend continues albeit with at lower margin with the positivity rate of the 25 –38 age group (38.4% where n = 723) and the 39 – 49 age group (44.7% where n =295) being at least twice the rate of the 19 – 24 age group.
It is evident from the graph that HIV is most prevalent after the 19 – 24 age group.

The graph 4 below shows the HIV positivity rate by marital status among VCT clients at the centre during the period April - September 2003. This six months period was also selected to represent the whole year (January – December 2003).

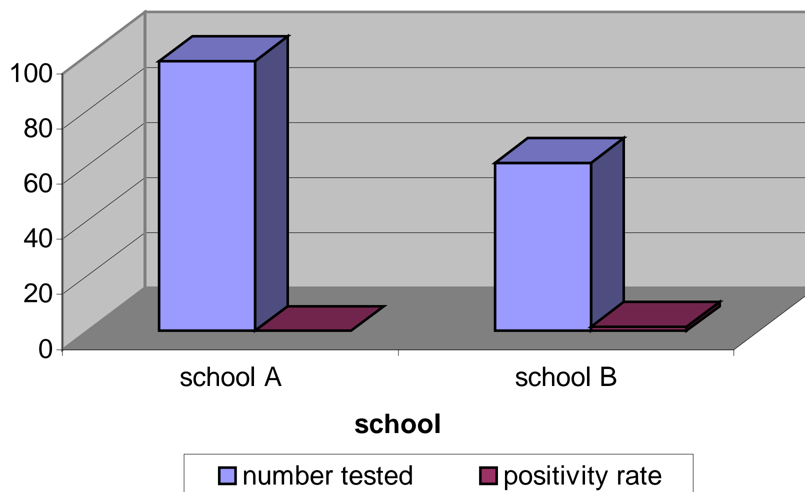
Graph 4



From graph 4 above, the HIV positivity rate was lowest among the single at 9.4% (n = 361), and highest among the widowed at 50.9% (n = 106).
It should be noted that the majority of the single were school going children. From this we note that the prevalence of HIV is about three times as much in the married couples than among the single. It is also about one and half times as much in the separated and widowed than in the married couples.

The graph 5 below shows HIV positivity in senior secondary schools (A & B) in Njeru town council, Mukono District visited in 2003, between the period April - September 2003. The identity of the schools is left out for confidentiality purposes.

Graph 5



From the above graph 5 we note that the prevalence of HIV among the students who attended VCT sensitization during the period of the report in the two schools was very low. School A had a positivity rate of 0% (n = 98) while that of school B was 1.6% (n = 61).

Thus from all the previous graphs we can note that HIV prevalence is lowest among the young age groups below 24 years and those who are single. It is also markedly lower in populations that have at least attained senior secondary education as compared to those with primary or no formal education at all. From the last graph, we note that the prevalence of HIV is very low among the senior secondary school student populations in Njeru town council.

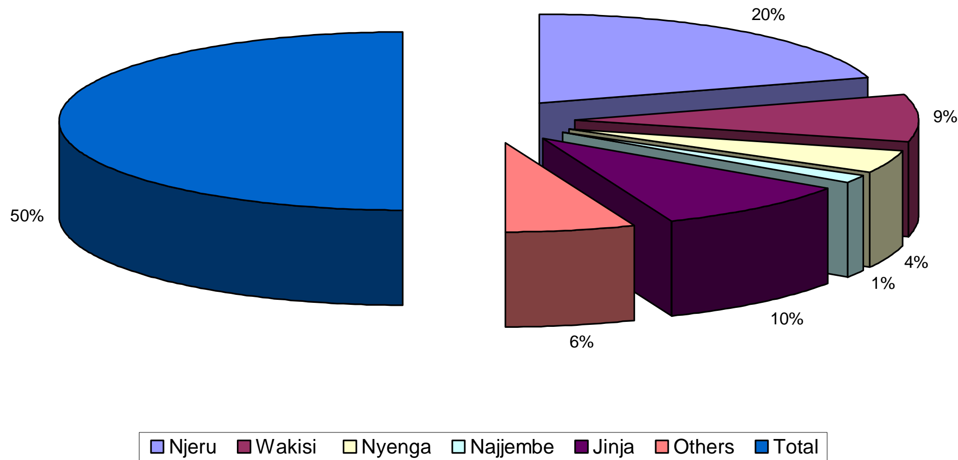
Finally all the above results were derived from the 1636 individuals who sought VCT services from St Francis Health Care services in the period January - December 2003.
Table 1 and graph 6 below further illustrate the distribution of these individuals by area of residence.

Table 1.

Clients attending VCT January – December 2003 by area of residence

Area	Clients attending VCT
Njeru	661
Wakisi	285
Nyenga	133
Najjembe	46
Jinja	315
Others	196
Total	**1636**

Graph 6.



From the above it is evident that the majority of the clients seeking VCT services from St Francis Health Care services resided in Njeru town council, Jinja town and Wakisi sub-county. The category others refers to clients who resided in places outside our current operational area. Nyenga and Najjembe sub-county had few clients seeking VCT services from the centre during this period.

SOURCE OF INFORMATION ABOUT VCT. SERVICES

When people are asked about how they got the information about voluntary counselling and testing services at the Centre, their response was as follows:
55% said through friends, 32% said through mobilization and 13% said that they heard over the radio.

CONDOM DISTRIBUTION

Between Jan and Dec. we distributed 68256 condoms. Some were distributed through our community counseling Aides (CCA), some during the sensitization programs, others during home visits and at the centre.

AWARENESS AND SENSITIZATION.

St. Francis drama group staged a number of sensitization shows in Njeru west, Wakisi, kalagala, Kirugu, Mafubira, kinabi, Mbiiko-Kasanja zone and four secondary schools. These sensitization shows improved on community awareness about HIV/AIDS. As a result many people came for voluntary counseling and testing (VCT) others came for treatment of sexually transmitted infections.

NJERU WEST

A total number of 260 people attended. 150 were female adults, 60 male adults and 50 children. 25 females and 19 males tested voluntarily for HIV.

WAKISI

Here 100 females, 60 males and 40 children attended. 30 people tested for HIV voluntarily.

KALAGALA

80 Females, 40 males and 30 children attended. 36 people voluntarily tested for HIV.

KIRUGU

90 females, 65 males and 35 children attended. 26 people tested for HIV voluntarily.

MAFUBIRA

100 women, 70 men and 140 attended the show and were sensitized about HIV/AIDS.

KINABI

St. Francis medical personnel, counselors and people living with HIV/AIDS (PLWA) drama group visited four different secondary schools for sensitization purposes. We St. Noa Secondary school with 600 students, Lords Meade with 700 students, Buwenge College with 500 students and Njeru secondary school with 400 students.

THE SHADOW IDOL PROGRAMME

St. Francis Shadow Idol programme is mainly for the Orphans and its major aim is to help the orphans envision what they want to be in future by giving them live examples of people who have "made it in life".

The Shadow Idol programme is also to enable the orphans take personal decisions relating to HIV/AIDS transmission and the facilitation of preventive behaviour.
In helping the youth evaluate on the personal risks of HIV/AIDS and facilitation of preventive behaviour. The Shadow Idol programme involves the youths in various activities and different educational topics of which the youth are actively involved in. The shadow idol programme has so far covered reproductive health topics for example, sex at the right time, sexually transmitted

diseases, staying away from sex, peer pressure, good friends, growing up and changing living positively to mention but a few. The good news is that the shadow idol club has also formed another club within its self to educate other youths on the dangers of early sex and its consequences.

The Shadow Idol club has gone to various secondary schools for sensitization. The club has visited three different secondary schools which are Lords Meade, St. Noa Mawagali and Buwenge College School. The purpose of these visits were to educate the youth in schools about HIV/AIDS and its consequences to young people.

The orphans hosted three guest speakers, namely: a professional doctor, a lawyer and an engineer. These professionals guided the shadow idol members what it takes to be of such profession.

The shadow Idol club also invited an expert on drugs and substance abuse to talk to the youth about drugs and their effects. The attendance of the youth was quite good and this can be seen from the table below.

Table showing "shadow idol" youth attendance by gender and month June –December 2003

Month	Females	Males	Total
June	188	164	350
July	220	164	384
August	228	160	388
September	186	160	342
October	205	150	355
November	219	148	367
December	220	180	400

. The centre offers them Breakfast and Lunch when they come for the different activities such as reproductive health and life skills, Drama, straight and young talks.

FUND ACCOUNTABILITY STATEMENT AS AT 31ST DECEMBER 2003

1. Introduction:

1.1 Background

St. Francis Health Care Services is a non-government organization established in 1998 to respond to the challenges of HIV/AIDS epidemic through sensitization and awareness about HIV/AIDS and provision of medical care and psycho social support to people living with HIV/AIDS and affected.

To prevent the spread of HIV and mitigate personal impact of AIDS through provision of quality medical care and counseling services to the infected and affected.

Objectives:

- Prevention of sexual transmission of HIV in the community.
- Mitigation of personal impact of AIDS in the community
- To advocate for rights of people living with HIV/AIDS
- To promote children's rights
- To create awareness among the youth on the dangers of chemical dependency and drug abuse through counseling and education.

1.2 Audit objectives and scope:

Bika & Partners Certified public Accountants were engaged by St. Francis Health Care Services to carry out and Audit the books of the organization for the year ended 31st December 2003.

The objectives of this engagement are to:

- Audit the funds accountability statement of the organization and express an opinion as to whether the funds accountability statement presents fairly in all material respects and in conformity with the basis of accounting described in this report, the use of funds in accordance to non government organization policies and procedures.

- Review the internal control structure in order to determine whether the project's management has put in place satisfactory controls aimed at preventing, detecting, reducing or eliminating errors and irregularities.

- Test the Auditees compliance with terms of the grant agreements and applicable laws and regulations as part of obtaining reasonable assurance about whether the fund accountability statement is free of material mis-statement, and report on any identified materials instances of non compliance.

2.4 Audit approach.

Pre Audit steps:

- Held Initial discussion with the project coordinator and the Hon-treasurer in the activities of the project.
- Obtained the Grant Agreements and the memorandum of understanding reviewed them in preparation of the audit; and
- Obtained expenditure statements for the year under audit:

2.5 Audit Procedures:

In summary, the following procedures were under taken in the course of the audit:

- Verified that all the expenditures were in accordance with the budgets for the year were properly authorized, supported and classified.
- Documented and tested the operation of the internal control system of the project in order to determine the adequacy of the system in processing transactions by the project.

BIKA & PARTNERS
AUDITORS' ACCOUNTANTS & INCOME TAX CONSULTANTS
(REGISTERED & CERTIFIED)

Your Ref: ………………….

P.O. Box 10
Jinja

Our Ref: 025/ BK/ 2003

Fund Accountability Statement
Report of the independent auditors to the members of:
St. Francis Health Care Services
P.O. Box 2210
Jinja.

REF: <u>REPORT OF AUDITORS TO THE BOARD</u>

We have audited the accompanying statement for the financial year of St. Francis Health Care Services as at 31st December 2003 and the related statement of activities for the year ended. We obtained all the information and explanation which to the best of our knowledge and belief were necessary for the purpose of our Audit.

RESPECTIVE RESPONSIBILITY OF FINANCIAL COMMITTEE AND AUDITORS.
The Finance Committee is responsible for the preparation of financial statements which give a true and fair view of the organization activities state of affairs and its operations. Our responsibility is to express our independent opinion on the financial statement based on our Audit and to report our opinion to you.

We conducted our Audit in accordance with International Standards on auditing. These standards require that we plan and perform our audit to obtain a reasonable assurance that the financial statement is free from material mis-statements

An audit includes an examination in test basis of evidence supporting the accounts and disclosure in the financial statement it also includes an assessment of accounting policies used and significant estimates made by the finance committee.

Opinion
In our pinion, proper books of accounts have been kept and financial statements which are in agreement there with shows a true and fair view of the statement of affairs as at 31st December 2003 and its transactions and surplus for the year ended on that date.

JINJA

…………………2004 JINJA

2004

FUND ACCOUNTABILITY STATEMENT 31ST DECEMBER 2003

1. **REVENUE**	**UGSHS**
Opening Bank Bal.	8,535,454=
Funding	291,966,874=
Other Income	19,079,330=
	319,581,658=

EXPENDITURE

A. Sensitization, Mobilization & Education;	
Drama & video shows	8,330,450=
Workshops, Training/Consultancy	9,125,000=
B. Medical /Support;	
Home care/ visits	1,419,000=
Procurement of Drugs + Sundries	30,474,622=
Fuel for operations	16,855,990=
C. Office Administration;	
Taxes	934,780=
Registration fees	-
Office running	2,434,380=
Rent for Office Premises	6,860,000=
Water bills	201,000=
Electricity bills	681,400=
Postage + Stationary	4,303,250=
Email, Tel + Internet	5,826,778=
Traveling expenses	585,500=
M/V Maintenance	8,957,000=
Bank charges	545,064=
Governing council meetings	898,900=
D. Volunteer allowances	76,762,000=
E. Social Support;	
Client support/IGA's	1,320,300=
Radio spot	12,050,000=
OVC's	39,876,200=
Food for clients	11,460,000=
F. Fixed Asset Acquisition	14,873,000=
G. AGM/Staff stress	
Management	2,101,000=
Total expenditure	256,875,614=
Surplus for the year	62,706,044=
	319,581,658=

BALANCE SHEET FOR THE PERIOD ENDED 31ST DEC 2003

FIXED ASSETS	UGSHS
As per schedule	59,861,250=
CURRENT ASSETS	
Cash at hand	650,000=
Cash in Bank	63,038,995=
Stock at close (Drugs)	765,000=
	124,315,245=
LESS LIABILITIES AND ORGANIZATION EQUITY	
Organization equity	124,315,245=
Total liabilities and equity	124,315,245=

The fund accountability statement was approved by the project management team on …../1/2004 and signed on its behalf by:

Chairman Board of Directors ………………………………………………………..

Hon Treasurer ………………………………………………………..

Programme Coordinator ………………………………………………………..

NOTES TO THE ACCOUNTS FOR THE PERIOD ENDED

Accounting Policies

3. The Fund Accountability statement is prepared on cash basis. All income is recorded as revenue when received and expenses are recorded as expenditure when paid.

3.1 Depreciation on fixed assets on cost variation provision in the accounts at the following rates on reducing method intended to note off the estimated value of the usefulness lives over period.

3.2 Funding	Ugshs
Fr. Tom McDermott CSC	1,948,000=
Elton John AIDS Foundation	153,570,990=
Development Cooperation Ireland	100,416,638=
Firelight Foundation USA	7,824,246=
Mercury Phoenix Trust	16,375,000=
J. Homer Burtler Foundation	11,832,000=
	291,966,874=

Other Income	
Users charge	14,103,950=
Maria	750, 000=
Sisters of Holy Cross	950,000=
Mukono District AIDS Project	1,415,380=
Jinja District AIDS A/C	1,860,000=
	19,079,330=

Bank Account

Opening balance on A/C No 7988 1/01/2003 8,535,454=

Closing balance		
Account No.	7988-01	58,601,538=
Account No.	7988	1,484,517=
Savings	01205007988	2,952,940=
		63,038,995=

Stock

Since St. Francis Health Care Services is non governmental organization. Therefore stock has not been treated as a business concern.

Rate

Exchange rate is $1-1945 Ushs and were respectively converted to local currency.

SCHEDULE OF FIXED ASSETS

FIXED ASSETS	VALUE b/f	ADIITIONS	TOTALS	RATES	DEPREC	NET VALUE
Land, Mbiiko & Bukaya	9,000,000	5,000,000	14,000,000			14,000,000
MOVABLE ASSETS						
M/V Double Carbin	18,750,000		18,750,000	10%	1,875,000	16,875,000
M/V Ambulance	6,000,000		6,000,000	10%	600,000	5,400,000
M/V Saloon Car	4,725,000		4,725,000	10%	472,500	4,252,500
Motor cycle	1,200,000		1,200,000	10%	120,000	1,080,000
Furniture & Fittings	900,000	2,500,000	3,400,000	2%	68,000	3,332,000
Panasonic T.V & Deck	858,000		858,000	5%	42,900	815,100
Computers		4,950,000	4,950,000	10%	495,000	4,455,000
Lab. Equipment	2,850,000		2,850,000	2%	57,000	2,793,000
LCD Projector		2,500,000	2,500,000	5%	125,000	2,375,000
Fridges	405,000		405,000	5%	20,250	384,750
Patients wheel chair	50,000		50,000	2%	1,000	49,000
Kitchen Utencils	250,000		250,000	5%	12,500	237,500
Generator	900,000		900,000	5%	45,000	855,000
Tent	1,530,000		1,530,000	2%	30,600	1,499,400
Public Address System	1,620,000		1,620,000	10%	162,000	1,458,000
TOTALS	**49,038,000**	**14,950,000**	**63,988,000**		**4,126,750**	**59,861,250**

females and 19 males tested voluntarily for HIV. rally transmitted infections. si, kalagala, Kirugu, Mafubira, kinabi, Mbiiko-