

KAMWOKYA CHRISTIAN CARING COMMUNITY
MID-TERM REVIEW OF THE PSYCHOSOCIAL PROGRAMME

Executive Summary

KCCC has completed the period of implementation (2004 – 2006). KCCC psychosocial programme has had its major focus areas;

- Primary health care (VCT, immunization and dental health inclusive)
- Vocational and practical life skills development
- Orphans and vulnerable children support
- Community Based Health Care
- Street children prevention and youth activities
- Social and Gender activities (with a bias to Income generating)

New programme components initiated during review period;

- ART (initiated to scale up above programme build up)
- Community mental health

The report presents the mid term review of KCCC performance in order to re-cast its next phase of implementation. This review aimed at (i) assessing KCCC's implementation performance after 2 years and (ii) drawing lessons of what worked and what failed in order to inform the implementation of the future. Herein performance measure was based on an assessment of relevance, effectiveness, efficiency, sustainability and impact for which specific indicators were developed (at the commencement of these programmes). Lessons learning therefore consisted of an in – depth understanding of the process/strategies employed in KCCC implementation.

The Review Process and Methodology

The review process started with a process of reviewing the available written progressive reports about the past implementation operations which was followed by a stakeholders' forum of KCCC partners focusing on implementation and the results there presented by primary implementers. The review team designed different independent and participatory tools to collect data. 150 questionnaires to PLHAs were administered. Seven (7) focus group discussions were held with; PLHAs and general clients, post test club members, peer educators, SACCO empowerment beneficiaries, children guardians and community leaders. Key informant interviews were conducted among 10 purposively sampled people comprising of PLHAs, social workers/counselors, development workers, KCCC partners, police, and school administration. These mixed approach to data collection aimed at triangulating the findings.

Summary Findings

a) Relevance

From the literature review it was evident that KCCC programmes relevance fits within, broader programme objectives developed but also (rhymed well with the 4 key organizational strategic objectives). Implementation design responded to community needs and also integrated best practices were upheld in the community interventions. Established local change agents have reinforced community participation and appreciation of the programme.

b) Effectiveness

Overall KCCC programmes are being effectively implemented. Most planned activities were accomplished, timely and in most cases targets were surpassed (Ref PHC programmes). In instances where accomplishments were never realized or not done on time, the following reasons stood; late disbursement of funds, particular insistence on specific dates for implementation (Youth awareness activities mostly done during holiday seasons). For programmes with no attained targets, the team noted ineffective mobilization as the primary cause (Voc training, FAL and Intern Voc targets). But overall services with strict user fee requirements (VCT), non – attainment of targets was largely attributed to lack of user fees and inadequacy of VCT services (e.g. in outreaches).

c) Efficiency

With approximate budget of 3.5 billion shilling KCCC is functionally regarded as efficient. It's estimated that the gross efficiency and operational efficiency (with approx constant budget allocations) has risen from (approx 25,000 primary and secondary beneficiaries to 35,000 people) over the period under review (Ref Audit reports). During the implementation of year (2004) activities 42.1% and 67.5% gross and operational efficiency were attained respectively which once compared to the plan indicated a considerable level of resource utilization efficiency. More utilization efficiency was attained in (sensitization on HIV/AIDs and treatment and care of PLHAs and training of volunteers, funds trained more people).

d) Sustainability

Attempts have been made to establish adequate and relevant local structures. Basic functional skills in project management, home care, psychosocial counseling and peer – to – peer relation have been provided to them (SBCC, Child care advocates, Peer educators (more recently CBVs). These structures are

optimally functional and very effective (Ref ART success). They are operating with minimal supervision and financial support. They have set their own local leadership structures (youth management committee), yet they are committed and continue to deliver services to the community. However, the negative development about those structures is that while the new ones come with more vigour, old ones have not stood the test of time (SBCCs). They have been surpassed by new ones (peer educators and CHWs). New ones have more organizational capacity than the old ones.

e) Most significant impacts

From both the review and the subsequent interviews it became pertinent that KCCC interventions caused the following changes in the lives of the people or community

i) Knowledge about HIV/AIDS

Although almost all respondents had heard of HIV/AIDS through friends, radios and newspapers or other forms/mediums of communication (churches or public gatherings), KCCC beneficiaries (in catchment areas) have had 100% comprehensive knowledge about AIDS compared to non-beneficiaries.

ii) Stigma and Discrimination reduction

High levels of stigma and discrimination have over time been the biggest impediments or obstacle to the fight of HIV/AIDS. The review team noted with resounding surprise the level of appreciation (openness). Ideally, over 42.1% recognize that it's not only important to take VCT, but also helping people presumed infected with HIV/AIDS. This presents a big leap from the early years (period) when AIDS was considered a dirty disease and many shunned it.

Majority now recognize its presence amidst the community and are willing to fight it.

iii) Positive Practices to prevent /Mitigate HIV/AIDs

The changes noted (i) and (ii) above triggered positive practices that catalyze reduction of exposure to infection, stigmatization and increases social safety nets for mitigating the effects of HIV/AIDs. The review notes that people have high core competence knowledge on HIV/AIDs (not necessarily risk takers) than non-beneficiaries. Some reported changes among beneficiaries in the catchment area are as hereunder;

- Open discussion (open testimonies) before 2004 was a rare occurrence (actually those who dared mere named "heroes"). The silence today has been broken.
- Positive attitudes towards health seeking behaviors (this have diverse implications, ushering of more better treatment products (ARVs), numbers of infected people rising against constant treatment centres (e.g. KCCC). This is not the case with the male gender.
- The community is also shunning away from certain cultural practices that promote HIV/AIDS(e.g. sharing sharp objects, wife inheritance)
- Traditional healers have also adopted practices that prevent predisposition to HIV/AIDs infection and are referring some clients for counseling/treatment
- Trained community health workers (CHWs) are practicing and delivering safe HIV/AIDs messages and are acting as a super referral factors (SPFs).

Advisory services on health, sanitation and nutrition have been noted widely.

- More and more people have developed a high willingness to test (in 2004, 1,561 people registered for VCT as compared to 1, 863 in 2005) registering a 20%) in just over 12 months.
- PLWAs are shunning stigmatization as they are able to openly declare their status and associate with the wider community. 4 post test clubs have been established within a period of 24 months to this effect (Lungujja Kitunzi, Mengo – Kisenyi, Namugongo and Bukoto).
- Increased collective community responses to fight against HIV/AIDs by supporting people affected and infected by HIV/AIDs. Orphans and vulnerable children and PLHAs have been the prime beneficiaries.

f) Community assessment of KCCC

KCCC is considered by all respondents in the programme area to have impacted greatly in the areas of; Increasing AIDs awareness, catalyst in mitigating pain among PLHAs, orphans/street children prevention and a social support agency. Surprisingly though many people still view KCCC as a mere “Relief” agency. Many did not think or even thought about KCCC as a resource in forwarding their advocacy agenda programmes.

g) Resource leverage

KCCC's progress has been registered in part due to support from; similar partner NGOs, activeness of PLHAs, network of trained volunteers, home grown

committed staff and the deep rooted linkages (the organizations) has with the surrounding people (within the catchment area)

h) Achievements over the period

- improved care and support in scope and quality
- accelerated HIV/AIDs prevention measures
- community empowerment

i) KCCC challenges

The implementation of KCCC is also faced with a number of challenges such as; extreme poverty in the community, gender issues(imbalance with reference to patriarchy society), isolation of HIV/AIDs as only a medical issues(at community level), limited access to treatment (ARVs), VCT not yet at optimum levels, stigma and discrimination taking another form etc.

j) lessons learnt

In this period (2 years), we have been able to learn the following;

- Attitudinal change in (reference) to what is perceived of HIV/AIDs cannot change with verbal communication/interpersonal alone
- social categorization is a basis for effective communication for social change as it allows on learning
- A coordinated multi – sectoral approach enhances quality assurance, resource efficiency, and accountability and registers multiple results.
- Effective community empowerment occurs when they are involved in the entire project cycle so that they are able to own the entire project as theirs.
- local Capacity building is basis for sustainability

- HIV/AIDs is broader than just a medical problem and not a unilateral health challenge
- Participatory monitoring integrates beneficiaries knowledge and practices with all other social sectors affecting their lives such as poverty and way of lives.
- Change as a process takes time. It takes time for people to openly declare their sero status. Testing services alone is not enough but regular rapport building with the community increases the chance of trust upon which individual to individual counseling starts bear impact on people's responses to VCT.

k) Recommendations

In this regard, given the challenges and lessons learnt, it is important that at KCCC project level;

- Routine home care services be replanned at dept level
- Basic dental health sensitization and education be incorporated in the KCCC community based health care manual
- KCCC needs to strengthen its partnership with other NGOs to improve care and support for children living with HIV/AIDs
- KCCC needs to increase collaborative relationships with other players such as traditional healers
- Strengthening outreach centers to increase clientele and continuum of care.
- KCCC HIV/AIDs prevention (especially) among young people be more action – oriented (use drama, role playing) be adopted in HIV/AIDs sensitization as opposed to seminar/ w/shops.
- Youth programmes need to adopt and initiate working integral linkages with other youth programmes in the area

- Voc training programmes need to strength follow up mechanisms for beneficiaries in their homes
- Voc training need to adopt a more commercial approach by introducing more short marketable trades at the centre
- Children welfare programmes should be redesigned to reflect all development aspects of children
- KCCC develops a staff development plan/policy to organize its human resource capacities

ACRONYMS

CRS	-	Catholic Relief Services
CBO	-	Community-Based Organization
KACHEPA	-	Kamwokya Community Health and Environment Protection Association
KCCC	-	Kamwokya Christian Caring Community
KICHWA	-	Kisenyi III Community Health Workers' Association
MIP	-	Mentally III Persons
MKYDA	-	Mengo Kisenyi Youth Development Association
PHC	-	Primary Health Care
PLHAs	-	People Living with HIV/AIDS
TB	-	Tuberculosis
TLC	-	Treasure Life Centre
TDH	-	Terres Des Homes
DR	-	Doctor
SR	-	Sister
KVTC	-	Kamwokya Christian Caring Community Vocational Training Centre
OVCS	-	Orphans and Vulnerable Children
FAL	-	Functional Adult Literacy

List of Tables and Figures

1.0 Introduction

KCCC has completed the period under review (2004 – 2006) in its primary catchment areas and beyond. This psychosocial programme had the strategic objective of mitigating the effects of AIDS in the slums of Kamwokya. As a management function, periodic and routine programme reviews are undertaken to feed the learning process into the future for better results or performance. It's by far important to undertake periodic review exercise to refocus and reconstruct programme objectives for clarity.

This internal review is therefore primarily concerned with what has transpired during the implementation of this psychosocial programme among the beneficiaries. The review report is divided into seven parts. It starts with an overview of KCCC background and origin and derives into the objectives and process of the review. Performance measure using selected indicators are presented in part three. Part four places the impact created by KCCC Intervention within a wider context appreciating the inter – linkages the programme has with other institutions. The challenges affecting progress of work is presented in part five. Part six presents the lessons learnt this far. In the last part recommendations are provided.

2.0 KCCC Background and Focus

Established in 1997, KCCC grew out the psychosocial economic impact of HIV/AIDS on Kamwokya community. Through voluntary efforts of small basic Christian communities locally known as “Bubondo” there arose a concerted resistance to HIV/AIDS pandemic despite their low-income status or low resource environment. The support program focused on HIV/AIDS related concerns and challenges in the slums of Kamwokya and its neighborhood.

The initial support program provided information on HIV/AIDS, counseling, relief supplies, medical care and attention to PLHAS and their dependants including children orphaned by the disease.

Drawing from lessons about its holistic nature, KCCC pschosocial support programme has therefore attracted small and big funding grants/donations in contribution to the overall programme build up. The period under review therefore has had; Scottish Catholic International Aid Fund (SCIAF), Catholic Relief Services (CRS), Caritas Switzerland/Luxemborg and agencies contribution to the same programme.

Thus KCCC has main streamed and linked the above factors in the holistic HIV/AIDS care to alleviate its psychosocial impact among the affected people. KCCC thus employs a holistic social service provision as a strategy to encourage community involvement, participation and contribution through such interventions;

- Medical care & support to PLHAs including V.C.T
- Community based health care & environmental
- Support to Orphan and vulnerable children infected/ affected by Aids.
- Women education and empowerment initiatives

- Youth-to-Youth programmes including Vocational & life skills development
- Elderly support programmes
- Functional adult literacy

With this programme, the overall goal of the program has been to improve the existing community structures and networks in Kamwokya II parish and its surrounding areas in order to mitigate the medical, psychosocial, economic, and physical effects of Aids.

To guide this pschosocial programme, KCCC drew its overall strategic plan with four key strategic objectives;

- Empowering of the community to access social services promotion of spiritual and human values for the most disadvantaged and vulnerable groups.
- Enhancing community capacity to deliver social services to the beneficiaries.
- Putting in place manageable sustainable and accessible communication system.
- Enhancing the existing base for sustainability, consolidation and development of programme benefits.

To fulfill, guide and review programme implementation to facilitate learning experience, a mid – term review exercise has been carried out to asses the performance of the implementation process in view of the program objectives.

3.0 The drive for and Process of the Review

3.1 The Driving Force

During this period of implementation, especially after registering a series of best practices, a number of operational issues surround the project context and its achievement. It's therefore, inevitable to ascertain how the programme is progressing and how those experiences can be relevant to the future. There is need to learn from the various strategies and outcomes so as to produce better results. Ideally in project contexts, certain targets would not be attained and the

set standards would not be realized 100% as planned. Set Indicators would realistically adjust to realism other than idealism – hence the need to review progress (inform the future)

3.2 The Review Objectives

The objectives of a programme review depend on its purpose. The following were the objectives of the review;

- To assess and review the progress made in view of the original objectives, whether still appropriate in light of the lessons learned during implementation (experience)
- To review the relevance and performance of activities carried out and identify what problems might have arisen and how they are being addressed.
- To generate recommendations on the way forward on the basis of findings mentioned in the review.

3.3 The Scope of the Review

In conducting the review, the agreed upon primary focus and scope of the work is summarized in the table below;

Table 1: Scope of work for the Review

Programme Relevance	<ul style="list-style-type: none"> • Programme rationale and context in view of beneficiary contribution to living conditions foregone • Changes to living standards/alternatives • Relevance of project intervention strategies with due attention to beneficiary participation in planning, implementation and M &E beneficiary satisfaction with intervention strategies or results
Programme Efficiency	<ul style="list-style-type: none"> • Cost utilization of resource vide budget and plan • Time management in project progress
Programme	<ul style="list-style-type: none"> • Programme and realization of set objectives in

Effectiveness	view of planned activities for the period under review
Programme sustainability	<ul style="list-style-type: none"> • The extent to which the programme will be becoming sustainable
Programme Impact	<ul style="list-style-type: none"> • The foreseen and unforeseen changes in the lives of programme beneficiaries
Lessons learnt	<ul style="list-style-type: none"> • Operational lessons related to the programme itself • Developmental lessons related to development process that can reference future need.

Finally it is expected that such an assessment should state the programme contextual and operational challenges and recommendations. This should be documented in a report that details all the above state and scope.

3.4 The Review Focus

In order to assess performance it is important to clarify what performance is in this case. Performance herein is taken to refer to the extent to which KCCC implementation is fulfilling the organizational objectives. Five facets as summarized in table 2 below were critically looked at to assess the objective realization and meet the scope of work indicated above.

Finally, lessons learning was based on an understanding of the process /strategies employed by KCCC implementation. Using plausible changes as pronounced by beneficiaries (primary and secondary) it became clear to the review team as to why certain changes occurred and what good practices are a must. The team endeavored to collect dependable information in relation to the major review focus areas by putting formed probe questions in relation to indicators justifying /reporting change.

Table 2: Key Performance Measure Questions

Performance focus	Key Questions	Indicators
Relevance	<ul style="list-style-type: none"> • Does the programme fit within the entire stakeholder diverse needs • What is stakeholder perception of the programme 	<ul style="list-style-type: none"> • Extent to which Prog meets stakeholder needs • Stakeholder satisfaction
Effectiveness	<ul style="list-style-type: none"> • Is the programme meeting set targets 	<ul style="list-style-type: none"> • Number of clients targeted Vis – vis reached
Efficiency	<ul style="list-style-type: none"> • Are financial resources used optimally in favor of benefits • what are comparative ratio of costs and outputs • Are services provided in time both in terms of programme execution 	<ul style="list-style-type: none"> • Size of dev't Vs recurrent budget • Cost per Client • Project activity, completion rates
Sustainability	<ul style="list-style-type: none"> • Are locally established 	<ul style="list-style-type: none"> • Org/finance viability of

	structures able to operate on their own (SBCCs) in short,medium and long term	structures(SBCCs, peer educators, CHWs)
Impact	<ul style="list-style-type: none"> • What are observable changes in beneficiary living conditions 	<ul style="list-style-type: none"> • Change in quality of life

3.5 Review Process and Methodology

This review was completed after a number of processes. The process started with a stakeholder forum which attracted (partners, staff, beneficiaries and volunteers). Presentations of progress reports were done by programme implementers and coordinators. A discussion session followed every report presentation giving opportunity to partners to closely take an analytical look at the results. Subsequent submissions were reflected upon by the review team. The team reached out to the outer programme beneficiaries through different ranges of tools. To generate data requisite to meeting above objectives a number of data collection methods were used namely;

Questionnaire – This tool targeted PLHAs and general clients administered by research assistants. This tool about from fetching demographic facts about the respondents, was also helpful in soliciting information on KAP on HIV/AIDs, strategic issues such as stigma and discrimination, coping mechanisms/capabilities, importance of positive living, the impact stigma and discrimination.

Focus Group Discussion (FGD) – FGDs were held with 10 – 12 people separately for different social categories (peer educators, SACCO beneficiaries, Post test club members, ART clients, PLHAs, OVCs guardians, local leaders etc). From these discussions, stakeholders views were sought regarding the programme, its contribution, impact, gaps and its sustainability opportunities.

Key Informant Interview (KIs) – KIs were conducted with 10 people comprising of KCCC partners, counselors, PLHAs, local leaders, Police, Religious leaders and teachers. From these interviews, views on change in the community, external influencing factors, best practices and comparative analysis (on cost effectiveness done by this tool)

3.6 Sample Selection

Two sampling methods were used in undertaking this review process. Random sampling technique was used to identify individuals for the questionnaire respondents. Attention was particularly given to people who are registered with KCCC clinic so as to get a spot on information by primary beneficiaries of the programme. Purposive sampling was also used to identify respondents of FGDs KIs because those instruments targeted those who are involved in the project implementation. These are respondents who were either directly involved in the execution of KCCC programme (and had views of the project and its results an “outsider observation”) and those who were the primary project beneficiaries (with “inside views “on what they are gaining and /or loosing from the project.

4.0 PERFORMANCE MEASURE

KCCC Programme implementation has been a joint effort between programme staff and a team of volunteers that are delivering services in the community.

KCCC pschosocial support programme mainly comprises of four specific programme areas; Primary health programme (HIV/AIDs clinic, laboratory services, Community based home care, HIV/AIDs counseling and Ant Retroviral Therapy (ART), Orphan and vulnerable support programe(practical and vocational training opportunities),Advocacy and community empowerment. This intervention has been largely comprised of medical and social progressive measures to prevention and control infectious diseases like TB and other diseases such as STDs and Malaria.

Treatment, Care and Support for individuals and families infected and affected by HIV/AIDS including provision of ARVs and spiritual support and counseling has formed the basic core intervention for KCCC pschosocial support programme. Disease diagnosis, Pastoral care, Paramedical services which include dental care, eye care(still in initiation stages), nutritional support, Home based care and outreach clinic services, Referral services in and out of station, Capacity building and empowerment of communities, and of recent integration of mental health services has taken centre stage during this scaling up

4.1 HIV/AIDS counseling, treatment and care services.

KCCC with its multi - sectoral approach to HIV/AIDS has continued to give, treatment, counseling, care and support services to its clients. The Primary Health Care unit has been bolstered with 2 more medical doctors, 6 more community nurses, pharmacist, drug dispenser, laboratory technician, 6 more counselors and 30 more community based volunteers (CBVs). With this strength we have reached out to 12,246 HIV/AIDS registered clients during the period under review (62% women: 34%men and 4% children below 12 years). Further more a total of 12,359 general clients sought medical attention for other ailments such as malaria/fever, chest complications, headache, skin rashes and diarrhea

at the same unit. The clinic registered 2,890 new HIV/AIDS clients during the period under review. The team noted that a good number of these clients are referred from other centres such as; Taso centres (from different parts of Uganda), AIC, Joint Clinic Research Centre (JCRC), Kampala private testing laboratories, Mulago/ Nsambya//Kibuli Hospitals and Traditional healers around Kamwokya.

During the period under review, the problem of TB especially among HIV/AIDS clients has become one of the most common opportunistic infection. Over this period a total of 347 (1.5 % of total client coverage of 24,605) clients were diagnosed with T.B (338 female: 472 male) and were subsequently administered on T.B therapy using the directly observed therapy (DOT) by the programme medical practitioners. Many of these clients have registered positive results at the end of the year. Drug adherence among most T.B clients has been hampered by their inability to provide for their nutritional requirements in the homes.

4.12 Immerging Issues among Clients on Therapy

- Drug default among clients has been largely as a result of inability to provide for nutritional requirements to counteract strong TB drugs.
- There has been little follow up on clients on therapy which perhaps explains why there is little record on clients ever administered on therapy. DOT approach has been a timely deterrent to this problem.

Testimonies still indicate many more are still hesitant to get on the drug regimes because of their uncertainty to provide for their own nutritional requirements.

The Primary Health Care team conducted 810 home visits involving over 1,000 clients and their carers.

The team noted that there were high enthusiasm about home care services among people who experienced the same. One participant noted that; this is no more

(We no longer have nurses and doctors visiting us in the homes, but we here they visit in other places may be they have forgotten us, Female participant, Kisalosalalo)

However it was noted individual home visitations were still conducted on a personal and compassionate basis were counselors were visiting clients more attached to them (clients attached to those counselors).

4.13 Dental services

Over this period dental health services have been offered at subsidized rates. The clinic attended to a total of 1973 (332 males: 559 females 1082 children) during the period. The dentist has also embarked on a program to educate clients attending other organizational services like nutritional free dental education to help protect children and adults from dental decay. There has been more children presenting dental problems than adults.

The survey concluded that there was still inadequate community sensitization especially among parents and guardians about how they can protect their children's dental health.

4.14 Out reach clinics

The bulk of KCCC clientele had been handled in the established 4 outreach clinics to decongest its clientele base at the main clinic. The established clinics are in Kyebando (Kawempe Division), Bukoto (Bukoto Sub - Parish), Mengo –

Kisenyi – St Balikuddembe Parish and more recently Lungujja – Kitunzi have reached out to 11, 424 (people for similar case for both HIV/AIDs registered and non – registered. They have provided and brought closer health services to the people around these places. Some outreach clinics have demonstrated progress in terms of coverage and more client contact. The outreach expressed some challenges in the view of getting empowered to handle the volume of work facing them. The following concerns were expressed;

4.15 Expressed concerns

- There has been inadequate supervision to some outreaches (Mengo – Kisenyi) which has affected services provision (decline in clientele)
- Management crisis would not be over looked in future as conflict of interest was visibly reported during the review exercise (leadership struggles)

Table 3: Summary Aggregate Coverage for the period under Review

Programme Area	Gender		Children		Total	% of Total
	M	F	M	F		
Registered (HIV/AIDs) Re-attendance	3711	8078	168	289	12246	18
General Clients (unknown HIV Status)	1938	4199	180	284	12359	20
New HIV Clients Registered	995	1840	28	33	2890	5
T.B	164	178	4	1	347	0.5
ART	282	631	2	2	917	1.5
Outreach Clinics (POS)	2626	3546	2303	2841	11424	18
Referrals to other Health Units	314	300	7	6	320	0.5

Dental Services	332	559	658	424	1973	3
Mental Health Services	79	96			175	.3
Immunisation	9	53	5624	7380	13017	22.7
Pschosocial Counseling	2210	3520	72	80	5882	9
Home care	292	421	46	51	810	1.3
Death	29	18	3		50	0.2
	GRAND TOTAL				62,410	100

4.16 Laboratory Tests

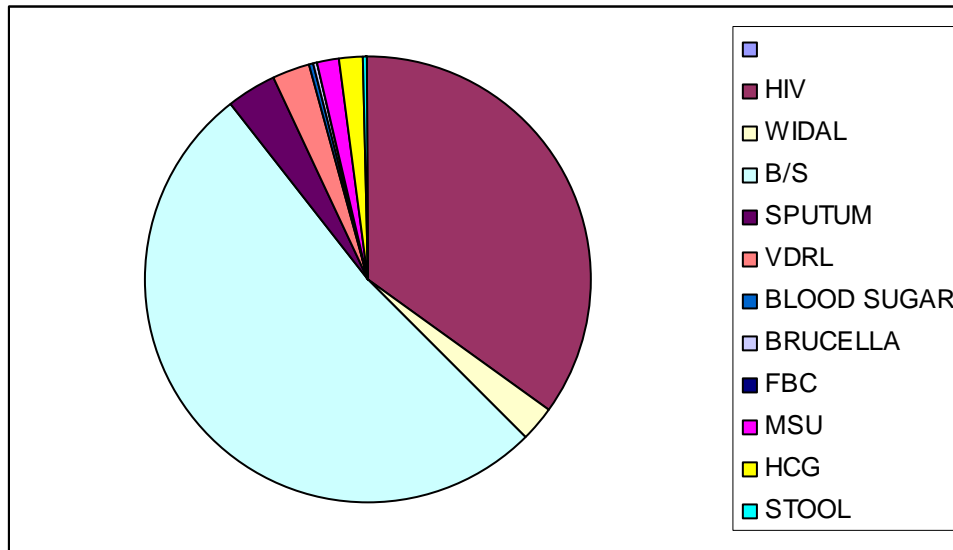
KCCC has further improved its health service provision with the extensive care and support to the general population in the catchment area. Disease diagnosis has been in the areas of HIV, Malaria, VDRL, Widal, Sputum, heamoglobin, Urine Sugar test, Cell Count, Film Comment, Blood Sugar, Blood Group, Brucella, Full Brood Count (FBC), Rh factor, Gyptocccocal, Knee Tap, MSU, HCG and Stool test were carried out. HIV and malaria are by far the highest tests carried out at the facility as indicated in table below.

Table 4: Laboratory tests for January - December 2004

Test	Positive	Negative	Total
HIV	2554	2389	4943
WIDAL	178	249	427
B/S	3772	4488	8260
SPUTUM	264	586	850
VDRL	213	435	648
BLOOD SUGAR	16	126	132
BRUCELLA	10	60	70
FBC	1	28	29
MSU	153	177	330
HCG	120	121	241

STOOL	17	54	71
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Fig 1: Tests comparisons for the period 2004- 2006



4.17 Pediatric counseling

Report presentations indicated an ever increasing numbers of children offered counseling services at the clinic. They indicated that children below 10 years were on the increase. Over this reporting period, in partnership with Mild may centre, the number of children infected with HIV/AIDs have risen from 61 before (2004) to 256 in (2006). Although there is still very minimal numbers of children tested for HIV, many guardians had requested for their testing. Although the mandatory age for testing young children is 5 years – it has become increasingly important to test children young than that to enable carers manage their health better. The organization still chances immense challenges in meeting medical needs of children below 12 years. Thus the organization is teaming with specialized institutions (Mild may centre) to supplement care and treatment appropriate to children living with AIDs.

However children faced with trauma, stigma, social discrimination and abandonment have been the centre of attraction to our orphan support team (OSTs) which include social workers, trained children care advocates/counselor and community leaders. The team noted significant inadequacies of aides such as (learning visuals like Dolls, story books, recreations) and other logistics used in individual and group counseling when dealing with children less than 12 years.

4.18 Ant Retroviral Therapy (ARVs) Intervention

Although this review will not look ink greater details the ART programme, its important to mention that the programme was adopted to focus on pro-longing lives, restoring hope and scaling up the wider psychosocial interventions to PLHAs. Simple basic criteria to select beneficiaries was: CD4 less than 250; Liver and kidney functional Test; clients willing to disclose to family members or spouse and clients being registered clients of KCCC. KCCC model of attaching ART clients to specific community based volunteers (CBVs) has been proven to be a highly effective application, which had tremendously reduced the gap between medical workers and clients themselves. Clients information flow and problems solving has significantly improved with the increase in clients/volunteer contact hours.

Table 5: ART coverage since inception

Cumulative	Total	Active patients	Total	% Of active patients
Females	631	Females	566	89%
Males	282	Males	244	86%
Girls	2	Girls	0	0
Boys	2	Boys	1	50 %
Total	917	Total	811	

While clients administered on therapy have demonstrated visible and tremendous improvement in their lives, some clients have been terminated from this therapy for reasons such as; self discontinuation, changed to another point of service point, change location therefore unable to adhere drugs, inability to cope with nutritional supplements/requirements and many others simply absconded from treatment.

TESTIMONY ONE,

Kawuki Douglas is 40 years old, married with 6 children and working as a tailor, he lives in Kikaya Zone in Kyebando II parish in Kawempe Division Kampala District. He has been in this profession for the past 18 years. His wife is also living with HIV/AIDs and a teacher by profession, has not been involved in any meaningful profession because she has had to remain at home nursing his husband who has been bedridden since December 2004. Douglas's monthly income of 400,000 which was enough to support his family seized the moment he got bedridden last year, because he could no longer cope with his job requirements.

When Douglas first came to register with KCCC in June 2004 under the HIV care, he was not only seriously ill but it actually appeared that his days were numbered on earth. No one could believe that he could ever support himself to his feet again. He had suffered from all the

HIV/AIDS defining illnesses, with a severe skin rash and wounds both in the mouth and all over the body.

He spent most of his time contemplating the pain and suffering he was going through, and had much fear, anger, stress and anxiety with no hope of surviving the next day.

He was thus conspicuously enrolled on the ART programme, because indeed ARVs were the last option for him. He had heard of a neighbor who was bedridden and improved upon taking ARVs which he bought for him self

After a long period of intensive prayers, God answered Douglas's prayers, and in December 2004, he was enrolled on therapy, but before enrolment, he had a 1 CD4, today his health status has improved and he is doing well on therapy, he has not had serious drug side effects ever since he started taking ARVs. Douglas calls KCCC his hero.

The biggest achievement for this programme has been that 864 patients of the total 917 clients administered on drugs had adhered registered 87% drug adherence (one of the biggest amongst several points of service), this has been a big achievement.

4.18 Important factors emerging as a result of ART

- Significant number of clients on therapy have sought professional counseling upon recovery whether to engage in hard manual labour/ remarry/have children or not.
- Client (primary and secondary) base of the organization has risen tremendously as a result of this therapy (this is attributed to confidence built among people about the availability of treatment and care services for PLWAs)

- There has been a noted increase and restoration of hope at the same time reduction in stress, fear and anxiety among clients administered on therapy.
- There is now a tripartite partnership between the community members, private sector and civil society organizations that have supported us in the struggle to alleviate human suffering (have encouraged their workers to register for treatment). The linkages between clients, carers, social workers and other service providers (traditional healer) have developed further.
- There is an influx to people seeking advice/information on ARVs from within and outside catchment area (implying that – there has been effective publicity about the drugs and also increasing health seeking behaviors among people)

4.19 ART challenges

The programme has registered some notable challenges

- Transport challenges to follow up every other client on therapy
- Nutritional requirements
- People still transient in nature
- Spiritual fanaticism (influencing drug defaulting)
- More clients are now highly motivated to engage in marriage (which may affect negatively affect their health)

4.20 Posttest Activities

With the aim of fighting stigma and discrimination and encouraging positive living among the people affected and infected HIV/AIDS, a post test club has tremendously increased and created awareness among the infected and affected

people with HIV/AIDS. With a view of reducing idleness and give support and restore hope among clients, the club has created linkages between the clients and the rest of the community members.

The team noted that the club had over the period advanced and initiated different models of message transmission to their target audience including role playing, live testimonies, public communications and one – to –one and group counseling to communities. Members in focus group discussions wondered whether new post test clubs (in the outreaches) had ever got any empowerment because they thought they were lacking in almost everything. Capacity building in music dance and drama, craft making, baking, script writing and singing had been part of the empowerment over the years. However the team noted that the club continued to lose skilled members for lack of sustainable income or facilitation. Members of the club noted that their morale had been greatly affected by,

- Constant sickness by members
- Transport challenges (daily to come for rehearsals)
- Welfare facilitation to enable them attend to their activities regularly
- Weak leadership of the club

The team therefore ascertained that although the club had taken over successfully the role of community HIV/AIDS sensitizations, the above had affected their innovativeness, curbed more recruitment of club membership and their abilities in delivering sensitization messages.

(Testimony)

The target audience has included; Public functions, schools, outside invitations, national celebrations (Public days), KCCC outreaches, teamed with partner

organization to advance sensitization had lost skilled members which con among the club members by imparting different skills through training. Learning from responses of both HIV/AIDS registered and non – registered respondents, the review observed that HIV/AIDS sensitizations had focused on reduction of stigma and discrimination which had impacted negatively on prevention, care and affected social support structures like traditional family system, good neighborliness and sense of humanity people had for one another. The following observations were noted;

Learning Points

- HIV-related Stigma and discrimination remains an enormous barrier to effectively fighting the HIV and AIDS epidemic in our communities. Fear of discrimination often prevents people from getting tested, seeking treatment for AIDS or from admitting their HIV status publicly. More HIV/AIDS action oriented education (with actions of drama or live scenes) are needed in since no comprehensive national strategies are effective enough to reach more people. The fear and prejudice that lies at the core of the HIV/AIDS discrimination needs to be tackled at both community and national levels.
- The toll of HIV/AIDS has been more severe on low-income households. Many families who have lost their income earners and the families of those that die have found it extremely hard to survive in this highly commercialized environment. Many of those dying have surviving partners who are themselves infected and in need of care. They leave behind children grieving and struggling to survive without a parent's care. HIV/AIDS strips the family assets further impoverishing the poor. In many cases, the presence of AIDS means that the household eventually

dissolves, as the parents die and children are sent to relatives for care and upbringing.

4.21 Community mental health

KCCC's philosophy of community mental health has been to enhance and improve individuals' and families' quality of life through determined, positive action, rights advocacy directed toward recovery, independence, and productivity to the greatest degree possible as opposed to institutionalized approach (Treatment and discharge). All services have been directed by the principles of person - or family-centered planning using service of community-based volunteers.

Based on this model, this period since the inception of this programme, over 313 mentally ill persons identified have been identified and registered (M 145 (46.3%) F168 (53.7%). Of these, 127 were diagnosed with epilepsy (40.6%), Mood disorders 73 (22.3%), Organic disorders, (HIV/ AIDS related) 41 (13.1%), Schizophrenia 37 (11.8%), Mental retardation 27 (8.6%). 9 (2.8%) patients died – due to HIV/ AIDS (6), intercurrent infections (2), and TB (1), 87 (27.8%).

Some patients dropped out due to various reasons including spiritual/traditional healers influence, migration, unreported deaths and self drug holiday, Home visits – 86 MIPS visited and 1012 visits made.

The model highly regards partnership as a strong pillar and thus partnerships with MIPS, careers, CBVS, police, small basic Christian communities, friends of persons with disabilities, women groups, schools, Butabika hospital, ministry of health, Mental health Uganda, SACCO, peer educators, traditional healers,

THETA, DRT and Kampala central division. The success of this model also largely rests with volunteers as a result, 700 partners including patients, careers, CBVS, police, youths, theta, traditional healers, KCD health workers, boda-boda riders, KCCC staff and basic needs – Kenya partners,4 animation/ consultation workshops carried out – 365 (MIPS, careers, CBVs) participated, Sensitized communities, About 8,026,07 reached (radio, T.V, print media, stalls, mental health activities), 196 patients stabilized, 144 gone back to work,19 children gone back to school, 136 mips and carers formed user group and enrolled with Sacco, A baseline survey carried out, A study on HIV/AIDS/ substance abuse/ mental illness done, Clinical and participatory data analyses conducted to make meaning of data collected, 10 life stories written to make patients' voices heard, Work plans, budgets, and reports made

4.22 Specific lessons learned in regard to the model:

- Family unit as the first step to identify mental health problem, should be used from the very beginning to design and develop key prevention strategies.
- Multi-level family involvement, at both the individual case level and the system level, ensures that family involvement is not only a support structure but determinant of sustainability
- Family members can play key roles as trainers, data collectors and direct service providers in community based interventions like community mental health
- Trust is necessary to build and maintain positive relationships among new partners
- Integration of a family perspective in all training and technical assistance activities is important

4.2 HIV/AIDs prevention (Youth Activities)

Prevention of HIV/AIDs among young people has taken different forms. Change agents to facilitate information, education, and behavioral change communication (BCC) has been done through training of trainers for parent/youth to conduct positive parenting skills to other people. Trained youth peer/promoters have provided information and guidance to fellow youth. Trained peer educators have conducted personal development skills workshops for fellow youth. Facilitate formation of peer support clubs, Disseminate IEC materials among communities, Furnish and strengthen the youth centre's capacity to offer sports and recreation to youth and improve its ability to provide sexual and reproductive health services to young people.

The period under review 40 active trained parents trained (20men-20women) have acted as trainers, continued to Identify and build capacity to other 240 parents in positive parenting skills. According to reports presented, they have been very instrumental in equipping other parents with basic parenting skills, have encourage fellow parents to encourage their children especially girls to utilize TLC, Parents are reporting cases of child abuse/labour to KCCC.

The resultant effect of youth/peer educators intervention in as far as creating a change in young people's lives is that in and around catchment areas trained youth have started developing their own HIV/AIDs prevention programmes. For instance in Kyebando and Kisenyi parishes young people have spearheaded education, development and dissemination of information on HIV/Aids in 14 schools, 2 workplaces, 4-community peer group stations.

(We provided young people with what they miss at home, Peer educator)

They have provided peer-to-peer and group counseling, guidance to fellow youths. In their “meet the people where they are” approach; they have reached to 18,000 youths and adults using their outreaches in schools, parking lots, washing bays and “bases”. They have helped identify and support 101 youth that are under our rehabilitation and resettlement programs during the same period.

Many young people have now taken keen interest in leadership roles and responsibilities in the community. Primary beneficiaries have provided support to each other through positive peer-to-peer support networks and most importantly have influenced other youth to choose similar healthy lifestyles. They have also helped to train 4 youth groups in leadership and group management and to initiate replicas of TLC activities. An active peer support group in Lungujja – Kitunzi is a valid example to this effect. 12 PDS workshops benefiting 480 youths (140 male-140 female) have been conducted. The team noted that there is actually a lot of improved knowledge about HIV/AIDs, and many young people yearning for VCT at the youth clinic because of this development. The team also noted that many young people now want to engage in community oriented development because of this awareness (youth environment activities). Young people have used this centre as a place of attraction and development.

To strengthen the youth centre’s capacity to offer sports and recreation to youth and improve its ability to provide sexual and reproductive health services to young people, the centre has purchased sports and recreation equipment that has helped develop young people’s talents and skills. Equipments such as balls, Television set and a VCR have aided the centre in attracting and helping in mobilizing young people to access the youth friendly health services offered at the TLC and at the KCCC main clinic. A total of 267 youths have accessed VCT and STI treatment. 10 youths from the netball club have acquired educational scholarships from schools in and around Kamwokya. The sports teams at the centre have earned national sports recognition from National Council of Sports

for their unending contribution to the development of sports in the country. Youth peer instructors of various sports disciplines have landed coaching opportunities from schools surrounding Kamwokya. 6 schools that include Sr. Mirriam Duggan primary school (formerly KCCC informal school) have acquired the expertise of these youths in the co-curricular activities.

4.2.1 Challenges

- There is still a scarcity of recreation facilities at the centre.
- Transient/Migrant nature of the beneficiaries - the community empowerment interventions are often affected by the departure of some trainees-peer educators.
- There is still a lot of gender disparity at the centre (there is less female participation in youth centre activities compared to male) with a ratio of 1:8. This is rather a general problem in other KCCC activities.

4.2.2 Emerging issues:

- Many factors discourage young people from using health services: lack of privacy and confidentiality; insensitive or disapproving staff; threatening environments; cost; and requirements that minors be accompanied by an adult or be married.
- Prevention plans and programs using different approaches like "open talk" have been hampered by adults' beliefs about what young people should know. Many adults, including local leaders, hold to baseless fears that sex education might lead to promiscuity.
- There is a growing concern about increased youth vulnerability to HIV/AIDS/STDs and the main contributors to this include: Increased prevalence and incidence of HIV among youths. Early sexual involvement. Risky cultural practices and misconceptions. Increased orphaned

generation and street children, multiple sexual partners, Increased cases of sexual abuse and harassment.

4.3 VOCATIONAL AND PRACTICAL TRAINING.

HIV/AIDs prevention on the other hand has taken the form of Vocational, practical training as well as other skills training. Vocational training programmes were established to cater for the needs of vulnerable marginalized youth, rehabilitation of street children, orphans and young people whose educational needs were never met due to problem of HIV/AIDS. Different vocational trades have included; Art and Design, Brick/Block laying and Concrete Practice, Carpentry and Joinery, Catering, Computer, Leatherworks, Tailoring, Functional Adult Literacy, External Sponsorship, Local artisans. In the era of high illiteracy rates, provision of functional adult literacy opportunities has a huge transformational factor that has not only benefited beneficiaries but also promoted HIV/AIDs prevention as well as livelihood promotion especially among the poor. Thus FAL (**Functional Adult Literacy**) has not in many instances been treated as a vocational skill but one which has stimulated development by providing more opportunities to semi illiterate and disadvantaged community members to join the development process. It was observed that beneficiaries are prepared for 6 – 12 months and then released into the general work force.

This reporting period the intervention has reached out to 761 trainees (400 males/361 females) in the period 2004 and 2005. Dropouts were 89, which is 11.7%. Dropout rate for 2004 – 2005 was 17%.

Table 6: Indicating number of beneficiaries for the reporting period Achievements

Year	of	Candidates who	Passed	Failed	Percentage
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Examination	registered and									that passed
	M	F	Total	M	F	Total	M	F	Total	
2004	37	36	73	32	25	57	5	11	16	78%
2005	47	44	91	42	37	79	4	8	12	87%
Totals:	84	80	164	74	62	136	9	19	28	82.9%

In 2004 and 2005 162 trainees were passed out with the Uganda Intermediate Crafts Certificate and / or the KVTC Leaving Certificate. In 2006 alone we have a total of 250 trainees that is 148 male and 102 female with 142 in Year I and 108 in Year II.

However for different reasons, the team noted drop out was as a result of such reasons as; pressures or tight schedules in homes especially for those who serve as house-helpers, early pregnancies, orphan house heads drop out due to intense pressure, attending to sick relatives, relocation or migration of parents / guardians and failure to cope up with theoretical sessions of their vocational courses.

The review revealed that over this period, of the 162 graduates, 110 are placed in different employable occupations (i.e. of the 162 who graduated in 2004 – 2006). However the team also ascertained that most beneficiaries still unplaced were from tailoring and bricklaying and concrete practice. The team drew two implications; its possible that the market for both trades are circulated (and therefore no more demand for both of them or because the trades are faced with cheaper or more resourceful substitutes).

Follow up drop out cases responses from former beneficiaries, noted that inadequate follow up and supervision had indirectly affected their performance at school. Many young people would experience social problems but would not share them hence affecting their studies.

4.3.1 Emerging issues

- There is no immediate response to issues affecting young beneficiaries at the Centre (pressing issues include, career guidance, lack of peer counseling, teenage girls and boys faced with extreme peer pressure without redress and household pressures leading to drop out from school)
- Continuing beneficiaries have long looked forward to interacting with former beneficiaries, which would enforce experience sharing to foster confidence building.
- Beneficiaries with minimal literacy capacity have not had enough support to help them compete favorably with their more literate counterparts.
- Most beneficiaries still unplaced were from tailoring and bricklaying and concrete trades signifying that a review of both trades and their market is long overdue.

4.4 CHILDREN WELFARE PROGRAMME

KCCC psychosocial programme has for long time supported the plight of HIV/AIDs affected orphans. In the process of providing medication, spiritual and emotional support to the people infected and affected by AIDS, stress and lack of basic needs were observed among children. Many of the AIDS patients were worried about their children's future. This is what one parent said

"I have come to terms with my HIV/AIDS condition, death is not my greatest fear but my children's uncertain future is an ever ending nightmare".

One experience also made us to realize that the lives of children were also affected when their parents were diagnosed with HIV/AIDS. Families face increased poverty and stress when the adults are too sick to continue with employment or engage in any income generating activity. Thus children become irregular in schools due to unmet school needs or end up dropping out of schools something that renders them vulnerable to multiple abuses like living on streets, drug abuse, child labor and sexual abuse something that might lead to HIV infection. It was therefore considered necessary to seek support to keep these children in schools. We have over 3000 children who have benefited from our programmes like capacity building and empowerment through counseling.

In the reporting period 2004-2006 the department has been able to provide formal education to a number of orphans and vulnerable children. Many sponsored children have been able to qualify in professions such as teaching, Business Administration, pharmacy, Engineering, Tourism, Information Technology, Statistics, Agriculture, Bachelor of Commerce, Journalism and Social Sciences. The table below summarize the figures; Because of the enrichment in our programme we have been able to see some of our sponsored children graduating in professionals like teaching, Business Administration, pharmacy, Engineering, Tourism, Information Technology, Statistics, Agriculture, Bachelor of Commerce, Journalism and Social Sciences.

During this reporting period alone close to 56 (34 boys: 22girls) are awaiting their graduations after the accomplishment of their studies in different disciplines in tertiary high learning Universities or institutions. Some of our children have been empowered with vocational skills trainings at KCCC VTC and some have already got jobs and are working. The children development programme (formerly a street children prevention programme) has been blessed with construction of a fully-fledged primary school, which will cater for 450 children

upon completion. KCCC foster care system (foster home model) has provided more learning opportunities to children entrusted under the system.

Children welfare programme has enriched its model by training community volunteer counselors/children care advocates. The little partnership linkage exhibited with a few development agencies have demonstrated immense potential there exist which can harness more to support children cause. Although educational and economic fields have been emphasized, cultural, tradition or even scientific have not been yet potentially explored. Many of these volunteers have joined hands with department staff to provide counseling, follow up children at home and schools and helped create partnership linkages with institutions such as the police, traditional healers, advocacy groups for children and many organizations in children development ministries.

Summary activities for the period

- Children welfare programme has during the period accomplished and participated in the commemoration of the day of African child twice last year 2006 and this year.
- The programme has developed a referral system which has enabled referral of children abuse cases to organizations like FIDA Uganda, Women In Crisis, children and Family Protection Unit of Police, Save the children Fund, Legal Aid and the District Probation welfare office etc.
- We have had several exchange visits to with other organizations to share and exchange experiences and best practices. The programme has also been able to participate in the commemoration of the World AIDS Orphan day every year.

4.4.1 Issues affecting Children

- Over 500 children have lost sponsorship opportunities (are now more exposed to the dangers of HIV/AIDS infection)
- Negative media has affected and exposed a lot of pornography to children affecting their lives in the long run.
- Inadequate formal opportunities to children already affected by HIV/AIDS causes more dropouts hence exposing them to more dangers of HIV/AIDS infection.
- Child defilement, incest and child sexual abuse are still rampant in low resource communities like Kamwokya.
- Children support need a holistic approach where their physical, social, economic and psychological needs should be addressed equally.
- Death of parents/Guardians/relatives directly affects children forcing them to drop out of school and end up on streets.

4.4.2 Lesson learnt:

- Sufficient and prolonged educational opportunities for children enable them stay in longer in school making its less risky for them to have HIV or early pregnancy for girls, since at school they are able to get HIV educative messages and are also able to access HIV/AIDS/IEC materials relevant to their lives.

4.5 KCCC Savings Cooperative and Credit (SACCO)

At the advent of HIV/AIDS KCCC initiated an empowerment aimed at improving income-generating opportunities for HIV infected and the affected families and the needy to enable the families meet their basic needs. The scheme was designed with a strategy of attaining sustainable development and thereby improve the economic well being of the urban 'poor'. It targeted the section of

the community that cannot obtain credit from the other commercial lending institutions.

The KCCC empowerment scheme has since improved business skills and management ability for the HIV/AIDS infected and affected clients, has increased self-employment opportunities to raise income for the target beneficiaries. The scheme has to date revolved into a sustainable savings and credit scheme charged with transforming individual groups into viable economic entities. The scheme has also promoted growth and cultivated a culture of saving among members.

In 2004 the empowerment scheme transformed into a Cooperative Savings and Credit Society by the registering as a cooperatives society and it was registered accordingly with the registration number P 718. with membership of 1420(564 females : 856 males) with over 16% PLWAs, the scheme has accumulated assets worth of over 100,000,000 million shillings.

Table 7: Finance collected in the last three years

Particulars	2006FY	2005 FY	2004 FY	2003 FY
Interest received from loans	40,140,000	72,604,000	37,700,000	12,475,000
Membership fee	3,030,000	7,190,000	4,732,000	629,000
Other income	3,828,600	6,999,000	3,188,000	538,000
Grants received	61,000,000	22,776,000	147,047,000	24,256,000
Shares	3,080,000	12,718,000	5,099,000	-

Table 8: Loans disburse in the last two years

Particulars	2006FY	2005FY	2004FY
Total loan applications received	371	820	473
Total applications approved and paid	344	815	469
Total loans given out	391,767,000	640,784,000.	252,428,000
Total loan repayments	200,732,000	389,777,000	119,320,000
PURPOSES			
Education	117,530,000	8,570,000	5,000,000
Business	254,648,00	620,214,000	241,928,000
Lands and buildings	19,588,000	12,000,000	5,500,000

The management wishes to introduce a 1% charge for loan protection fund (insurance) on every loan given out purposely to cater for eventualities. E.g. death such that when a member dies he/she dies with his / her loan.

Particulars	2006FY	2005 FY	2004 FY	2003 FY
Savings	304,731,000	218,700,000	80,659,000	8,563,000

How members have been saving with sacco

Particulars	2006FY	2005 FY	2004 FY	2003 FY
Simavi	0	-	-	10,900,000
COOPI Internationa le	45,000,000	-	101,000,000	-
Catholic relief services	0	-	38,744,000	-
SCIAF	13,500,000	18,000,000	2,000,000	12,711,000
American Jewish world service	2,514,000	4,776,980	5,303,475	11,545,000

Grants received above

Profits below

Particulars	2005 FY	2004 FY	2003 FY
SURPLUS before tax	80,234,244	10,590,071	197,256

Interest on savings

- SACCO has set aside .4, 370,000 Ugx during the financial year under review being interest to be credited on your savings account. Likewise 1, 600,000 Ugx was set-aside in 2004 FY for the same purpose.

4.5.1 Challenges:

- There is significant increase in loan defaulters every year which undermines the scheme capacity to provide more credit to borrowers.

- Loan recovery is such daunting taunting task given the fact that most borrowers are tenants and keep on changing locations.
- While scheme is now purely run on a commercial basis consideration of most vulnerable clients (the very traditional target beneficiaries) vis a vis sustaining the scheme is proving hard.

4.5.2 Lessons learnt:

- Use of guarantors in follow-ups simplifies monitoring process.
- Constant trainings in business management and skills have helped the clients to improve on their businesses skills and new entrepreneurship.
- Training caretakers of HIV positive beneficiaries helps them in running their businesses.
- Compulsory group meetings encourage members to interact with business associates fostering learning experience among beneficiaries.

5.0 REVIEW FINDINGS

- Home care services had been significantly neglected to a point where community members thought it was no more part of KCCC health care service
- There's inadequate community sensitization about dental health issues especially among children.
- KCCC has limited capacity in meeting the demands and requirement of children living with AIDs below 10 years.
- Some HIV/AIDs clients misinterpret and attribute their quick and fast health recovery to influence of mighty miraculous power/spirit.

- Some established clinics had demonstrated outstanding performance both in client satisfaction and coverage. However, the team also established that this performance is threatened with inadequate supervision from Mother Organisation (KCCC) and power struggles emanating from the pioneer volunteers at those centres.
- Establishment of more disease investigations and existence of more medical personnel had had a direct linkage with astronomical client influx at the centre.
- There is weak integral working interlinkages between youth programmes and other interrelated programmes within the area. (Youth-adult partnerships to focus on addressing sexual health among youth).
- Although the programme had been very vigorous in promoting youth friendly services, they had not lured Youth serving professionals to help foster leadership values especially among centre users.
- Established community structure(executive committee of the youth centre) has ably demonstrated potentiality to support other youth groups(particularly in sports disciplines)
- Although the vocational training programmes started as a programmatic intervention to uplift and ensure livelihood security for young people affected by HIV/AIDs, given the numbers targeted and benefiting today , the programme can no longer depend on charity support alone.
- Inadequate follow and supervision of vocational training beneficiaries has led to high levels of drop out since no immediate redress is put in place to counter social challenges faced by students faced with these problems.
- The team noted that although vocational training programme had undertaken a market skills analysis, some of its recommendations to regularly survey the market and operate according to market demand have not been implemented.(Firsher and recent skills analysis report make reference of this)

- Strict observance of set operations and guidelines is not the best option to manage a loans scheme. Consideration of conditions and circumstances prevalent at a given time is the best option (applicable model)
- Although KCCC today has a huge staff body (86 persons), the organization does not have a comprehensive staff development plan in place to guide management on issues of career development (staff training opportunities, promotion or retirement) and manpower planning.

6.0 **RECOMMENDATIONS**

- Routine home care initiatives be re-planned and scheduled regularly and a home care coordinator be designated or appointed to coordinate these services once again(**KCCC mgt, 2007**)
- Basic dental health sensitization and education be incorporated in the KCCC community based health care manual(**PHC Coordinator, 2007**)
- Since KCCC do not envision provision of specialized care for children below 10 years living with HIV/AIDs, strengthening its partnership with service organization dealing with such children would be the best option (**KCCC mgt, 2007**).
- KCCC will continue to pursue and explore every available opportunity to strengthen collaboration and partnership with the relevant partners to create more forums for information sharing, educative assemblies and create collaborative linkages to clarify unnecessary contradictions(e. Traditional healers/spiritual ministers) (**KCCC mgt, 2006**)
- Continued strengthening or upgrading of the outreach centres to provide similar services would ideally reduce on the client influx at the centre(**KCCC mgt, 2007**)
- To effect more close quality supervision, effective management and smooth transfer of management skills, outreach clinics be placed under a

- specific KCCC contact person responsible for their supervision, monitoring and reporting to KCCC management (**KCCC mgt, 2007**)
- In empowering outreach service points (OSPs),KCCC Should ensure that outreaches are built on formal management structures not on individual good or personalities existent at the time of their establishment(**KCCC mgt, 2007**)
 - Youth programmes can start initiating working intergral linkages where youth programme solicits for action-oriented partnership with other youth/adult groups to foster collaboration (e.g. Youth at the centre can link with KYAD to create livelihood opportunities for centre users)(**Youth Cordinator, 2007**)
 - We do recommend that the centre through its leaders establish an alumni of current or former centre beneficiaries in professional engagements which would be used as a forum to build confidence and leadership programmes to current centre beneficiaries.(**Youth Cordinator, 2007**)
 - Youth at the centre should devise means and ways of linking up with other youth groups to benefit from umbrella organizations dealing in youth activities(**Youth Cordinator, 2007**)
 - Vocational training programme review its staff structure to appoint/assign or designate a social worker responsible for following up beneficiaries and deal with their social challenges both at school and home (**KVTC mgt committee, 2006**)
 - There is more need than before to commercialize or market vocational training programmes to target private self-sponsored community members who would substantially supplement charity support to this programme. Introduction of short highly commercial courses and hiring out the centre during examination seasons without such facilities would be such an idea to explore(**KVTC, 2007**)

- To cultivate a pupil – instructor relationship which is important in determining success of students, instructors be involved in understanding their clients challenges by visiting them at home(**KVTC mgt committee, 2007**)
- Children welfare programmes should be redesigned to reflect all development aspects of children (cultural, tradition and recreational or sports (innovativeness). This would give children a wider spectrum of choice to excel (Propose: Child care and development)(**KCCC mgt, 2007**)
- To foster more collaborative linkage, KCCC should initiate a functional partnership forum or linkage with children support agencies in and around Kampala district(to understand better issues affecting children from a wider coverage) (**KCCC mgt, 2007**)
- KCCC develops a staff development plan/policy to organize better its human resource capacities in guiding implementation process and plan for their career development(**KCCC mgt, 2007**)
- KCCC institutes a regular staff performance appraisal exercise to audit its staff core competencies and needs and man-power requirements for staff members(**KCCC mgt, 2006**)

7.0 EXTERNAL FACTORS OF CHANGE

While in KCCC's intervention a number of changes are noticeable, it is practically difficult to attribute these changes to the programme perse. With this in mind, it has been identified from the discussions with partners that some external factors also made a vital contribution towards the changes noticed in our programme success. Such include;

- **Partner intervention** - Many HIV/AIDs sensitization, care and support have been carried out by Concern world wide, Workers treatment centre

(WTC), Taso, Straight talk foundation and many others. These interventions have automatically contributed to the general welfare of the targeted population.

- **Support of other CBOs** – CBOs/NGOs dealing in charity or relief have targeted the same or partial population in the catchment areas.

8.0 Challenges facing KCCC

Table 9: KCCC programme challenges

Community - Related	Programme - Related	Administrative	External factors
<ul style="list-style-type: none"> • Target community are so drunk with “Charity Mentality” • Community Resources to OVCs and PLHAs to supplement KCCC are so scarce. • Communities are still very transient • There is extreme poverty levels • HIV /AIDs still treated as a medical issue only 	<ul style="list-style-type: none"> • Gender issues are still weakly appreciated and integrated • Male involvement in KCCC programmes is still very low • Care for carer givers is not provided for • Advocacy programmes still lack direction 	<ul style="list-style-type: none"> • Still have difficulty to synchronise collected data M&E framework/s ystem • Timely reporting still lacking in implementation process • Operational space for daily activities 	<ul style="list-style-type: none"> • Limited government funding • KCCC’s relationship with local partners needs to develop beyond “just relationship” to complimenting each others work

9.0 GENERAL LESSONS LEARNT

- BCC needs a coordinated multi – channel. Approaching or tackling negative KAP change requires a multi – prolonged communication

approach. Verbal (interpersonal) communication alone is not adequate. A wider source of information increases access to knowledge and reduces doubts from a single source. Much can be achieved if the information is packaged in a social category friendly manner. For instance the use of Videos, reading materials, and personal testimonies by PLHAs greatly made public awareness by PECs more relevant, felt and accepted. Yet other than forgetting, people also tend to neglect information from persons who they see doing the contrary.

- Social categorization is a basis for effective communication for effective communication for social change. Communication motivation demands a focused social categorization where each category behavior is analyzed in their own group, say young people have their own free interactions between themselves. This dispels fear that one could not be in the company of others. As such, it increases right health information seeking attitudes and practices.
- A coordinated multi-actor approach enhances quality assurance and resource efficiency. Through partnerships and information sharing this comprehensive information sharing promotes quality service provision among partners.
- Effective community empowerment occurs when they are involved in the entire project cycle. For a project to belong to people they must be at its forefront. The involvement of the local community – project beneficiary is thus cardinal. Winning people's participation requires commitment to their livelihood practices such as work time respected, and a motivator provided to reduce the usual "opportunity costs" way with which community activities are seen.
- Local capacity building is a basis for sustainability. It can be attained by building local capacity to effectively undertake in project implementation. Existing local organizations need to be strengthened and /or new ones formed to ensure that they take over the different aspects of the project

and execute them in their locally compatible strategies. This prepares room for project down scaling in the operational areas while presenting exit opportunities.

- HIV/AIDs is broader than health sectoral focus. While at the start it was apparent that HIV/AIDs is entirely a medical phenomenon, now it is clear that it is also a social and economic problem given the consequential effects to families and communities. This calls for multi – dimensional approach.
- Change as a process takes time. It takes time for people to openly declare their sero status. Voluntary Counseling and Testing alone is not adequate enough but regular rapport building with community increases the chance of trust upon which individual –to – individual counseling starts hence public, and self confidence to declare one's sero – status and support initiatives to prevent further spread.

10.0 CONCLUSION

Overall performance of this pschosocial programme has been successful. This programme has rightly fitted within the, national HIV/AIDs policies, community needs and the organizational visional and strategic directions. It is being implemented with viable strategies in a timely manner. Most project beneficiaries are applauding it and are conscious of the contribution it is making especially in widening KAP and social support to the fight against HIV/AIDs in these communities. However, with the recent drive and agency to ensure sustainability of these initiatives already put in place, most local and community structures established to facilitate this process need further strengthening and re-orientation to be able to stand internal and external pressures. In this regard, given the challenges and lessons learnt, the report has suggested some recommendations.

