

**HIV/AIDS PREVENTION AND
CARE PROGRAMME
(2001 – 2004)**

EVALUATION REPORT

**ST. FRANCIS HEALTH
CARE SERVICES**

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-retrovirals
CADI	Centre for African Development Initiatives
CBOs	Community Based Organisations
CCA	Community Counselling Aides
CHAI	Community-led HIV/AIDS Initiatives
CSO	Civil Society Organisation
CV	Client Volunteer
DOT	Directly Observed Treatment for TB
FGD	Focus Group Discussion
HIV	Human Immuno-deficiency Virus
HOD	Head of Department
IGAs	Income Generating Activities
MOH	Ministry of Health
NACWOLA	National Community of Women Living with AIDS
NC	Nurse Counsellor
NSSF	National Social Security Fund
ORS	Oral Rehydration Salts
PC	Program Co-ordinator
SW	Social Work
TASO	The AIDS Support Organisation
TB	Tuberculosis Bacillus
UACP	Uganda AIDS Control Programme
UK	United Kingdom
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
SFHCS	St. Francis Health Care Services

EXECUTIVE SUMMARY

After three years of implementation, the management of St. Francis Health Care Services (SHCS) found it pertinent to carry out a three-year evaluation, in order to compare set objectives with achievements, review strategies, approaches and practices. The evaluation covered the period from 2001 to June 2004.

The evaluation was conducted through a participatory process, which involved wide consultations and interviews with key stakeholders in the program. Secondary data in form of project reports, program work plans, evaluation reports and annual progressive reports were reviewed. Group discussions and key informant interviews were conducted to generate valuable information from the program staff, clients, community volunteers, orphans, schoolteachers, partners, donors, and officials from district local governments.

i) Key Findings

□ Medical and Nursing

The number of people receiving medical care from the program has increased tremendously from 1205 in 2001 to 3347 in 2004. The program has effectively responded to the medical needs of clients by treating opportunistic infections and referring complicated and bedridden cases to hospital. This has been possible mainly because of the grant from Elton John AIDS Foundation, Development Cooperation Ireland and Firelight Foundation, who have guaranteed regular drugs supply, acquisition of basic medical equipment such as HIV/AIDS testing tools, and accessing TB treatment facilities to the program.

The challenges of achieving health objectives, however, include: Inaccessibility to basic but expensive drugs, including ARVs.

□ Counselling

The program is providing counselling services, including Voluntary HIV/AIDS counselling and testing, and has attracted both PHAs and the general public seeking to establish their sero-status. This is putting further strain on the few counsellors of the program and may compromise the quality of counselling. Existing gaps in the counselling function, therefore, include insufficient counselling at PHAs' homes.

□ Income-Generating Activities

In response to the socio-economic impact of the HIV/AIDS pandemic, the program initiated a project to support orphans and guardians to run income-generating projects. Consequently, over 233 persons secured financial support, and the IGAs have demonstrated that PHAs have the potential to solve their problems with minimum external help. However, the financial packages are small and the support has been extended to only a few. In addition, the program does not seem to have the core competence in provision of micro finance, given its human resource base and organisational structure.

□ **HIV/AIDS Education and Information**

Like in the previous evaluation, HIV/AIDS education and information is being carried out mainly through music, dance and drama, radio talk shows and jingles, distribution of reading materials, workshops and seminars. Talks and drama about HIV/AIDS in schools are the dominant sensitisation activities. These have not only demonstrated SFHCS' leadership in the AIDS Crusade, but have also won public acceptability and recognition as evidenced by the drug donation from Ministry of Health and Lugazi Diocese Health Office.

□ **Institutional Capacity**

The program has significantly improved its institutional capacity to deliver quality services by streamlining its management structures and systems and working more closely with Uganda Catholic Medical Bureau. Consequently, the program clinic has attained the status of health III status and can also treat TB. The program has, in addition, retrained its staff and acquired two vehicles since 2001.

ii) Key Recommendations

□ **Medical and Nursing**

- Provide refresher training for medical staff to enable them cope with the dynamics of HIV/AIDS, especially with managing opportunistic diseases and administration of new HIV/AIDS drugs, including anti-retrovirals.
- The program should link up with other key stakeholders to advocate for the government to avail ARVs to poor PHAs.
- Caregivers should be sensitised about the need to bring clients in good time but not to wait until they are seriously sick.
- Provide training to caregivers who look after sick PHAs. The training for family caregivers needs to include; knowledge in first aid, treatment, hygiene, nutrition and patient care, care giving, nursing, feeding, identifying problems of patients and management of drugs.

□ **Counselling**

- The program should train more clients as volunteer counsellors and facilitate them to counsel their fellow PHAs.
- Improve on documentation and information management by opening files for clients, purchasing filing cabinets for storing files, and computer sets (to set-up a database for all clients).
- Provide ample time for pre-testing counselling so that the clients fully understand and appreciate the implications of establishing their sero status so that they are

able to manage both the excitement and sorrow associated with positive and negative results, respectively.

□ **HIV/AIDS Education and Information**

- Increase budgetary provisions to the HIV/AIDS music, dance and drama club to enable them carry out HIV/AIDS sensitisation. Its potential in the fight against HIV/AIDS is high.
- Provide technical support to the HIV/AIDS drama club in form of an external trainer to guide the club and introduce new techniques and better methods of conveying HIV/AIDS messages.
- Provide the HIV/AIDS drama club with equipment and materials such as costumes.
- Encourage new clients with talents to join the music, dance and drama club to provide new impetus and to replace the club members who have passed away.
- Radio messages and jingles need to be redesigned regularly to reduce monotony that could lead to poor listenership.
- The program should develop HIV/AIDS materials targeting children out of school and community members.

□ **Income Generating Activities (IGAs)**

- The program should consider exploring the services of a competent micro-finance institution to take over the functions of the IGAs.
- The program should train the beneficiaries in financial management, record keeping and business management before accessing funds for IGAs.
- Strengthen the management of IGAs by designating a staff with relevant qualifications in micro projects management to coordinate and provide support to IGAs beneficiaries.
- Ensure that technical support to clients implementing IGAs is given. This could be done by enlisting the services of technical personnel at specific intervals to provide on spot project technical advice to the beneficiaries.
- Work out a transparent and clear procedure for appraising and selection of projects/beneficiaries, especially with school support, in order to cope with the huge number of applicants, and reduce unnecessary complaints from clients.

□ **Resource Mobilisation and Finance Management**

- SFHCS should intensify resource mobilisation both internally and externally. This should involve all the key stakeholders such as the management board and heads of departments.
- Elton John AIDS Foundation should as a matter of urgency consider an exit funding program that will enable the program to continue with its operations until another source of funding is obtained. The exit plan should run for at least 18 months
- Maintain the financial management system which has been put in place by support of Development Cooperation Ireland because of its inherent mechanism for budgetary control and simplicity in use.
- On the basis of the existing financial policy of the program, develop a financial manual which should be flexible enough to accommodate both the program and donor financial policies.

□ **Monitoring**

- Strengthen monitoring of program activities by developing report formats for staff and community volunteers. The quantitative data provided in the reports should be substantiated by descriptive data. In addition, regular meetings between staff and field volunteers need to be intensified as fora for sharing experiences, reviewing objectives and plans, and solving problems.
- Document new experiences and ensure that these and annual reports are shared with a wider audience of stakeholders.
- The building of office premises is a good project in the right direction, as it will not only save money for office accommodation, but also generate money for the program through hiring of conference facilities to the public. Therefore, program donors and friends need to support the program to complete this noble project.

SECTION I

PROJECT BACKGROUND

1.1 Introduction

St. Francis Health Care Services (SFHCS) began its response to the HIV/AIDS epidemic in 1998 by offering medical and nursing care as well as counselling to HIV/AIDS patients. The program has since evolved into a more holistic project responding to many problems confronted by indigent HIV/AIDS infected and affected individuals and households in Mukono, Jinja Municipal Council and Jinja District. The program now provides a package of services that include priority issues of national interest in the fight against HIV/AIDS such as: Medical and nursing care (both at the clinic and home settings); a range of counselling services that cater for the emotional and spiritual health of clients and their families; strengthening of community capacities to respond to HIV/AIDS; educational support to orphans; income generating activities targeting needy widows and foster families; and HIV/AIDS sensitisation and voluntary counselling and testing.

Since 2001, a number of donors including Elton John AIDS Foundation, Firelight Foundation, Development Cooperation Ireland, Mercury Phoenix Trust and several others, provided support to the program for the implementation of its projects for three years. SFHCS completed the three-year funding cycle in August 2004. This report documents the findings of the final evaluation exercise carried out on the program following the end of the three-year implementation phase.

1.2 Location Description

The program originally intended to serve people in Njeru Town Council and Wakiso sub-county in Mukono District. However, due to lack of effective HIV/AIDS prevention and care services in the neighbouring areas, the program is currently serving people from Kayunga, Mukono, Jinja, Mayuge and Iganga districts. Also, patients seeking confidential service have shunned similar services offered by providers in their home areas and instead access them from the program clinic.

For its field activities and outreach services, the program has concentrated on Mukono and Jinja districts, and Jinja Municipal Council where majority of the PHAs reside.

1.3 Program Design

1.3.1 Overview

The project was designed to address HIV/AIDS through an integrated system combining conventional health care, home-based care and community based care.

1.3.2 Overall Goal

To preserve as well as improve the dignity, quality of life, and holistic well-being of HIV/AIDS infected individuals, their families, and communities.

1.3.3 Objectives

1. Prevention of sexual transmission of HIV/AIDS.
2. Mitigation of the community and personal impact of HIV/AIDS.
3. To strengthen and better manage HIV/AIDS prevention and care program.

1.3.4 Target Population

The project targets clients, orphans, and clients' family members.

1.3.5 Key Interventions and Strategies

- 1) Increase and maintain the enrolment of 600 HIV/AIDS orphans and vulnerable children in schools and vocational training:
 - a) Support orphans in primary school; and
 - b) Support orphans in vocational training.
- 2) Create a community care and support structure within the program catchment area:
 - a) Client volunteers;
 - b) PHAs; and
 - c) Family Caregivers.
- 3) Provide high quality medical care, nursing as well as counselling and referral services to clients sick with HIV/AIDS and their families:
 - a) Treat and nurse clients at the centre, at the outreach and at Home;
 - b) Provide referral services to clients who cannot be handled at the program clinic; and
 - c) Counsel clients at the centre, outreach and at home.
- 4) Increase the income of 300 poor households affected and infected with HIV/AIDS:
 - a) Select needy households to receive income generating activity support;
 - b) Train household members in business and technical skills; and
 - c) Provide trained members with funds to start own chosen project.
- 5) Provide an HIV/AIDS education and sensitisation package to orphans and vulnerable children, youths, registered clients and the general public:

Through HIV/AIDS drama, radio jingles and talk shows, distribution of reading materials and workshops and seminars.

1.4 Terms of Reference for the Final Evaluation

Objectives of the evaluation

- To assess the achievements of the program from the objectives and benchmarks as set out in the project document.
- To review the relevance of current activities.
- To provide an insight into the impact of the project on targeted beneficiaries.
- To point out the major problems and constraints that the project has faced during the implementation phase.
- To assess the sustainability potential of the project.
- To make recommendations about how the project could be improved.

1.5 Outputs

- a) Two hard copies of a three-year evaluation report.
- b) One soft copy of a three-year evaluation report.

SECTION II METHODOLOGY

2.1 Overview

In order to fulfil the terms of reference and satisfy the specific issues of concern for the program evaluation, Centre for African Development Initiatives (CADI) employed methods that were found to be most suitable. These included: A detailed review and synthesis of principal documents and other relevant literature to the project since its inception; extensive informal and formal discussions with the key implementers and partner organisations, and focus group discussions with beneficiaries (clients and orphans) and family caregivers to clients, as follows:

2.2 Key Respondents

Key respondents were identified and data was collected from them. These included: Board members, program staff, beneficiaries (clients, orphans, and clients' families); representatives of the donors; program partners; and program voluntary workers.

2.3 Sampling

At the program management level, three members of the Board were interviewed. At the program implementation level the program co-ordinator, the administrator and all heads of departments were interviewed individually.

Sampling also included HIV/AIDS patients (clients) receiving care from the program, and affected members of the family receiving care from the community level of the project. These included indigent orphans and caregivers. The evaluation team also consulted representatives of the main donors, Elton John AIDS Foundation, Cooperation Development Ireland, and Firelight Foundation, partners of the program such as Lugazi Catholic Diocese, TASO, AIC, Local Governments and schools training orphans. In addition, sampling included volunteers associated with the program. The samples were purposively selected and interviewed in places convenient for them.

2.4 Data Collection

A wide range of data collection techniques were used to ensure comprehensiveness, validity and reliability (for triangulation purposes). Among the techniques employed on this assignment were the following:

2.4.1 Review of Secondary Data

CADI devoted the initial period of the assignment to reviewing all existing literature at the program office. These included the strategic plan, project proposals, progressive and annual reports, and the mid-term review report. This helped the evaluation team

to capture and isolate key issues and components of the program on which they could focus during evaluation.

2.4.2 Preparatory Meetings

There were a series of preparatory meetings between the evaluation team and the program officials to discuss terms of reference, harmonise the understanding of the task, and refine the methodology and work plan. These meetings were also used to define co-ordination mechanisms during the assignment, and to other levels of the project, like community members and beneficiaries, explain about the evaluation.

2.4.3 Focus Group Discussions

Focus group discussions were held mainly at the beneficiary level. Five group discussions were held with clients who included: those receiving care from the clinic at the centre and out-reach stations; benefiting orphans in the schools in the sample; members of the AIDS drama club; and community counselling aides (CCAs).

2.4.4 Observation

The consultants' team carried out an on-spot observation of activities in progress, and on project facilities both at the centre and outreach station. These included: Treatment/examination rooms, VCT sessions and AIDS drama performances in progress at Kirugu village, counselling rooms and homes of HIV/AIDS bedridden patients, to establish the conditions prevailing and the effectiveness of the approach and activities taking place.

2.5 Data Analysis

Data analysis and field reports were progressively compiled basing on the expected outcomes and the overall purpose of the evaluation. This ensured that information gaps were identified and dealt with while still in the field. Most of the information collected was qualitative in nature. The evaluation team, therefore, employed qualitative methods of analysis and where appropriate, quantified some results to highlight their importance.

2.6 The Evaluation Team

The evaluation was conducted by Emmanuel Musoke Muyiyya, a development management consultant, and Richard Bwanika Kizito, a co-consultant from the Centre for African Development Initiatives (CADI). The two consultants have vast experience in the management and evaluation of HIV/AIDS projects and organisational development in Africa.

SECTION III EVALUATION FINDINGS

3.1 Introduction

This section provides the major evaluation findings. The findings are divided into five sections, namely: **A review of program objectives and achievements; program sustainability; program development and management; program impact on target beneficiaries; and program challenges, constraints and recommendations.**

The achievements, challenges, gaps and recommendations will be presented and discussed simultaneously in the sections that follow.

3.2 Orphans and Vulnerable Children (OVC)

In 2003, with financial support from Elton John AIDS Foundation, the program started the OVC project, whose main goal was to support families of HIV/AIDS orphans to address their problems adequately. In order to achieve the project goal, the following objectives were set: To support 600 orphans in primary schools and 50 in senior secondary schools; to increase access to medical care for orphans and their care takers; to extend counselling services to orphans; provide vocational skills to orphans out of school; and to provide up to 200 HIV/AIDS affected families with income-generating activities.

3.2.1 School Support

A needs assessment carried out in 2002 by SFHCS revealed a high number of orphans were no longer attending school. All homes visited had at least one child in this category. The project set out to increase and maintain the enrolment of 600 indigent HIV/AIDS orphans in primary schools and 50 in senior secondary schools for one year.

The project supported 612 and 105 orphans in primary and senior secondary schools, respectively. The package covered school fees (especially for senior secondary school students), and scholastic materials. Orphans were enrolled in both private and government schools mainly near their homes, because of the physical health of their ill parents.

The Universal Primary Education (UPE) program by the government of Uganda does provide tuition for all pupils. However, the pupils are required to procure their own books, lunch, uniform and stationery. An interview with the schoolteachers revealed that considerable support had been provided to the beneficiaries by the programme. This included school fees and scholastic materials such as books, uniform, stockings, school bags, sweaters, pens, toilet paper, brooms, reams of paper (especially for PLE candidates), geometry sets and shoes.

The orphans reported that they had benefited a lot with assistance from the program. They also reported that they were not sent home for school fees, uniform, or any other scholastic needs during the year of support. The support ensured constant attendance for orphans throughout the year.

3.2.2 Challenges

Project duration: The school support component was for one year and as a result most of the vulnerable children who benefited from it are stranded. In addition, the program did not state clearly to the beneficiaries at the beginning of the support that the assistance was to be for one year. This has not only raised their expectations but also many schools are waiting for school fees payment from the program for this financial year. In the absence of clear communication from the program on the position of the orphans' school sponsorship, the reputation of the program is at risk.

Needs of the girl-child: The program did not make budget provisions to address specific needs of maturing girls at school, which are crucial for their performance, and confidence at school. These include, sanitary towels, knickers and petticoats. It was established that some girls are forced to stay at home until some of these problems are over.

Selection criteria: The selection of orphans and other vulnerable children who benefited from the project was entrusted to a committee, which was composed of both program staff and members of the board. The committee received applications, assessed them and selected the beneficiaries. At some stage, the committee ignored the use of a selection criteria which could give priority to the most vulnerable children and limit school support to a limited number of children as outlined in the OVC project document. In addition, the selection process ignored the organisation's community structures such as community counselling aides and committees and counsellors, who know better their clients. Consequently, some indigent orphans were left out of the project

Monitoring: There was no effective monitoring system set in place to follow up the progress of the school support and to ensure that orphans are studying well, have scholastic materials, attend school and that the right beneficiaries were targeted. As a result, when the program later embarked on a monitoring exercise, it established the following: 102 pupils had dropped out of school without informing the program; 4 pupils died but the school authorities continued to receive school dues from the program; five students got scholarships but did not inform the program; three students changed schools without informing the program; and three senior secondary students absconded and the program was not notified.

Communication: There was no clear communication between the program and the parents and guardians of the orphans, as to what period the program was going to provide financial support to orphans. In addition, the school administrations did not also receive clear communication as to when the school support would end. Consequently, the consultant team established from the head teachers that all the schools are expecting the program to support the orphans this financial year; yet the sponsorship was for one year.

3.2.3 Recommendations

Concentration of support to a few institutions: The program was supporting orphans in 75 schools. In order to streamline the monitoring and co-ordination of beneficiary orphans, program staff suggested the idea of identifying few schools in different program areas on which to focus for orphans who are schooling. It was also suggested that beneficiaries should be encouraged to progressively report to the program.

Guardian participation: Sensitisation workshops should also be organised for caretakers and guardians of orphans to make them aware of their responsibilities in supporting the orphans. They should also appreciate the fact that the program does not relieve them of their parental responsibility but rather complements their efforts.

Monitoring: School administrators felt that it is important for SFHCS to participate in Parents and Teachers Association (PTA) meetings so as to be able to appreciate the problems facing both the schools and orphans. In addition, they suggested that there is need for more interaction between them and the managers of the program.

Co-ordination: SFHCS should step up the follow-up of orphans at school to at least three times a term. There is need to create more rapport between SFHCS, the orphans and the school authorities. The social workers need to look at the children's books, give them parental advice and also listen to them. School authorities also need to be in closer contact with SFHCS, most especially on disciplinary issues concerning orphans.

Textbooks: Although 50 children received textbooks, courtesy of Lugazi Catholic Diocese, there are specific textbooks needed at school and not provided by government e.g. *Nile English Course* (P.5 – P.7), and *Baraza of Social Sciences* (P.5 - P.7), which could be bought by SFHCS and given to the orphans to increase their opportunities of performing better.

Project duration: SFHCS need to discuss with her donors the urgent need of continuing with the school support component of OVC for at least three years. It does not serve the purpose of providing school support for one year and thereafter abandoning the orphans.

3.3 Counselling Services to Orphans

The major objective was to improve access of orphans to counseling services to enable them cope with their needs and situations. In order to provide counseling to orphans, the program trained two staff in child counseling so as to provide counseling to children.

Shadow Idol 'Mulengera' club is the major avenue for orphans and vulnerable children counselling. It was conceived after the realisation that vulnerable orphans lack career guidance and that they lack guidance from close relatives when their parents die. Shadow Idol aims at helping vulnerable and orphaned children to

envision what each wishes to be in future, in order to direct specific zeal to specific professional ‘dream careers’.

The program invites professionals to talk to children during school holidays, on what is required for one to join a specific profession. The professional who gives the talk becomes the ‘Shadow Idol’ for some younger person who admires them. The program envisaged arranging for these young people visits to their ‘Shadow Idols’ at their place of work. At the time of evaluation, however, only six professionals had visited the orphans and the program had not arranged for the orphans to visit their Shadow Idols.

Meetings for club members are organised on every Saturday for day students at SFHCS Day Care Centre. The following activities are conducted: Music, dance and drama, relating to HIV/AIDS and STDs; reproductive health services; counselling individual children; indoor games and reminding them of Firelight Calendar themes.

Shadow Idol Club members identified the following benefits from the club:

- Orphans received career guidance from professionals visiting the club.
- Drama has lifted the talent of club members to perform on stage.
- The club has enabled orphans and vulnerable children to live positively like other people, and helped them to learn to share with friends i.e. on Christmas day, they share the little available with friends.
- Receive free medical treatment from the program clinic and program outreach medical services.
- Receive education support such as school fees.
- Behavioural change.

The club experiences the following problems:

- Lack of adequate training materials for music dance and drama performances.
- Several members of the club do not attend training sessions regularly due to school programs that run on Saturdays, while other members stay far from the centre and others are required by their guardians to stay at home and do housework. Besides, absenteeism on the part of members makes the work of the trainer quite difficult because every Saturday a different group is trained.
- Some club members are indisciplined and do not respect the trainer. This was attributed to poor upbringing and lack of parental care for orphans and vulnerable children.
- Late coming. Some members report late for club activities. They come when sessions are about to end. This is because some of them go to gardens and school before they report for Saturday club activities.
- Lack of recording materials for original compositions.
- Lack of sports equipments at the centre for the young. These include but not limited to balls, nets and indoor games.

3.4 Medical and Nursing Care

3.4.1 Overview

The program provided high quality direct medical care, nursing, counselling and referral services to 3347 clients with HIV/AIDS and their families, in the three year period (Oct. 2000 – Sept 2003). These services are provided for both at the centre and in the 16-outreach stations and at the household levels. At the centre, medical and nursing care is provided every day of the week and Mondays, Thursdays, and Fridays are reserved for home visits and care. The project has been having a medical staff of 2 program doctors, 2 clinical officers and 4 nurses. This team is supported by an elaborate community structure of client volunteers.

Apart from treatment, the medical department provides home care and makes visits to sick clients' homes; registration of new clients; training of family carers of clients at home, and supervision of client volunteers.

The common diseases reported and treated at the program clinic include: Malaria, fever, diarrhoea, skin diseases, TB and cough, and there is an increasing number of patients suffering from cryptococcal meningitis. Many clients reported that skin rash infections have proved resistant to most of the drugs.

The program's efforts have led to an improvement in the general well being of clients, especially by reducing pain, and common opportunistic infections. Patients now live positive healthier lives. All clients interviewed by the consultant find the treatment and drugs given to them satisfactory in terms of quality and quantity. It is only the supply of expensive and critically needed drugs, especially ARVs which is inadequate due to supply and financial constraints. The program, has however, been able to secure ARVs treatment for 6 clients and 4 children, courtesy of Lugazi Catholic Diocese and Jinja Hospital. Following is an observation made by a client, on medical services provided by the program:

"I was on my deathbed by the time I reported to the program but now there is a big difference at no cost." Client Kalagala.

It was reported that because of the good quality of treatment, patients are not reluctant to pay user fees imposed by the program as noted below:

"We pay UShs 1000 as user charge but it does not matter because what we get is worth much more," a client remarked.

Trained volunteers have boosted the work of trained medical workers especially in penetrating the community, and in identifying new clients and ensuring that clients access assistance in a timely manner. As a result, more clients have been able to access the services. The stigma is steadily being overcome and more people are coming out for VCT. Consequently, better hygiene and feeding of clients has been realised in the homes of clients.

Other achievements realised by the program include the attainment of health centre III status which means that it can provide a wide range of services to clients and open opportunities for accessing government medical support. In addition, the program clinic is now fully accredited with Uganda Catholic Medical Bureau (UCMB). Under this arrangement, the UCMB will provide drugs, furnish the clinic and provide

training opportunities to medical staff. The program also works closely with Nagalama Hospital to provide referral services to program clients.

The program is, in addition, providing resting beds for patients who are seriously ill and cannot go home immediately after receiving treatment. This was attributed to a large office space attained after the program acquired new office premises

3.4.2 Challenges

Inadequate support to caregivers: There is need for increased attention to the training of family members to care for sick PHAs. The training of family caregivers includes, knowledge in first aid, treatment, hygiene, nutrition and patient care, care-giving, nursing, feeding, identifying problems of patients and management of drugs.

Further challenges include inadequate medical and laboratory equipment for both diagnosis and examination of patients.

The staffing levels for the medical component is relatively low especially for senior personnel. Whereas the program has two medical doctors and two clinical officers, only one clinical officer is full-time. The two doctors and one clinical officer are part-time staff, working only three days a week (one doctor and some clinical officers were laid off in the course of conducting the evaluation). This was attributed to lack of funds to keep them on a full-time basis

Patients are increasingly demanding for ARVs and material support, in addition to common medical treatment of the opportunistic infections. The program is providing ARVs to only ten clients courtesy of assistance from Lugazi Catholic Diocese and Jinja government hospital. In the community, clients' dependants and siblings also demand for treatment from the program medical teams doing home visits. These demands are more than what was anticipated. Patients tend to come into the program very ill, and expect emergency treatment. There is also an increasing number of patients especially from outside the program catchment area. Besides that, program staff are not protected against infections like TB.

User fees: The program levies a token fee of UShs 1000 on each client accessing medical treatment. However, a few clients reported that they find it difficult to raise money for the user fees. They also reported that the program allows them to receive treatment even when they fail to raise money for user fees, and pay when they get it. However, this may reduce access to medical treatment of PHAs as they may fear to report back before clearing outstanding debts. The program counsellors explained that there is an arrangement in place to assess clients who can afford and those who may not afford to pay the user fees.

3.4.3 Recommendations

1. Embark on the sensitisation of caregivers about the need to bring clients in good time and not to wait until they are seriously sick.
2. The program should link with other key stakeholders to advocate for the government to avail ARVs to poor PHAs.

3. Provide training to caregivers who look after sick PHAs. The training of family caregivers should include: Knowledge in first aid, treatment, hygiene, nutrition and patient care, care-giving, nursing, feeding, identifying problems of patients and management of drugs.
4. Provide refresher training for medical staff to enable them cope with the changes in the management of opportunistic infections and the administration of ARVs.

3.5 Counselling

3.5.1 Overview

The program provides counselling services to its clients. The different types of counselling services provided by the program include: Pre-test counselling, post-test counselling, supportive counselling (ongoing), family therapy, group counselling and pastoral care. Of these, pre-testing and supportive counselling are the most commonly done. Many clients seek the pre-test because they need more information before the test and clients also normally access counselling when they come for treatment. In addition, the program now provides specialised paediatric counselling. This has been possible due to the successful training of two staff in child counselling. This is designed to cater for children although many times involves the parents or guardians for the sake of the children being counselled. Child sessions are normally organised on Saturdays as part of the Shadow Idol Club activities. This also reveals that parents are now being open with their children.

The program has five counsellors and all of them have received training in counselling. They are supported by a pool of community-based counsellors commonly known as community counselling aides (CCAs). However, the commitment of CCAs is declining steadily due to lack of satisfactory incentives. The provision of bicycles to CCAs which marked the end of a monthly allowance of twenty thousand shillings did not motivate them as expected. The number of counsellors is, therefore, considerably small compared to the huge number of clients.

Community volunteers and members of staff reported that counselling has reduced the stigma and promoted positive living especially among PHAs. This is evident in the increasing utilisation of counselling services. The program is witnessing many cases of married couples coming in together for HIV/AIDS testing and counselling.

Many clients gave testimony as to the benefits of counselling. Most outstanding were the following:

“My husband who was also a client here died and he was the bread winner. I actually thought that I was just waiting for my death. It was counselling from St. Francis that opened a new window in my life”. I am now working to support my family.” **A widow client in Buzika.**

3.5.2 Challenges

Exposure to infection: Counsellors are exposed to TB in counselling rooms because of their proximity to clients. The program has no provision for chemoprophylaxis.

Shortage of counsellors: The number of counsellors is very small as compared to the number of clients. Most times there is a shortage of personnel to provide counselling as nurses/counsellors are busy with the medical teams. For instance, a first contact counsellor is supposed to be the client's regular counsellor. But it is not always possible for the counsellor to be consistent. Sometimes a client reports for counselling and his/her first contact counsellor is absent on other duties. This at times leads to frustrations on both sides.

3.5.3 Voluntary Counselling and Testing

The program provides Voluntary Counselling and Testing (VCT) at both the centre and in the community. Between January 2003 and May 2004, 3486 persons received VCT services. At the centre each person seeking to be tested is charged US\$ 2000 while those tested from community or outreach stations are not required to pay. Prior to the community visits, community mobilisation is carried out by CCAs. This is followed by mobile teams on motorcycles and vehicles announcing the availability of VCT services in their community using a public address system.

At community level, voluntary counselling and testing is done simultaneously with music dance and drama performed by the program drama team. The drama, music and songs provide messages on the importance of HIV/AIDS testing and prevention, care for PHAs, positive living and dangers of discrimination and stigmatisation of PHAs. Those willing to go for testing seek counselling services from counsellors and after brief counselling, they are tested and results are given to them on the spot. It was further established that those tested positively are requested to register with SFHCS to receive ongoing counselling and treatment of opportunistic infections. Other services provided include distribution of condoms to those tested.

Challenges

The time available for pre-testing counselling at community VCT sites appears not to be enough, given the high number of people turning up to be tested, and may create more psychological problems for those tested.

3.5.4 Recommendations

Provide ample time for pre-testing counselling so that the clients fully understand and appreciate the implications of establishing their sero status in order for them to be able to manage both the excitement and sorrow associated with negative and positive results, respectively.

3.6 Income Generating Activities

3.6.1 Overview

The program has extended support to 233 clients in the form of grants to start or consolidate their income-generating projects. The grant size ranges from UShs 50,000 (\$25) to UShs 300,000 (\$150). Most of the beneficiaries invested in small projects such as poultry, piggery, retailing (kiosks), goat and cow rearing, and crop production. SFHCS clients and members of National Association of Women Living with HIV/AIDS (NACWOLA) are the beneficiaries of the IGAs scheme. The selection process involves submitting applications and filling in assessment forms from SFHCS. On receiving the application, an inspection team composed of program staff is dispatched to the homes of applicants to ascertain whether they will be in position to manage the IGA applied for. Most of the beneficiaries of this scheme were not selected using business criteria but on the basis of one's need and level of destituteness.

However, there was no technical project appraisal conducted to determine the viability of the project, and selected beneficiaries were not trained in project identification and basic record keeping before receiving the money.

Besides that, the income generation scheme is run by a client volunteer, Mrs Monica Isingoma, who lacks a micro enterprise development and business training background to mentor the beneficiaries. Apart from participating in beneficiary assessment and processing of grants, she has hardly carried out any field visits and follow-ups to supervise clients' projects, and so far no effort has been made to co-opt a technical person to undertake the supervision of the projects; Mrs Isingoma is overstretched in supervising so many projects.

Most of the clients interviewed, however, revealed that they have benefited from the funded IGAs. They were reported to have paid school fees for their children, built houses or paid house rent, paid user fees when visiting the program clinic, were in position to save some money, and could afford decent meals, while others reported that the IGAs had helped them to reduce on stress and worries because they are kept busy.

It was not possible to fully evaluate the success of IGAs basing on economic indicators, because non-economic indicators were preferred. Therefore, success was not measured entirely on profits generated by the projects. However, the practice of diverting money meant for IGAs was reported as common. Some clients used the money they received for the IGA to pay for school fees, thereby encroaching on their working capital.

3.6.2 Challenges

1. Lack of technical capacity to manage micro enterprises. The scheme is managed by a volunteer who does not have skills and experience in micro enterprise management.

2. Lack of technical support to IGAs leading to poor performance of IGAs. The most affected projects are those on crop production where some farmers made no use of high yielding seeds, while others did not take into account market considerations before investing and consequently found problems in marketing their produce. There was also extended drought during the period under review, which reduced farm output.
3. Most of the beneficiaries of IGAs complained that the grant size was too small to make any business sense.
4. Many beneficiaries lack business management skills and the program made no effort to train them.
5. Chronic sickness and death of beneficiaries has also affected the operation of IGAs. Deteriorating health leads to failure to operate the business venture and consequently diverting capital resources to manage the illness; diversion of capital towards medical expenses is very common.
6. Diversion of money meant for IGAs towards social activities. It was reported that some clients after diverting or squandering project funds stay away from accessing medical care and treatment in order to avoid answering questions. This creates a dilemma for the clients between seeking medical care and avoiding IGA queries.

3.6.3 Recommendations

1. The program needs to explore the possibility of contracting out IGAs to competent micro finance institutions. Contracting out should be done in such a way as to promote client's welfare and should not expose beneficiaries to exploitative tendencies, which are characteristic of some micro finance institutions in Uganda.
2. The program should train the beneficiaries before accessing funds for IGAs, in financial management, record keeping and business management.
3. Strengthen the management of IGAs by designating staff with relevant qualifications in micro projects management, to coordinate and provide support to IGAs beneficiaries
4. Ensure that technical support to clients implementing IGAs is given. This could be done by enlisting the services of technical personnel on specified intervals to provide on spot project technical advice to the beneficiaries.

3.7 HIV/AIDS Sensitisation

3.7.1 Overview

HIV/AIDS prevention is one of the cardinal objectives of SFHCS. It has been promoted through music, dance and drama, radio messages, radio talk shows, distribution of condoms, and through workshops and seminars

□ HIV/AIDS Drama

The program set up a music, dance and drama club composed of PHAs with a view of sensitising the community on HIV/AIDS. The club is made up of 32 members and has performed HIV/AIDS music, dance and drama shows in the program area and during public HIV/AIDS celebrations. The shows carry messages on how HIV/AIDS is transmitted, how it can be prevented, about care for PHAs, and about the importance of VCT and positive living by PHAs. Many clients said that they were encouraged by the HIV/AIDS dramas to seek VCT services.

However, the HIV/AIDS music, dance and drama club is experiencing many challenges which have seriously affected the quality of its performances. Some of the challenges include, death of key members of the club, lack of costumes and lack of effective leadership. In addition, club members attributed the decline in the quality of their performances on the absence of an external trainer to provide technical advice and instructions necessary for the club to maintain high standards. It was also reported by the club members that time for preparation and rehearsals of performances is not adequate, as observed below:

“We only prepare for about thirty minutes before we set off to the community to stage our shows which normally commence at 10.00 a.m.” a Drama Club member remarked.

□ Radio Program

Radio talk shows on local FM stations are one of the major ways the program embarked on sensitising the public. Radio talk shows discuss topical issues on HIV/AIDS counselling and transmission, condom use, positive living, care for PHAs, support to orphans and protection of the rights of widows and orphans. The talk shows begin by a presentation of the topic by a team of program staff or Shadow Idol Club children, for a few minutes, and is followed by questions from listeners who call in at the station, and the program team answers the questions. A random survey by community members in the program area revealed that many people listen to this radio program and find it easy to follow, and have learned a lot from the questions raised by listeners. However, poor members of the community without access to telephone facilities complained that they are unable to raise burning issues on HIV/AIDS to the panel.

In addition, the program designed HIV/AIDS messages, which are broadcast on FM radio stations at regular intervals. Community members consulted also observed that radio jingles serve as a constant reminder to the public that HIV/AIDS is still a real threat to the community.

“You see, sometimes we relax and think that HIV/AIDS is no longer a problem. But when you switch on the radio a louder message on the disease leaves no doubt that many people are still being infected. Normally the message is not only a reminder but sends a deeper fear.”

Shop attendant, Mbikko

□ **Distribution of HIV/AIDS Materials**

The program runs a school HIV/AIDS sensitisation program involving mainly the distribution of pamphlets and magazines specifically designed for young people. The program is collaborating with the Straight Talk Foundation that provides over 1000 copies of the magazine per month for distribution in both primary and senior secondary schools. The magazines are *Young Talk* and *Straight Talk* for primary and secondary schools respectively.

3.7.2 Challenges

The major challenge facing the program is lack of tailored HIV/AIDS materials for children out of school and members of the community.

3.7.3 Recommendations

1. Although the program has made efforts to adjust the messages to be in line with the World AIDS Theme Campaign, radio messages and jingles need be upgraded regularly to reduce monotony that could lead to poor listenership.
2. The program should develop HIV/AIDS materials targeting children out of school and community members
3. There is need to provide technical support to the HIV/AIDS drama club in form of an external trainer to guide the club and provide new techniques and better methods of conveying HIV/AIDS messages.
4. There is also need to provide the HIV/AIDS drama club with equipment and materials such as costumes.
5. New clients with talents should be encouraged to join the music, dance and drama club to provide new impetus and to replace the club members who have passed away.

3.8 Management

3.8.1 Program Management

St. Francis Health Care Service is a Non-governmental Organisation (NGO) whose overall management authority is the management board. There is a new board in place, which was democratically elected by the general assembly of SFHCS members in November 2003. The new board represents the diverse interests of stakeholders and exhibits a high level of interest and willingness to promote the cause of people infected and affected by HIV/AIDS. It is made up of people who have experience in NGOs management in general and HIV/AIDS programs, and volunteer staff members were withdrawn from the board to guarantee separation of roles.

The Program has a team of 28 voluntary staff and is headed by the program co-ordinator who is assisted by the administrator, program accountant and heads of departments, namely: Counselling, medical/nursing, orphans and vulnerable children (OVC).

To ensure effective implementation of program decisions, a management team was set-up. It comprises of the program co-ordinator, administrator, accountant and heads of departments. The management team holds monthly meetings to assess the implementation of program activities. The functionality of the management committee, however, needs further strengthening in the areas of, ensuring participation by clients' representatives, whose input is invaluable in making informed decisions; timing of the meetings; and preparation of agenda.

However, owing to anticipated resource flow constraints, especially following the departure of the major program donor, Elton John AIDS Foundation, the program has reduced the size of its workforce by 11 staff, including, the administrator, one clinical officer, two nursing assistants, one secretary, two guards, a laboratory assistant and one part-time doctor. Consequently, the management structures and systems of the program were re-organised and streamlined in 2001. This resulted into the development of new job descriptions and contracts for all volunteer staff, and in the recruitment of additional staff. The additional staff include: A program accountant, social workers in charge of OVC, a part time doctor, a clinical officer and a counsellor. Prior to staff recruitment, there were hardly any considerations into establishing optimum staffing levels for the program. The program was consequently compelled, within a short period, to reduce the size of its staff. By the time of this evaluation, however, most of the staff contracts had expired and were awaiting renewal.

3.8.2 Challenges

Office space: The program acquired new and larger sufficient office space in 2003. The premises, however, require serious renovation, which has not been done by the landlord. Also, following the withdrawal of major program donors, it may be difficult for the program to raise funds for office rent.

As a way of addressing the perennial problem of office rent, the program acquired land in Njeru Town Council and is in the process of developing it into its permanent home. The progress is, however, slow owing to lack of funds.

Internal Communication: Intercommunication within the project is ripe for improvement. The secretary and other staff have to constantly move from their desks to communicate, thereby creating unnecessary interruptions during work hours, and noise as a result of numerous movements.

Assets and Office Equipment: The program has three vehicles. However, one of the vehicles (a pick up) is old and has become expensive to maintain. While the ambulance lacks a four-wheel facility, rendering it ineffective to transport sick clients during rainy seasons. Also, though the existing equipment and assets appear to be well maintained, the program does not have adequate basic equipment such as computers and furniture. There is also over reliance on motor vehicles for movement,

which at times proves to be expensive and not suitable for certain small assignments; the program does not have motorcycles.

3.8.3 Recommendation

Strengthen the program management committee by promoting the participation of clients' representatives in the program, and improving agenda setting for the committee meetings.

3.9 Linkages with the community

3.9.1 Overview

The program established a network of client volunteers. The total number of Client Volunteers as of August 2003 is 60 but only 20 are active. The majority of these volunteers are living positively with HIV/AIDS as shown in **Table 1** below.

Table 1: Number of Client Volunteers

Category	Number
Male	22
Female	38
Total	60

Source: SFHCS Progressive Report, 2004.

The procedure of recruiting client volunteers for the program involves calling on interested clients to volunteer to do program work on a voluntary basis. Interested clients subsequently register with the program. The registered clients are invited to an introductory workshop for sensitisation on voluntary work. After sensitisation, clients decide whether they are still interested. Consequently, the program trains them for one week and passes them out.

The criteria for selection requires one to have an interest in care and management of PHAs. Volunteers are subsequently prepared for their roles through an initial training of one week. Topics covered in this course include: Basic facts on HIV/AIDS, caring for patients at home, basic counselling skills, and basic record keeping. After training, the client volunteer has to introduce him/herself to the community leaders in his/her parish. Refresher courses are organised annually (except for 2004), on similar topics for the volunteers.

Volunteers are a great asset to the program and their roles include: Home visiting to provide primary health care to clients; assisting the sick, especially those living alone, to prepare food and to clean them; counselling patients; peer support of fellow clients like fetching medical teams for the bed-ridden; identification of new clients to go for help; encouraging people to go for VCT; orientating caregivers in the family to look after HIV/AIDS patients; and training clients and caregivers on good nutrition and its importance.

According to the organisational set up, the CCAs have zone chairmen and a counsellor is assigned to a particular zone. However, discussions with CCAs established that there is no elaborate supervision and mentoring plan for CCAs. Apart

from the program coordinator, there are no staff responsible for evaluating their needs (including training needs); training them; monitoring their the work and ensuring that volunteers have necessary equipment and logistics. The monthly allowance of US\$ 20,000 which used to work as a motivating factor was abolished in 2003 when new bicycles were given to them by the program. The program, therefore, needs to maintain the vigour exhibited by a few active councillors who have provided the project with a frontline cadre of health workers in the community. Many of them have the confidence of the community and are role models for many new clients as observed below:

“Many members of the community have come up for VCT as a result of our work.”
Client Volunteer Naminya.

3.9.2 Challenges

Unmanageable demands and expectations: The family of clients (and sometimes clients themselves), expect more than the volunteer or even program can provide as observed in the following volunteer testimony:

“Clients die and the family invites us to take up responsibility for the funeral and orphans.” **CCA Buzika.**

“Sometimes we get clients seeking material help from us and we don’t have it. They claim we have embezzled assistance meant for them.” **CCA Njeru.**

Exposure to infections: Another prohibitive factor is the apparent risk of infection the volunteers face during the execution of their duties as observed by one volunteer:

“We are not protected against TB exposure and we are continually interfacing at a close range with patients who cough a lot”. **Volunteer at Centre.**

3.9.3 Recommendations

1. The program should reconsider reducing the number of CCAs to a manageable level and to pay them a monthly allowance. It is also necessary to get rid of non-performers and replace them with new ones who can perform.
2. Involve community leaders in the selection of volunteers. Community volunteers were selected from active clients who demonstrated organisational and leadership skills. They represent their communities but were not endorsed by the community. The program should involve the community in the identification of client volunteers in order to make them more community-oriented and in order for them to be owned by the community.
3. Equip client volunteers with protective clothing (raincoats, gumboots and an umbrella), to protect them from harsh weather conditions.
4. Train CCAs in the handling of class C drugs and to be equipped with drug kits, which include, panadol, aspirin, chloroquine, amodium, ORS, bandages, cotton wool, mackintosh gloves and soap. This will go a long way to alleviate PHAs

suffering from minor illnesses and save time and money for the program (when the medical team has to travel to the field for minor cases).

3.10 Financial Management

The major sources of program funds are Elton John Foundation, Development Cooperation Ireland, and Firelight Foundation. The program has also received support from other sources both local and international including individual personalities. These funds are kept on four separate accounts which include: Elton John AIDS Foundation and Firelight Foundation, Development Cooperation Ireland, and the Medical Private Scheme accounts, as well as the Pool Account for funds sourced from elsewhere.

There are other local sources of funds for the project, but which are insufficient to cover the program costs. These include: User fees of US\$ 1000 charged on every client accessing treatment from the program clinic days, and the medical fees charged to members of the public receiving medical treatment from the program clinic. Njeru town council and the districts of Mukono and Jinja also contributed some funds towards the program after realising the great contribution St Francis Health Care Services is doing towards PHAs.

Table 2: Financial support to SFHCS in the three years 2001-2003

Donors	Years		
	2001	2002	2003
External donors			
1. Elton John AIDS Foundation	232,369,580	14,174,589	153,570,990
2. Development Cooperation Ireland			100,416,638
3. Fire Light Foundation	17,734,460	27,038,900	7,824,246
4. Sisters of Holy cross	850,000		950,000
5. Samaritan Purse	8,000,000		
6. Sale of Salon Car	1,700,000		
7. Mukono District AIDS Project		360,000	1,415,380
8. Mercury Phonex Trust			16,375,000
9. Global Strategies for HIV		5,229,900	
10. Burther Foundation			11,832,000
11. Jinja District AIDS Project			1,860,000
12. Tides Foundation			20,723,690
13. Njeru Town Council			
14. Pan African Youth Alliance			
15. Lugazi Diocese			
16. Maria			750,000
17. Rev. Fr. Mcdemott CSC			1,948,000
18. User Charge	3,723,310	7,682,500	14,103,950
19. CIDA			
20. Interest on Fixed Deposit		5,874,463	
Total	264,376,350	64,880,352	331,769,894

Source: SFHCS 2004.

Table 2 above shows that availability of program funds initially was uneven. The year 2002 witnessed an insignificant flow of funds, which led to a decline in service delivery and demoralisation of staff, while some staff and volunteers joined other organisations. The availability of funds improved in the year 2003 following an intervention by Elton John AIDS Foundation and Development Cooperation Ireland. This led to improved service delivery.

Funding from Development Cooperation Ireland was preceded by staff capacity building in financial management. This has gone a long way in strengthening the financial management system of the program. SFHCS is now adopting the finance management system introduced by Development Cooperation Ireland because of its simple accountability, vote monitoring and budgetary controls. The internal financial control system of the program for requisitioning, processing and effecting payment, financial reporting and accountability were consequently found to be functioning well. This is partly owed to the continuous technical support by Development Cooperation Ireland, competent accounts staff, and the involvement of board members in financial decisions on expenditure.

However, the consultants' team established that there is a delay in the release of funds by the donors, which affects smooth service delivery and the morale of volunteer staff.

In addition, the program was faced with a serious financial crisis after the Elton John AIDS Foundation ended her three-year funding of the program. Apart from the major program activities, the Foundation had been funding the program's overhead costs such as staff salaries. Therefore, her withdrawal may led to the closure of the program. Consequently, the program adopted coping mechanisms, which included laying off eleven staff volunteers.

Besides that, the second major donor for the program, Development Cooperation Ireland, is unfortunately not prepared to cater for the payment of staff salaries. While the exit strategy which was proposed and funded by Elton John AIDS Foundation did not work out. It involved the hiring of an international fundraiser to raise money for the program. The fundraiser was recruited but left as soon as she was hired.

3.10.1 Financial Manual

The program has a financial policy in place, which broadly outlines the program's financial management system. The financial policy, however, needs to be operationalised by a financial manual detailing the project financial procedures and rules. The accounts section is undertaking the responsibility of doing this and it is hoped the financial manual will be operational in the 1st quarter of the next project cycle.

3.10.2 Audits

The program has had regular audits since its inception six years ago, and these include all the program accounts in its annual audit exercise. Regular auditing is a good practice that fosters adherence to financial and accounting regulations.

3.10.3 Facilities Management

The program has acquired assets over the past years, notably among them are, three vehicles, computers, and laboratory equipment. All the assets have been put to good use and in executing the activities of the organisation. However, due to rough roads and frequent field travel by the mobile medical teams, most of the vehicles have depreciated and require replacement.

In addition, the program embarked on building its own office premises as a way of reducing expenses on rent for office accommodation. The building project reached the foundation stage and stopped due to lack of money. The funds for the project were obtained majorly from user fees and the private scheme for non-clients utilising the program clinic.

3.10.4 Recommendations

1. The Elton John AIDS Foundation needs to reconsider setting-up an effective exit strategy that will involve funding of the program for at least one additional year while the services of another fundraiser are being sought. This will allow the program either to discuss with its partners the possibilities of funding overhead costs or securing new donors.
2. Develop a financial manual, which should be flexible enough to accommodate both the program and donor financial policies.
3. Embark on a resource mobilisation strategy that will target both domestic and external resources.
4. The building of office premises is a good project in the right direction as it will not only save money for office accommodation, but also generate money for the program through hiring of conference facilities to the public. Therefore, program donors need to support the program in order for it to be completed.
5. Mobilise funds to purchase new vehicles and motorcycles for effective fieldwork.

3.11 Human Resource Management

3.11.1 Staffing

The program has 28 staff (the ongoing reduction is reducing them to 18). These include: A program co-ordinator, assistant program co-ordinator, accountant, cashier, clinical officer, doctor, nurses, social workers, secretary, drivers and cleaners. A team of client volunteers supports them. However, the volunteers are no longer active due to poor motivation and lack of incentives.

3.11.2 Personnel Records and Performance Appraisal

The program has no staff designated to manage the human resource. The program coordinator keeps the personnel files, and these files appear not to be continuously updated and lack key documents such as academic certificates, personal data, and

disciplinary letters. Staff performance appraisals are carried out though there isn't any evidence that performance appraisal results are used for staff training or allocation of responsibilities.

3.11.3 Capacity Building

The care and management of people living with HIV/AIDS is a dynamic area, which requires continuous training, learning and sharing of information on new drugs and prescription, diagnosis and management of opportunistic infections. Training and refresher courses were organised internally for volunteers and a few staff have attended training in child counselling and project monitoring. The program coordinator attended training in the areas of HIV/AIDS administration and management, organisational development, and gender and environment mainstreaming. Training needs, however, still exist especially in the areas of record keeping, report writing, project monitoring, computer skills and human resource management. Unfortunately, the program is ill equipped to finance these training needs.

3.11.4 Staff Welfare

Salary levels for program staff are low as compared to other similar non-governmental organisations in Uganda, although they are comparable to those of civil servants. There are no other benefits for the staff apart from medical treatment for volunteer staff and their families.

Besides that, the welfare of program field volunteers has remained poor despite their invaluable contribution to the program. They neither receive salary nor field allowance. There is an urgent need, therefore, to review the welfare of volunteers given the fact that volunteerism is a delicate and active service that needs to be nursed and nurtured.

3.11.5 Recommendations

1. The program needs to reconsider designating the human resource management function of the program to the program administrator who should liaise with the program coordinator.
2. There is also need to develop a capacity building plan and allocate adequate funds to address the program's staff training needs.
3. There is further urgent need to improve on staff welfare and to harmonise benefits among different categories of staff and field volunteers.
4. Key program staff such as the program coordinator, administrator, accountant and heads of departments should be employed on a full-time basis rather than on volunteer terms. This will ensure a well-motivated, responsible and accountable program leadership.

3.12 Program Development

3.12.1 Overview

The administrator is responsible for program development. He has been involved particularly in project proposal formulation and fundraising. However, there has been lack of participation of the beneficiary communities and other staff members in these activities. Program volunteers expressed the desire to be involved in developing project proposals. In fact, some members have written proposals under the Community-led HIV/AIDS Initiative (CHAI), which were funded. The situation has been exacerbated by the absence of a strategic plan to guide program development.

3.12.2 Scaling Up

As noted earlier, the number of clients reporting for services is growing every day; there is an increasing number of clients coming from outside the program catchments area. This has led the program to consider options for scaling up program activities outside the present operation area. Scaling up program activities requires additional financial, human and physical resources, which the program seems not to have at the moment. Besides, the program has not been able to address fully the needs of those affected by HIV/AIDS such as orphans and widows, yet their numbers are also increasing.

In view of the above, it appears rational for the program to concentrate its core services within its catchment area and strengthen its service delivery. However, considerations can be made to extend crosscutting services such as HIV/AIDS music, dance and drama, radio jingles and talk shows beyond the current catchment area and continue to provide counselling and medical treatment to PHAs reporting to the program clinics from outside the catchment area.

3.12.3 Recommendations

1. Involve beneficiaries and staff volunteers in program development schemes.
2. The program should focus on strengthening service delivery in the current area of operation and in addressing unmet needs of clients.

3.13 Management of Data

3.13.1 Overview

Efforts were made after the 2001 evaluation, to improve on data management. Consequently, three computers were purchased and, clients' and orphans' particulars were fed into the computers. However, monitoring continues to pose a serious challenge to the program. There is no section in the program in charge of monitoring program activities and in ensuring that deviations from planned activities are corrected immediately. The program hardly hires trained staff in monitoring, and lack of computer skills has complicated attempts to put in place an effective database.

3.13.2 Recommendations

1. The administrator should be assigned the responsibility of co-ordinating program monitoring.
2. There is need to put in place equipment necessary for a modern management information system. The computer software should be upgraded if it is not feasible to procure new ones.

3.14 Collaborations

St. Francis Health Care Services works closely with NGOs, local governments, government, ministries and other home care programs in the implementation of its projects as shown in **Table 3** below.

Table 3: Collaborators and Areas of Collaboration

Name of Organisation	Areas of Collaboration
TASO	<ul style="list-style-type: none"> ▪ Staff training ▪ Joint planning
Mildmay	<ul style="list-style-type: none"> ▪ Staff training in Palliative Care and referrals
Lugazi Catholic Diocese	<ul style="list-style-type: none"> ▪ Information Exchange ▪ Training. ▪ Provision of medical equipment ▪ Quality control
Njeru Town Council	<ul style="list-style-type: none"> ▪ Provision of Land
Jinja District Directorate of Health Services	<ul style="list-style-type: none"> ▪ Provision of funds. ▪ Provision of ARVs to clients and to sick orphans
Mukono District Directorate of Health Services	<ul style="list-style-type: none"> ▪ Provision of funds
Straight Talk Foundation	<ul style="list-style-type: none"> ▪ Supply HIV/AIDS reading materials to youth and children
AIDS Information Centre (AIC)	<ul style="list-style-type: none"> ▪ Information Exchange ▪ Training in VCT ▪ Joint planning
MOH/UACP	<ul style="list-style-type: none"> ▪ Provides funds for client groups under CHAI Component.
Mukono Network of AIDS Service Organisation (a branch of UNASO)	<ul style="list-style-type: none"> ▪ Sharing of experience ▪ Facilitating national and international visitors. The program received visitors from Ethiopia, Eritria, Cambodia, Thailand and South Africa
UNAIDS	<ul style="list-style-type: none"> ▪ Provision of resource Materials ▪ Recommendations for funding
NACWOLA	<ul style="list-style-type: none"> ▪ Information sharing ▪ Technical Assistance in IGAs

It should be noted, however, that the existing channels of collaboration between SFHCS and other partner organisations has not included significant areas like joint development of training materials, advocacy and networking.

3.15 Summary of Unmet Needs

3.15.1 Education needs

Many clients are finding it difficult to meet school requirements for their children. The school support program was run for only one year.

3.15.2 Poor feeding

Guardians and sick parents find it difficult to buy food for themselves and the orphans because of lack of money. Schoolteachers reported that many orphans report to school when they are hungry. The current food supplementation program targets only a few people.

3.15.3 Essential necessities

Orphans lack essential necessities such as clothes, soap and beddings.

3.15.4 Secondary education

There are many orphans who cannot afford paying school fees in secondary school.

3.15.5 Vocational training

The need for vocational training is enormous given the fact that the program did not cater for vocational training, yet the number of orphans dropping out of school in primary is big.

3.15.6 Support to volunteers

In order to effectively play their role, community volunteers such as CCAs need facilitation and motivation.

3.15.7 Drugs

Some drugs are inaccessible yet they are essential for the treatment of opportunistic infections. These include, but are not limited to anti-retrovirals (ARVs).

3.15.8 Business skills

The business skills of the beneficiaries of IGAs are far from sufficient to enable beneficiaries initiate and manage micro enterprises. This stems from the lack of technical expertise in the management of micro enterprises and inadequate training of beneficiaries of IGAs.

3.15.9 IGAs support

The number of beneficiaries of the IGAs is very negligible yet the demand for IGAs is high. Most of the program clients are genuinely needy and destitute. Therefore, 233 projects for 3434 households are not sufficient to make an impact, especially since the support is benevolent.

3.16 Sustainability

3.16.1 Resource Mobilisation

The program is dependent on donor funding. However, to date, the program has not succeeded in finding new donors. As noted earlier, the major donor withdrew on 31st March 2004, and there is no elaborate strategy in place to mobilise local resources. This is partly attributed to the helplessness of the clients and the biting poverty in the community. In addition, the attempt to use an international fundraiser has not yielded tangible results as the program lost contact with the fundraiser who had been recruited.

3.16.2 Community Participation

The sustainability of the program will heavily depend on the existence of a sound community structure. The program established a network of volunteers and trained them to address the problems of PHAs. However, the community volunteers are still viewed by the community as SFHCS representatives. There has not been serious effort to link the volunteers to the community. The network is, therefore still weak.

The volunteers' work has also been weakened by lack of incentives in form of monthly allowances and regular training. The community HIV/AIDS committees which had been set up by government, so as to link government to the program have also collapsed owing to lack of support from government

Community participation is, in addition, likely to reduce operation costs of the program due to expenses that arise such as lunch allowances to field teams and purchase of fuel. However, with community participation, field co-ordination would be easier and certain functions such as counselling will be performed by community counselling aides. Community participation can also provide opportunities for tapping local resources, through community mobilisation. Above all, community members will learn not only to manage their own affairs, but also to link up with other service providers.

3.16.3 Collaboration

The program is collaborating with organisations providing HIV/AIDS services. As a sustainability strategy, therefore, the program has tried to develop partnerships with both local and international organisations that are providing services to PHAs, including advocacy. These include: Uganda Catholic Medical Bureau, Lugazi Diocese and Uganda National AIDS Support Organisations (UNASO). The program has, in addition, explored possibilities of collaborating with local councils (LCs), which has led to the securing of financial assistance from both Mukono and Jinja districts. Such

partnerships could lead into the integration of home care activities into local council development plans and budgets.

SECTION IV RECOMMENDATIONS

4.1 School Support

4.1.1 Concentration of support to a few institutions

To streamline the monitoring and co-ordination of beneficiary orphans' project staff suggested that a few schools and vocational training centres be identified in different program areas to focus on orphan schooling. It was further suggested that beneficiaries should be encouraged to progressively report to the program

4.1.2 Increased participation of guardians of orphans

Workshops should also be organised for caretakers and guardians of orphans to make them aware of their responsibilities in supporting the orphans.

4.1.3 Selection of Beneficiaries

The program should involve the community in the selection of orphans and other vulnerable children for school support. This will ensure that the most needy orphans receive support.

4.1.4 Monitoring

School administrators felt that it is important for SFHCS to participate in Parents and Teachers Association (PTA) meetings so as to be able to appreciate the problems facing both the schools and orphans.

4.1.5 Co-ordination

The program should step up follow-ups of orphans at school to at least three times a term. There is need to create more rapport between SFHCS and the orphans and school authorities. The social workers also need to look at the children's books, give them parental advice and also listen to them. School authorities, in addition, need to be in closer contact with the program management, most especially on disciplinary issues concerning the orphans.

4.1.6 Textbooks

There are specific textbooks needed at school and not provided for by government e.g. *Nile English Course* (P.5 – P.7), and *Baraza of Social Sciences* (P.5 -P.7), which could be bought by NHC and given to the orphans to increase their opportunities to perform better in school.

4.1.7 Training duration

The school support to orphans was for one academic year and has had made minimal contribution to the educational advancement of the beneficiaries. The program and the donors need to raise more money for school support; otherwise, programs such as the Shadow Idol will be rendered irrelevant since the children will not have realistic visions without education.

4.2 Community Structure

4.2.1 Strengthen the community structure

The program should involve the community in the identification of client volunteers in order to make them more community-oriented and in order to create a sense of community ownership.

4.2.2 Equip Client Volunteers

Provide training to field volunteers to be able to provide first aid care to clients before referring them to the program medical team and equip them with a drug kit. They should be able to administer class 'C' drugs, which include, panadol, aspirin, chloroquine, amodium and ORS. They should also be provided with protective clothing (raincoats, gumboots and an umbrellas), to protect them from harsh weather conditions.

4.2.3 Motivate volunteers

The program should reconsider reducing the number of CCAs to a manageable level and to pay them a monthly allowance. It is also necessary to get rid of non-performers and replace them with new ones who can perform.

4.2.4 HIV/AIDS Sensitisation

1. There is need to increase budgetary provisions to the HIV/AIDS music, dance and drama club in order to enable them carry out HIV/AIDS sensitisation. The club has a high potential in the fight against HIV/AIDS.
2. Radio messages and jingoes need to be re-designed regularly to reduce monotony that could result into poor listenership.
3. The program should develop HIV/AIDS materials targeting children out of school and community members.
4. There is also need to provide technical support to the HIV/AIDS drama club in the form of an external trainer to guide the club and introduce new techniques and better methods of conveying HIV/AIDS messages.
5. There is further need to provide the HIV/AIDS drama club with equipment and materials such as costumes.

6. In addition, there is need to encourage new clients with talents to join the HIV/AIDS music, dance and drama club, to provide renewed impetus and to replace the club members who have passed away.

4.3 Medical and Nursing

1. Caregivers need to be sensitised about the need to bring clients to the program in good time and not to wait until they are seriously sick.
2. The program should link up with other key stakeholders to advocate for the government to avail ARVs to poor PHAs.
3. There is need to provide training to caregivers who look after sick PHAs. The Training for family caregivers needs to include, knowledge in first aid, treatment, hygiene, nutrition and patient care, care giving, nursing, feeding, identifying problems of patients and management of drugs.
4. There is also need to provide refresher training for medical staff to enable them cope with the changes in the management of opportunistic infections and the administration of ARVs

4.4 Voluntary Counselling and Testing

1. Provide ample time for pre-testing counselling so that the clients fully understand and appreciate the implications of establishing their sero status so that they are able to manage both the excitement and sorrow associated with negative and positive results, respectively.

4.5 Finance Management

1. There is need to maintain the financial management system built by support from Development Cooperation Ireland, because it has an inherent mechanism for budgetary control and is simple to use.
2. On the basis of the existing financial policy of the program, develop a financial manual, which should be flexible enough to accommodate both the program and donor financial policies.
3. Embark on a resource mobilisation strategy that should target both domestic and external resources. The strategy should involve the management board and all heads of department in fundraising activities.
4. Make a follow-up on the fundraiser and appoint a new one in case the efforts to trace the first one fails.
5. Elton John AIDS Foundation needs to consider setting-up an effective exit strategy that will involve funding of the program for at least one additional year while the services of a new fundraiser are being sought. This will also allow the program to either to discuss with its partners the possibilities of funding overhead costs or securing new donors.

6. The building of office premises is a good project in the right direction as it will not only save money for office accommodation, but will also generate money for the program through hire of conference facilities to the public. Therefore, program donors and friends need to support the program to complete this noble project.
7. Mobilise funds to purchase new vehicles and motorcycles for effective fieldwork.

4.6 Income Generating Activities

1. The program needs to explore the possibility of contracting out the IGAs to competent micro finance institutions.
2. The program should train the beneficiaries in financial management, record keeping and business management before accessing funds for IGAs.
3. Strengthen the management of IGAs by designating staff with relevant qualifications in micro projects management to coordinate and provide support to IGAs beneficiaries.
4. Ensure that technical support to clients implementing IGAs is given. This could be done by enlisting the services of technical personnel at specific intervals in order to provide on spot project technical advice to the beneficiaries.

4.7 Institutional Development

1. Strengthen the program management committee by promoting the participation of clients' representatives and improving agenda setting for the meeting.

4.8 Program Development

1. Involve heads of departments and program beneficiaries in program development schemes.
2. The program should strengthen service delivery in the current area of operation and in addressing the unmet needs of clients.

4.9 Monitoring

1. The Administrator should be assigned the responsibility of co-ordinating program monitoring.
2. Put in place equipment necessary for a modern management information system. Upgrade the computers if it is not feasible to procure new ones.

4.10 Staffing

1. Provide appointment to key staff on a full time basis.