



**Survey on Client Satisfaction and Delivery Models for HIV and AIDS  
Services supported by IRCU in Uganda**

*A Consultancy Report*

Submitted to

**Inter-Religious Council of Uganda (IRCU)**

By

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## Acronyms

ART/ARV	-	Anti Retroviral Therapy
CBO	-	Community Based Organization
C.O.U	-	Church of Uganda
FBO	-	Faith Based Organization
HBC	-	Home Based Care
HBHCT	-	Home Based HIC Counseling and Testing
HCT	-	HIV Counseling and Testing
IGAs	-	Income Generating Activities
IP	-	Implementing Partner
IRCU	-	Inter-Religious Council of Uganda
JCRC	-	Joint Clinical Research Centre
MARPs	-	Most at Risk Populations
MGLSD	-	Ministry of Gender, Labor and Social Development
NSP	-	National Strategic Plan
OIs	-	Opportunistic Infections
OVC	-	Orphans and Vulnerable Children
PHA/PLWHA	-	People Living with HIV/AIDS
PMTCT	-	Prevention of Mother to Child Transmission
SDA	-	Seventh Day Adventist
STIs	-	Sexually Transmitted Infections
UMSC	-	Uganda Muslim Supreme Council
USAID	-	United States Agency for International Development

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## **Executive Summary**

### ***Introduction and Methodology***

The “Survey on Client Satisfaction and Delivery Models for HIV&AIDS Services” aimed at assessing client satisfaction with HIV&AIDS services provided by faith-based organizations (FBOs) with support from IRCU. The study focused on the following HIV&AIDS services: ART services, palliative care, support to orphans and vulnerable children (OVC), and training of OVC caregivers. The survey sought to identify gaps and to provide strategic information to align HIV&AIDS programming to the needs of the clients. The ultimate objective of the survey was to inform IRCU future approaches and strategies in program implementation.

The survey was carried out in all the regions of Uganda covering a sample of 38 IRCU implementing partners (IPs) involved in the provision of services for people living with HIV&AIDS (PLWHAs/PHAs), OVCs, and caregivers of OVCs. Data were collected through survey interviews with a sample of 404 PHAs, 401 caregivers of OVCs, 449 OVC supported in formal education, and 213 OVCs supported in vocational skills training and apprenticeships. In-depth interviews were held with providers and managers of services while observation was used to assess the physical facilities of the implementing agencies.

### ***Key Findings***

#### ***ART and Palliative Care Services***

The services provided to PHAs included HIV counseling and testing (HCT), management of opportunistic infections (OIs), provision of anti retroviral drugs (ART care), provision of home based care kits, laboratory services, referral and training among others. Overall, clients affirmed that their needs had been met with more than half (53.4%) reporting their needs to be fully met by the implementers, while 46.6% reported that their needs were only partially met. The needs of clients that were insufficiently met include drugs/medicines, food and nutritional needs, beddings, and children’s needs. These findings point to what may be considered service gaps from the point of view of the clients. The implementers pointed to the need for more resourcing of their services in order to better meet the needs of the clients.

It is, however, worth noting that some of the services that should have reached all clients had been received only by some and not others. A case in point is the home based care kits, where only 43.8% of the respondents reported to have received such kits. Moreover, majority (60.8%) of the PHA reported that they had received basic care items only once; 15.8% reported that they had received them a few times, while 8.8% reported that they received them every year. Only 4% (n=11) reported that they received them biannually, and only 1.8% (n=5) reported that they received them every quarter of a year. On the other hand, majority of the respondents (66.7%) reported that they received drugs from the implementing agency every month.

Quality in service provision was perceived by clients in terms of the service being able to meet the client’s individual health and social needs as well as the needs of their families, especially children. This implies the need for holistic services. The providers perceived quality in terms of being able to follow policy guidelines, use of technically qualified staff, short waiting time, and availability of physical and medical facilities to provide services.

Majority (73%) of the PHAs interviewed reported that at the last visit, they had obtained all the services they needed or expected to get. Similarly, 92.3% reported that they had seen all the service providers they sought to see. Majority respondents (92.9%) were generally happy with the way they were handled, and 79.3% reported that they were able to get the prescribed medicine. An equally big majority (86.8) reported that they

were promptly attended to. Almost 60% reported that the services they received had helped them a lot to deal with their problems as PHAs. On quality rating of services provided, 44.3% rated the quality of services received as very good; while another 44% rated them as satisfactory and 10.2% rated them as fair. Only 1.5% rated them as poor. The attributes of services liked most by the clients were their availability, quality, the friendly/good staff, and the fact that the services met their needs. The highest levels of satisfaction were expressed for HCT (facility based), cotrimoxazole prophylaxis, education on water use and nutrition, screening for ART, clinical follow-up, provision of ART drugs, blood testing for malaria, and CD4 count tests. On the other hand, the lowest levels of satisfaction were expressed for follow-up of clients on TB-DOTs, provision of HBC kits, and follow up of HBC clients.

The key barriers to provision and accessing of effective ART and palliative care services reported by clients and service providers were: inadequate facilities for outreaches and home-based services such as mobile x-ray machines; inadequate staff; the high cost of maintaining vehicles and use of old vehicles; persistent problems of stigma among men; ceilings on the number of clients that can be enrolled for services; long distances from the health facilities to the homes of clients; and inadequate space, logistics, and other physical resources

The dominant service delivery models found in use included facility-based and home-based care. Under the two dominant models various approaches were found to have been adopted including outreaches; use of referrals and follow-up of clients. These complement each other, thus harnessing from the strengths of each. The models and approaches used have been effective in delivering the services, although each is faced with unique problems. For instance, outreaches need transport and extra staff to implement; while referral sometimes suffers from problems of ensuring that services are obtained and getting feedback from clients.

### ***Support to OVC in Formal Education***

Almost all the children in the sample (97.5%) reported that they had received scholastic materials and 84% had received uniforms. Common items given out include: school uniform, exercise books, pens, pencils, mathematical sets (for upper primary classes), duplicating paper (for upper primary), sanitary pads (for girls in upper classes), school bag, and underwear (for girls). A few IPs also gave out shoes. OVC supported in formal education mentioned their needs to include educational related needs, feeding, health care, and housing. Unfortunately, some of these needs were not within the scope of the programs and therefore could not be met by the IRCU-supported agencies.

Service gaps were also identified from the services needed by the OVC but not provided by the IRCU-supported agencies. Up to 72.7% (n=319) of the OVC reported that there were certain services that they would have wanted but which were not provided to them by the IRCU supported agencies such as food and nutrition support, school fees, and support for health care. With respect to school charges, it was reported that although schools are not meant to charge fees under the UPE scheme, most schools charged what they call 'development fund' and 'academic fund' ranging from Uganda Shillings 5,000 to 20,000. As a result, some children are often sent home due to failure to pay. The same shortfalls applied at secondary school level where the support consisted of only a top up, leaving the rest to be met by the OVC/caregivers.

Many IPs also supported the medical care of children by referring the supported children elsewhere for medical care and meeting their transport costs. The limitation with this was that the facilitation for transport covered only one person, yet the child would need to go with an adult to accompany him/her. Another limitation was that the transport was paid as a refund not in advance of seeking medical treatment. As such it meant that children/caregivers had to look for money, go for treatment and ask for a refund later.

More than half (56.9%) of OVCs reported that the services received had helped them a lot to deal with their problems with majority (55.7%) rating the quality of services as very good, while 31.8% considered the quality to be satisfactory. The services which the OVCs were not satisfied included food and nutrition support, support to access health care, home visits, and training in IGAs. Variations existed in the extent of meeting

OVCs needs depending on the levels of education at which they were attending. Implementers themselves noted that they had met the needs of clients for primary education to a large extent and only to a small extent for those in secondary school due to the fact that the demands for secondary higher and more costly, and the support only covered a small proportion of that.

In supporting the formal education of OVC, the key models used included the provision of scholastic materials in-kind (rather than paying fees or supporting IGAs) and to a lesser extent the family-based approach – whereby all children in a vulnerable family are supported. These models were not exclusive of each other, but instead, they existed simultaneously. Each had its strengths and weaknesses. As already pointed out, provision of scholastic materials in-kind filled a critical need but was insufficient in situations where schools charged extra fees, and where children's other needs such as for feeding were unmet. The other limitation of this form of support is that it carries the potential to create dependency, rather than build capacity. With regard to the use of the 'family-based approach' it was found that in many cases, the IPs did not adopt this approach despite the recommendation by the MGLSD. The family-based approach would entail supporting all OVC from any one selected household, i.e., if an OVC from a household was identified for support, all the children in that household would be reached with support. In practice, many IPs reported that this approach proved problematic to implement as it meant concentrating the few available resources in a few households.

Key challenges in supporting formal education were noted; overwhelming numbers of children that need to be supported; the fact that the support did not cover meals; limited staff; inadequate facilitation for volunteers including religious leaders; clients being dispersed over wide geographical areas; failure to build capacity of households; continuing poverty in OVC households; late disbursement of funds; the escalating costs of scholastic materials; and supported OVC being chased out of schools due to other fares not supported by IRCU. One of the unintended consequences of the support is that schools that host supported OVC have experienced increasing enrolments because parents know that there is a project supporting children in such and such a school.

### ***Support to OVC in Vocational Skills Training/Apprenticeships***

Skills training of OVC mainly targeted those children who were out-of-school or unable to continue with formal schooling. Skills training consisted of both training through attachments to local artisans (apprenticeships) and enrolment in vocational institutes. Some of the OVC who benefited from skills training had previously been supported in formal education, thus 66.7% of the interviewees reported having received support for formal education as well. This linking of formal education with skills training or put differently—the continuation of support from one level of education to another is a good practice necessary for ensuring that children are not abandoned half way during their schooling.

The major types of trades or skill areas for which children were trained included carpentry and joinery; tailoring; bakery; saloon; metal works and fabrication/welding; and hair dressing. Tailoring was the most popular trade in which OVC were trained, reported by 77.5% of the trainees, followed by carpentry (11.3%). Up to 71.8% of OVCs reported to have received a start-up kit upon completion of their training as opposed to only 13.1% who did receive start up kits, while 15% were still training. The provision of start up kits constitutes a good practice that helps to ease the transition of trainees from school to work.

The reported needs of OVC were not restricted to skills training, but ranged from education to health care. Important to note is that the need for employment featured highly, reflecting the demand for jobs sparked off by the skills acquisition. More than half of the OVCs interviewed had their needs only partially met. The needs that were insufficiently met were mainly in form of start up capital in form of cash, tools, or materials. It was reported for instance that whereas trainees who graduate in tailoring are given a sewing machine as a start-up tool, they would also need some cloth materials, a pair of scissors, a tape measure, and some money for rent in order to start work. Some IPs were able to give out the tape measure and a pair of scissors as part

of the kit, while others did not. Most implementers wanted the duration of the training courses to be extended.

Close to half of the interviewees (46.6%) reported that the services received had helped them to deal with their problems. A similar proportion rated the quality of services as very good. The attributes of services most liked by the OVC were: the package/content of services; the fact that they gained skills, and the fact that the trained enabled them to work and earn a living. On the other hand, the OVCs pointed out the support that they needed but which was not provided or was insufficiently provided such as start-up capital and other forms of support including health care and food. From the rating of satisfaction with the services, the service components that scored highly were skills training, provision of start up kits, HIV&AIDS education and school visits. Those for which the OVC were most unsatisfied included food and nutritional support, home visits, and trainings in counseling and in children's rights. The overall model of skills training was assessed to be appropriate and relevant. The courses taught are practical, and enable acquisition of usable skills as evidenced by the fact that some OVC were reported to have started earning from their skills even while still undertaking courses. The training approach was adapted to the local environment for sustainability purposes involving use of local materials other than sophisticated ones to enable trainees cope easily after graduation. The courses also allowed both sexes (girls and boys) to undertake non-traditional courses as previously gender ascribed.

Good practices were identified, which included provision of start-up kits, which is a necessary element of support to enable trained OVC to enter work. It was also found out that some implementers provided basic literacy/numeracy skills to OVC and imparted values and discipline, which were not necessarily part of the project plan. The key limitations identified included incomplete kits; short training periods; limited options available to OVC in the choice of skill areas; stiff competition for some skill areas in the market, such as tailoring; and lack of start up capital beyond basic kits.

### ***Support to OVC Caregivers***

The core interventions that IRCU supported under this service area or component were capacity building and training of OVC caregivers in IGAs and household economic security. For the majority of caregivers, no materials support was provided to the caregivers by most IPs apart from the trainings. Caregivers were trained in IGA management skills and group formation but no funds or material support were extended to enable them implement IGAs. IPs reported that they were meant to link the caregivers to micro-finance institutions where caregivers could obtain loans to start up IGAs. In practice, this was hampered by the stringent conditions (including high interest rates) imposed by micro-finance institutions. Only a tenth (i.e., 10.2%; n=41) of the caregivers who had received training in IGAs reported to have received support in form of start-up capital.

Whereas most caregivers appreciated the trainings received, the major concern was that the training was not accompanied by materials or financial support to translate the training into practice. Most caregivers expected to be supported with start up capital for instance to run IGAs and other forms of support to meet the needs of OVC under their care. Two thirds of the caregivers thought the support provided only partially met their needs and those of the OVC. The needs insufficiently met were mentioned to include school fees, bedding materials, food, clothing, health care and start-up capital. This, notwithstanding, a relatively big proportion (45.6%) of the caregivers noted that the training received had helped them to deal with the problems of OVCs under their care. Similarly, 40.4% of the caregivers rated the quality of services received as very good and 46.2% as satisfactory. Although up to 68.1% (n=273) of the caregivers reported that there were certain services that they needed but which were not provided by the IRCU IPs, there were aspects for which there was very high satisfaction e.g., training in IGAs, and training in parenting skills and succession planning. The aspects with very low satisfaction included provision of start-up capital for IGAs, support for referral, and food and nutrition support.

The good practices identified, which at the same time constituted the major factors contributing to quality of services were found to include: trainings being facilitated by specialized agencies competent in the respective areas of training; where good networking was available, caregivers benefitted from additional advice, support and inputs from other agencies to undertake IGAs and improve their agricultural production; and some IPs have trained drama groups that are facilitated to go out the community to sensitize people about the importance of OVC care and support.

The major limitations of this intervention were that: support to caregivers was largely limited to trainings, while no material support was given; many caregivers were never linked to micro credit schemes to access loans; limited medical access is given to OVC caregivers who look after the OVC; Some trained caregivers failed to access loans / credit services because they could not meet requirements of accessing it; and limited or no refresher training courses for caregivers.

### ***Key Recommendations***

Detailed recommendations are contained on the report on the overall IRCU HIV&AIDS programming, ART and palliative care, OVC programming, capacity-building and training, partnerships, advocacy and networking, sub-granting, inter-faith planning, co-ordination and sustainability. Some of the salient recommendations include the following:

- Overall, IRCU HIV programming should take into account rural and urban differences/contexts to guide future support to IPs.
- Integrate more complementary services such as feeding programs into ART and palliative care services
- Support approaches aimed at coping with inadequate facility based capacities – such as more training of home-based care workers, support to outreaches, and support to models such as home based HCT
- Support pediatric HIV&AIDS services
- Increase the amount of support per IP if recommended government approaches such as the family-based approach to OVC support are to be implemented
- Strengthen linkages with other service providers to meet the needs of caregivers for start-up capital and IGAs
- Address procedural and administrative issues relating to the release of funds

## 1.0 INTRODUCTION

### 1.1 Introduction

The “Survey on Client Satisfaction and Delivery Models for HIV&AIDS Services” carried out for the Inter-Religious Council of Uganda (IRCU) was commissioned in November 2009. The survey was carried out in all the regions of Uganda covering a selection of IRCU implementing partners involved in the provision of services for people living with HIV&AIDS, caregivers of orphans and other vulnerable children (OVCs) as well as the OVCs who are supported through formal education and apprenticeship.

### 1.2 Background to the Client Satisfaction Survey

Inter-Religious Council of Uganda (IRCU) is an initiative constituted by five traditional religious organizations or faith-based organizations (FBOs) in Uganda, who include the Roman Catholic Church, the Uganda Muslim Supreme Council, Church of Uganda, Uganda Orthodox Church and Seventh Day Adventist Church-Uganda Union. Founded in 2001, IRCU also works with other religious organizations notably the independent Pentecostal and born again churches in Uganda. IRCU provides a forum for inter-religious dialogue to enhance unity of focus and interventions in areas of common interest. IRCU’s mission is to promote peaceful co-existence, moral and spiritual integrity, socio-economic welfare, and collaborative action through sharing of knowledge and resources for the common good. Its vision is a divinely peaceful, prosperous and AIDS-free Uganda.

IRCU has since June 2006 been implementing a comprehensive HIV&AIDS program through faith based organizations funded by the United States Agency for International Development (USAID). This three year project was scheduled to end in June 2009 but was extended to officially end on December 18, 2009. The overall program objective was to scale up access to and utilization of quality HIV&IDS prevention, care, and treatment for People Living with HIV&AIDS (PLHIV) and their families through religious institutions and community organizations. This program objective was to be achieved by:

1. Scaling up HIV&AIDS prevention activities targeting children, youth, women, men as well as HIV&AIDS positive individuals and their immediate families.
2. Expanding access to and utilization of quality palliative care services for persons affected and infected with HIV&AIDS and their families.
3. Expanding access to and utilization of ART services for eligible PLHIV.
4. Scaling up access to appropriate support services for orphans and vulnerable children as well as their caretakers.
5. Developing functional health and HIV&AIDS networks that support individuals and communities to easily access quality HIV/AIDS prevention, care and treatment services.

The activities implemented under this program aimed at contributing towards the achievement of the objectives of the Uganda HIV&AIDS National Strategic Plan (NSP) and the United States President’s Emergency Plan for AIDS Relief (PEPFAR) targets in Uganda. These activities are implemented through sub-granting and capacity building to a network of over 75 FBOs and community-based organizations (CBOs).

The Mid-Term Review (MTR) of IRCU's HIV&AIDS program carried out by USAID in the last quarter of 2008, indicated good achievements registered by IRCU in the provision of HIV&AIDS services. The review also identified key gaps. While IRCU innovatively tried to address the identified gaps to improve programming and coordination, issues of quality of services, delivery models and relevancy remained a challenge and continued to be identified during support visits and reviews. These factors created the need for a Clients' Satisfaction Survey to further identify gaps and provide strategic information to align HIV&AIDS programming to the needs of its clients.

### **1.3 Purpose and Specific Objective of the Survey**

The purpose of this survey was to assess client satisfaction with HIV&AIDS services provided by IRCU through supported faith-based health facilities, FBOs/CBOs and IRBs. The survey aimed at identifying gaps and providing strategic information to align HIV&AIDS programming to the needs of IRCU clients. The ultimate objective of the survey was to inform IRCU future approaches and strategies in program implementation. The specific objectives of the survey were to:

1. Understand the expectations of clients from IRCU supported HIV and AIDS programs
2. Assess the extent to which clients' needs have been met
3. Establish clients perceptions about quality of services provided by IRCU supported FBOs
4. Assess the relevancy, appropriateness and acceptability of service delivery models used by IRCU partners
5. Document the factors that contribute to quality HIV and AIDS service provision through faith based structures
6. Document good practices in the provision of quality HIV service that are attributable to the implementation of IRCU HIV and AIDS program
7. Assess program limitations and recommend ways of improving program design and delivery models to address client's needs in regard to services being provided now and for future programming.

### **1.4 Methodology and Approach**

#### **1.4.1 General approach and study area**

A combination of quantitative (survey) and qualitative methods were employed to undertake this study. The study covered all the six "regions" of Uganda where the Program was implemented, namely, West Nile, Northern, Eastern, Central and Western.

#### **1.4.2 Survey population, sample size and sample selection**

The survey population comprised PHAs receiving ART and palliative care services, OVC both in and out of school, OVC caregivers and program implementers. A total of 13 districts out of 26 where the program was implemented were covered. From the 13 districts, a total of 10 health facilities out of 20 providing palliative care and ART services, and 19 FBOs/CBOs out of 38 providing OVC care and support organizations were covered. For every sampled partner organization, key staff such as the Project Managers or Co-ordinators were recruited into the study.

Using a scientific formula, the sample size for the various categories of respondents was derived. A total sample of 1467 respondents was covered in the quantitative sample for this evaluation from the 13 districts. See Table 1 below.

**Table 1: Sample size and distribution**

Region & District	Sampled respondents			
	PHAs on ART and Palliative Care	OVCs in Formal Education (N=449)	OVCs in apprenticeship or vocational training (N=213)	Caregivers of OVCs (N=401)
<b>Central Region</b>				
Wakiso	59	66	29	60
Kampala	32	43	32	32
Luwero	54	63	1	59
<b>Eastern Region</b>				
Kamuli	-	43	28	44
Kumi	38	27	14	29
Jinja	41	15	4	15
<b>Northern Region</b>				
Lira	-	19	28	39
Nebbi	61	28	6	33
Arua	41	22	-	-
<b>Western</b>				
Rukungiri	40	34	29	38
Bushenyi	38	42	18	19
Mbarara	-	21	12	11
Kyenjojo	-	26	12	22
<b>Total</b>	<b>404*</b>	<b>449</b>	<b>213</b>	<b>401</b>

\* Of the 404, PHAs, only 47 were supported only for palliative care

### 1.4.3 Data collection

Quantitative and qualitative methods of data collection were used to generate both primary and secondary data on client satisfaction. Quantitative data were collected through personal interviewing with PHAs, OVCs, caregivers and implementers.

**Structured Interviews:**– Personal interviews were administered to a sample of 1467 respondents (PHAs, OVC, OVC caregivers).

**Exit Poll Interviews:**–These were conducted to service users that were found at the facility immediately they left the service facility.

**Structured Observation/Site visits:**–Observation was aimed at assessing the physical facilities, space, and other infrastructural elements that might determine the quality of service provision.

**Document Review:**– Key documents were reviewed, which included the IRCU annual reports, the Strategic Plan, the ART and Palliative Care review reports and the OVC review report among others. To put the study in the broader policy context, relevant policy documents produced by the government of Uganda such as ART and Palliative Care Guidelines as well as the National Quality Standards in the care and protection of OVC were consulted.

**In-depth Interviews** – These were conducted with selected key informants including project staff, implementing partners, and other identified stakeholders.

## **1.5 Data Management**

For the quantitative data, all filled questionnaires were verified and edited while in the field. Open ended responses were post-coded and all coded questionnaires were entered into the computer using EPI-INFO software and analyzed using SPSS. With regard to qualitative data, all interviews were transcribed to generate patterns and dominating sets of responses. Individual key observations and experiences were discerned. Content and thematic approaches were used to analyse the data.

## **1.7 Organization of the Report**

The rest of this Report is organized into the following chapters: Chapter Two presents the findings relating to ART and palliative care services; Chapter Three focuses on the findings relating to support to OVC in formal education, while Chapter Four presents the findings in relation to support to OVC for skills training/apprenticeship. Chapter Five presents the findings on support to Caregivers of OVC. The final Chapter i.e., Chapter Six draws the Conclusions and Recommendations that can aid future programming.

## 2.0 ART AND PALLIATIVE CARE SERVICES

### 2.1 Introduction

Under ART and Palliative Care Services, IRCU supports IPs in provision of HCT, ART, palliative care, HBCT and laboratory services. A total of 20 IPs have been supported by IRCU, out of which 13 were visited during this study.

### 2.2 Socio-Demographic Characteristics of the Respondents (ART and Palliative Care Clients)

The Socio-demographic characteristics of clients on ART and palliative care revealed pertinent issues for programmatic considerations. For instance, the clients of ART and palliative care services who participated in this study were predominantly female (70.3%) compared to males (29.7%). See Table 2 for details.

**Table 2: Socio-demographic characteristics of ART and palliative care Clients**

Characteristics	Frequency (N=404)	Percentage
<b>Sex of respondent</b>		
Female	284	70.3
Male	120	29.7
<b>Age of respondent</b>		
< 18 yrs	8	2.0
18-29 yrs	81	20.0
30-39 yrs	145	35.9
40-49 yrs	111	27.5
50-59 yrs	45	11.1
60yrs+	14	3.4
<b>Marital status of respondent</b>		
Single	56	13.9
Married	186	46.0
Widowed	109	27.0
Divorced/separated	39	9.7
Living together/cohabiting	14	3.5
<b>Highest level of education attained</b>		
No education	73	18.1
Primary education	216	53.4
Secondary education	97	24.0
Post secondary education	13	3.2
Vocational education	5	1.2
<b>Main source of income for respondent</b>		
Nothing	65	16.1
Peasant Farmer	167	41.3
Business	67	16.6
Vending	22	5.4
Formal skilled	25	6.2
Formal unskilled	6	1.5
Informal skilled	7	1.7
Informal unskilled	30	7.4
Still a student	9	2.2
Other specify	6	1.5

As Table 2 further shows, majority of the ART and palliative care clients were in the reproductive age range 18-49. Almost half (46%) were married but with a substantial proportion being widowed (27%). Majority had attained education only up to primary level. Peasant farming and petty business were the main sources of income.

## 2.3 Needs and Expectations of Clients

The needs and expectations of clients enrolled for ART and palliative care services were assessed from the point of view of the clients themselves as well as that of the service providers. First of all, clients were asked to mention the common health needs for which they often required the attention of the service providers. These were reported to consist of mainly malaria, skin infections, respiratory problems and diarrhea as shown in Table 3.

**Table 3: Clients' Needs vis-à-vis Services Provided as reported by PHAs**

	Frequency	Percentage
Diseases or health complications PHAs commonly bring to the attention of the Service Providers		
Malaria	205	50.7
Skin infections	90	22.3
Respiratory illnesses	88	21.8
Diarrhea	45	11.1
TB	37	9.2
Pneumonia	20	5.0
Other	135	33.4
PHA's assessment of services/products provided to them by IPs in relation to their needs		
Agency fully meets needs	210	52.6
Needs only partially met	186	46.6
Needs not met	3	0.8
Critical needs of PHAs insufficiently met		
Drugs/medicines	94	23.3
Food/nutrition (for self)	49	12.1
Children's needs	14	3.5
Bedding materials (for self)	12	3.0
ITNs	8	2.0
Psycho-social support	6	1.5
IGA	2	0.5
Others	38	9.4

Slightly more than half of the respondents assessed their needs to be fully met by the implementers, while close to half (46.6%) reported that their needs were only partially met. The needs of clients that were insufficiently met were reported to include drugs/medicines, food and nutritional needs, beddings, and children's needs. These findings point to what may be considered service gaps from the point of view of the clients. Clients expected the service providers to provide a comprehensive set of services that would meet all their needs as well as those of their family members especially children. Thus issues of food, beddings, and the like features high on the client's needs list. Most clients interviewed pointed to the need for good feeding when taking ARVs. Yet most service providers did not have any feeding programmes.

Clients' needs and expectations were also assessed from the point of view of the service providers and managers. The following Table presents the needs / expectations reported by IPs that were involved in the survey. The need / expectations vary from IP to IP but those which commonly featured among all IPs visited were as follows:

### Box 1: ART/Palliative Client needs and Expectations as identified by Service Providers

<i>Intervention (s)</i>	<i>Needs / expectations</i>
HCT	<ul style="list-style-type: none"> <li>• Train lower level cadres in communities including community caregivers to do HCT in the spirit of task shifting, rather than leaving it to few / limited qualified service providers</li> <li>• Introduce HBHCT to maximize access to the HCT services</li> <li>• Support mobile HCT services to reach out to difficult-to reach populations and MARPs</li> <li>• More HIV testing among children is necessary.</li> <li>• Train more men in PMTCT / PPTCT to support the program</li> <li>• Need for more demand creation in communities for HCT services</li> <li>• Need more HCT rooms</li> <li>• Need for contextualized IEC materials for HCT</li> </ul>
ART / Palliative care	<ul style="list-style-type: none"> <li>• More counselors needed. In some places such as Mengo Hospital, the ratio is 1 counselor per 30 clients. This might compromise the quality of counseling and it leads to long waiting time (approx. 5 hours)</li> <li>• Need for more counseling rooms to boost privacy. Some clients are counseled in consultation rooms, others in the open / public places</li> <li>• Support Pediatric ART provision</li> <li>• Conduct regular refresher training in ART due to new treatment dynamics regarding drug combinations as new evidence evolves through research</li> <li>• Support provision community ART other than facility based ART only. Some clients come from very long distances, this affects adherence</li> <li>• Increase funding for ART services to enroll more clients in need of this service</li> <li>• Need for CD4 count machines because samples sent to JCRC delay (a week or so) which slows down recruitment of clients on ART. It also increases the cost for transport as poor clients come twice (first when samples are taken and second to get results)</li> <li>• Great need for training of service providers in pediatric ART</li> <li>• There is need for follow up people trained in ART</li> <li>• Need for contextualized IEC materials on ART</li> <li>• Need for private clinics at facilities to provide ART services to special categories of people who cannot line up or those who are still stigmatized</li> <li>• Poor clients on ART and other treatments need food supplementation to adhere to drugs better</li> <li>• Need for inclusion of weight taking –Body measure index (BMI)</li> <li>• Need supplementary feeding for children</li> <li>• Need reagents that test cryptococcal meningitis</li> </ul>
HBC	<ul style="list-style-type: none"> <li>• Train more community counselors / caregivers to do this job</li> <li>• Provide modest facilitation (better incentives) to community workers to do their job better (provision of and maintenance of bicycles, provide identity cards, uniforms and other forms of motivation)</li> <li>• IRCU supported kits only focus on bedridden clients. This should be balanced with PSI / PACE kits which focus on prevention of OIs however, we need more of these (PSI) because their supplies are irregular.</li> <li>• Need for contextualized IEC materials on HBC</li> <li>• Need more ITNs. What IPs obtain are not enough for IP beneficiaries. PHA educators also need them too</li> </ul>

Some IPs reported types of services which clients would want but which were not available. In Kisii hospital for instance, these included meals for clients; transport to the facility and back home as some clients live far away from the health facility; support to expert clients, like lunch; more medical supplies; increasing the scale of payments for OI bills for clients; scaling up palliative care medical bills; motivation of volunteers. It was also reported that CD4 count services are no longer free, and a charge of U.shs.11,000 is put on clients. Similarly, Ishaka Adventist Hospital reported that they needed to do adherence monitoring and

follow-up, to undertake baseline studies for services like CD4 count. The hospital also provides septrin and fluconazole for prophylaxis but not management of OIs. Nyapea Hospital wanted cotrimoxazole and other drugs so that they are able to treat all the OIs. Dependency on MoH was reported to be unreliable.

## 2.4 Services Provided/Services Supported by IRCU

The services supported by IRCU were reported to include: HCT, ART, lab investigations, psycho-social support, support to PHA associations, supporting the work of religious leaders, training counselors and lab technicians, reagents (testing kits), mosquito nets, and logistical support (bicycles, tents, etc). All IPs providing ART and palliative care services reported that they distributed HBC kits. These included items like ORS, multivitamins, soap, coon wool, hand towels, scissors, water containers, gloves, calamine lotion, bandage, and petroleum jelly. The table below presents the results regarding the types of services that respondents had received from the IPs.

From the results in the table, the most commonly received services were management of OIs, followed by HCT, TB/HIV management, laboratory services, ART care, and information/education in that order. Others mentioned were pain control and management, referral services and training. It should be noted that mention of the services by clients relied on memory as well as on how much value the clients attach to a particular service. Thus, whereas services such as information/education were mentioned by only 62.4%, in practice all clients who went for whatever services would under normal circumstances also receive HIV and AIDS related information ad education. In the rest of Table 4, data is shown about the specific services/products received under each service component.

**Table 4: Services Received by ART and Palliative Care Clients**

Type of Services ever received from IRCU Implementing Partner	Frequency	Percentage
Information/health education	252	62.4
HCT	363	89.9
Facility based care package	213	52.7
HBC package	177	43.8
Management of OIs	366	90.6
ART care	304	75.2
TB/HIV management	342	84.7
Laboratory services	312	77.2
Pain control and management	57	14.1
Referral	38	9.4
Training	28	6.9
Other	15	3.7
<b>Services/products under HCT ever received from IRCU IP</b>		
Facility based counseling and testing	331	91.2
Home based counseling and testing	71	19.6
Outreach based counseling and testing	59	16.3
Other	3	0.8
<b>Services/Products under Basic Care Package ever received from IRCU IP</b>		
Gloves	25	9.1
Soap	102	36.4
Detergents	38	13.8
Mosquito spray	27	9.7
IITNs	249	88.3
Safe water container	201	71.0
Others	74	26.0
<b>Services/Products under Management of OIs ever received from IRCU IP</b>		
Septin prophylaxis	353	96.4
Fluconazole prophylaxis	29	7.9
Blood screening for diagnostic tests	108	29.5
Drugs for treatment of OIs	161	44.0
Others	5	1.3

Type of Services ever received from IRCU Implementing Partner	Frequency	Percentage
<b>Services/Products under ART Care ever received from IRCU IP</b>		
Screening for ART	212	69.7
Anti-retroviral drugs	279	91.8
Clinical follow-up	192	63.2
Adherence monitoring	110	36.2
Pediatric ART	8	2.6
Other	1	0.3
<b>Services under Lab Services ever received from IP</b>		
Blood slide for malaria	174	50.9
Complete blood count	31	9.1
Liver and renal functional test	33	9.6
CD4 and viral load tests	289	84.5
VDRL	52	15.2
TB screening	66	19.3
Other	12	3.5

It is however worth noting that some of the services that should have reached all clients had been received only some and not others. A case in point is the home based care kits, where only 43.8% of the respondents reported to have received such kits. Moreover, majority (60.8%) of the PHA respondents reported that they had received basic care items only once; 15.8% reported that they had received them a few times, while 8.8% reported that they received them every year. Only 4% (n=11) reported that they received them biannually, and only 1.8% (n=5) reported that they received them every quarter of a year. On the other hand, majority of the respondents (66.7%) reported that they received drugs from the implementing agency every month.

## 2.6 Perceptions of Quality of Services

Key informants were asked to rate the quality of service they provide. Responses from each IP ranged from 60-80% quality service provision and enumerated several aspects as shown in Box 2 that demonstrated quality service:

### Box 2: Attributes of Quality ART/Palliative Care Services as identified by Service Providers

- *Use of national guidelines on service delivery and SOPs during ART screening process*
- *Adherence follow up for clients on ART*
- *Minimal loss of clients on ART*
- *Full laboratory services to conduct range of testing services and timely feedback of results*
- *Qualified technical staff with ability to conduct clinical diagnosis*
- *Regular supplies of drugs and laboratory reagents / testing kits.*
- *Adequate space with chairs where triage is done and functional TV. Waiting shade with chairs*
- *Well organized drug stores manned by qualified personnel with no or limited cases of drugs expiring stores*
- *Availability of suggestion boxes*
- *Availability of physiotherapy services which help clients to do a number of physical exercise in the morning to be healthy. Those too weak to do these exercises were excused*
- *Interpersonal communication between clients and service providers. Clients unable to express their issues through their providers have suggestion boxes as their opportunities.*
- *All service providers considered client waiting as a key factor for client satisfaction. The least time observed was 20 minutes (Saidana Abubaker) and highest was 5 hours (Mengo Hospital). This was relative to the number of clients turning up for services.*
- *Dispensers taking time to describe and explain how the drugs should be taken and adhered to.*
- *Continuing medical education (CME). Continuously and internally done for IP staff to keep them updated*
- *Availability of interest groups through which peers freely share challenges and seek their solutions for example discordant and TB clubs. This was perceived to be a quality fostering element of the program*

- Routine spiritual education for clients
- Routine health education for clients
- Sufficient VCT and counseling rooms to maximize privacy

The team verified through observation and questions as to whether the above aspects were in existence, and whether they were functional. Findings varied from IP to IP. However most of the IPs visited were found with these services. Facilities that did not have them noted that they were aware that they are needed but lacked resources such as personnel and funds to put them into effect.

At a glance, the quality of services offered under IRCU support was found to be good. The support supplements the efforts of implementing agencies and indeed comes handy to improve service delivery. At Nyapea Hospital, for instance, clients on ART were getting uninterrupted service. The testimonies of the clients corroborate the assessment by the health staff. Adherence was above 95% for ART while no deaths had been reported in the recent past:

*The highest score in provision of quality service could be ART treatment because the service is not interrupted by any stock outs and with the adherence counseling our clients always get, our clients are responding well. We do not experience lost follow up especially for those clients on ARVs because there is no where else they can buy ARVs but sometimes we loose track of the clients on CTX prophylaxis who believe they can access septrin from any where else (Nyapea Hospital In-charge ART)..*

## 2.7 Levels of Client Satisfaction with Services

PHA respondents were asked to report about their experiences with services at the last visit to the IRCU supported service facilities. For most of them, the last visit was the same of the interview as many were interviewed as they exited from the facility. Majority (73%) reported that at the last visit, they had obtained all the services they needed or expected to get. The rest reported that they had only obtained partial services or did not get services at all. Similarly, 92.3% reported that they had seen all the service providers they sought to see. In a few cases, some clients wanted to see a doctor but were unable to due to different reasons. Majority (92.9%) were generally happy with he way they were handled, and79.3% reported that they were able to get the prescribed medicine. An equally big majority (86.8) reported that they were promptly attended to. See Table 5.

**Table 5: Clients' Experiences with services at Last Visit to the IP**

Obtained all the services needed at the last visit to the agency	Frequency	Percentage
Yes, definitely	292	73.0
Yes, only some	93	23.3
Somehow	7	1.8
No	8	2.0
Services/products obtained from agency at last visit		
ART care	231	57.2
Information/health education	110	27.2
Palliative care	105	26.0
Laboratory service	63	15.6
Pain control and management	33	8.2
HCT	28	6.9
Facility based basic care package	28	6.9
TB/HIV management	21	5.2
HBC package	16	4.0
Referral	5	1.2
Training	4	1.0

	Other	19	4.7
Particular service provider clients sought to see at last visit	Doctor	250	61.9
	Nurse	116	28.7
	Lab technician	66	16.3
	Counselor	75	18.6
	Pharmacist	93	23.0
	Other	1	0.2
Attended to by all those intended to be seen	Yes	361	92.3
	No	30	7.7
Health worker intended to be seen but were	Doctor	22	5.4
	Nurse	1	0.2
	Lab technician	2	0.5
	Counselor	4	1.0
	Pharmacist	2	0.5
Reasons for not seeing some of the service providers explained to client	Yes	52	78.8
	No	14	21.2
Client satisfied with the way service providers handled him/her	Yes, all	352	92.9
	No, only some	19	5.0
	Not at all	8	2.1
Got all the prescribed medicine	Yes	315	79.3
	No	82	20.7
Reasons for not getting all the medicines prescribed	Medicine not available	60	73.2
	Did not have money to pay	13	15.9
	Others	7	8.4
Client attended to soon after coming in	Yes	310	86.8
	No	47	13.2

In order to further assess client satisfaction with services, clients were asked further questions about the services they normally receive from the IRCU-supported agencies. Almost 60% reported that the services they received had helped them a lot to deal with their problems as PHAs. However, only 44.3% rated the quality of services received as very good; while another 44% rated them as satisfactory and 10.2% rated them as fair. Only 1.5% rated them as poor. Similarly, the rating of the range of services received was as very good (38.5%); satisfactory (45.9%), fair (13.9%); and poor (1.7%). The attributes of services liked most by the clients were their availability, quality, the friendly/good staff, and the fact that the services met their needs. See Table 6.

**Table 6: Aspects of Client Satisfaction**

	Frequency	Percentage	
Has the service you have received helped you to deal more effectively with your problems as a PHA	Yes, helped a great deal	240	59.7
	Yes helped	128	31.8
	Helped somehow	30	7.5
	No, not helped	4	1.0
Overall rating of the quality of services received from IP	Very good	178	44.3
	Satisfactory	177	44.0
	Fair	41	10.2
	Poor	6	1.5
Overall rating of range of services received from IP	Very good	155	38.5

	Satisfactory	185	45.9
	Fair	56	13.9
	Poor	7	1.7
Attributes of services particularly liked by the PHAs			
	Availability of services	155	38.4
	Quality of services	90	22.3
	Staff are good/friendly/helpful	86	21.3
	Services meet my needs	47	11.6
	Timeliness of services/quick service	16	4.0
	Am given information	15	3.7
	Others	15	3.0
Services needed by PHAs but not/insufficiently provided by IP			
	Home based care package	104	32.8
	Facility based care package	48	15.1
	ART care	35	11.0
	HIV/AIDS education/information	34	10.7
	Palliative care	30	9.5
	Pain control and management	25	7.9
	Training	21	6.6
	Laboratory services	10	3.2
	TB/HIV management	7	2.2
	Referral	5	1.6
	HCT	5	1.6
	Others	191	60.3

Client satisfaction was further assessed by asking respondents to state their level of satisfaction with a range of services provided by the IPs. Table 7 shows the results.

**Table 7: PHA's Level of Satisfaction with IRCU Supported Services**

IRCUC Supported Services	Highly satisfied	Fairly satisfied	Not satisfied	Don't know
Facility based HCT	87.8	9.2	2.2	0.8
VCT Outreaches	45.2	21.0	9.6	24.2
Provision of cotrimoxazole prophylaxis	85.6	10.0	4.1	0.3
Provision of fluconazole prophylaxis	29.9	11.0	14.2	44.9
Blood screening for diagnostic tests	72.8	12.4	7.6	7.2
TB prevention education through health education talks at facility	57.5	17.8	12.6	12.1
Clinical and diagnostic screening for TB	53.4	15.5	13.7	17.4
Provision of anti-TB medication	36.8	19.8	17.0	26.4
Follow-up of clients using TB-DOTs	27.2	20.4	19.4	33.0
Distribution of HBC kits	20.1	41.8	27.8	10.3
ITNs, bed-sheets, blanket etc	38.1	35.3	21.7	4.9
Follow-up of HBC clients	29.7	28.6	30.4	11.3
Education on safe water use and nutrition	70.2	20.3	6.8	2.7
Spiritual counseling and support	64.1	19.8	6.8	19.3
Administration of oral morphine	32.1	20.3	8.3	39.3
Provision of other analgesics	38.6	27.6	14.2	19.6
Screening for ART	77.8	8.7	4.5	9.0
Clinical follow-up	74.7	15.3	3.8	6.2
Adherence monitoring	69.9	10.8	8.1	11.2
Pediatric ART	33.6	17.6	10.1	38.7
Provision of ART drugs	81.1	5.8	6.2	6.9
Blood slide for malaria	71.9	12.5	7.6	8.0
Complete blood count	36.4	12.4	14.0	37.2
Liver function tests	23.4	3.2	16.9	56.5
Renal function tests	21.8	5.0	17.5	55.5
CD4 count and viral load tests	76.1	10.2	9.9	3.8
VDRL/STI tests	46.2	12.7	13.9	27.2
Screening for TB	61.5	9.8	13.2	61.5

From the above table, it can be observed that the highest levels of satisfaction were expressed for HCT (facility based), cotrimoxazole prophylaxis, education on water use and nutrition, screening for ART, clinical follow-up, provision of ART drugs, blood testing for malaria, and CD4 count tests. On the other hand, the lowest levels of satisfaction were expressed for follow-up of clients on TB-DOTs, provision of HBC kits, and follow up of HBC clients.

Service providers and managers were also asked to comment about the satisfaction of their clients with the services offered. Client satisfaction was reported to be reflected in the appreciation that clients express towards services.

*Whenever we go for the VCT outreaches we talk to the community, give health education, instead of asking questions, they tell us how they appreciate what we have done (Nyapea Hospital In-charge ART).*

On the other hand, some of the issues for dissatisfaction pointed out were cost of OIs treatment like malaria and transport of clients to the facilities.

## **2.8 Barriers to accessing ART and palliative care**

The barriers to provision and accessing of effective ART and palliative care services were reported by clients and service providers to include the following:

- Lack of mobile X-ray
- Staffing; we have small staff to handle clients like in Lab, counseling, pharmacies, we have challenges on the quality of care which is compromised.
- Cost of maintenance of vehicles and use of old vehicles
- Persistent problems of stigma among men
- Ceilings on the number of clients that can be enrolled for services – Some IPs reported that IRCU had given them a limit on the number of patients to be enrolled on ART for their site and were about to hit the ceiling. This means that all the existing demand would not be satisfied.
- Long distances from the health facilities to the homes of clients
- Inadequate space, logistics, and other physical resources

## **2.9 Relevance, Appropriateness and Acceptability of Service Delivery Models**

This study sought to among others assess the relevance, appropriateness and acceptability of different service delivery models used by the IPs supported by IRCU. The service delivery models found in use include the facility-based model; the home-based care model; the outreach model; the use of referrals to other service providers; follow-up of clients; the faith-based model; the community-based model; and the systems strengthening model. The Table below shows the extent of use of different models by different implementing partners.

**Table 7: Models of Service Delivery used by IPs implementing ART and Palliative Care Services**

Implementing Partner	Facility Based	HBC	Outreach	Referral	Follow-up	FB Model	Community Based	Systems strengthening
AOET	X	X		X	X	X	X	
Kumi Hospital	X	X		X	X	X		
Kisiizi Hospital	X	X				X		
Ishaka SDA Hospital	X		X			X		
Saidana Abubaker	X		X	X	X	X		
Namungoona Hosp.	X		X	X	X	X		
Kampala Diocese		X			X	X		
Mengo Hospital	X		X		X	X		
Meeting Point Kampala		X	X		X	X		
Kiwoko Hospital	X		X			X		
St. Luke H/Centre	X		X	X		X		
Holy Family Hospital	X		X		X	X		
Kuluva Hospital	X					X		

Key informants were asked to comment on service delivery models used, their relevance and appropriateness while highlighting their strengths and limitations / barriers. They reported that the service delivery models used are relevant, appropriate and acceptable to them. Asked what delivery models being used, responses varied from IP to IP but the following featured prominently across IPs:

- (i) **Facility-Based model of service delivery** - Facility-Based Care/Services – Most IPs provided services based in the clinics, hospitals or other clinical settings. Some run specific clinic days when PHAs come for services. This model was commended because of the following strengths;
- It provides a venue for sufficient investigations, diagnosis and treatment. Laboratories are available to carry out various tests as may be required;
  - Technical staff are available to provide a range of services and IRCU fills staffing gaps where appropriate to offer specialized services.
  - The team found out that IRCU supported clinics are strong and offer more comprehensive, affordable and or free HIV and AIDS services. As such, most of them were being used as referrals for HIV and AIDS services from other communities / facilities not supported by IRCU. The key informant from Saidana Abubaker Hospital said ***“Since IRCU brought HIV and AIDS services here, people in communities think that we offer HIV and AIDS services only. They think we have dropped provision of other services. They all come and others are referred here to access these services”***
- (ii) **Outreach model of service delivery** - IPs reported that outreaches are another delivery model appreciated by communities. Most services except ART had the outreach component. They appreciate the model due to the following strengths;
- Services are brought closer to beneficiaries

- They also noted that outreaches provide the opportunity to follow up clients and attend to treatment of minor opportunistic infection that do not require clients to travel to health facilities.
- In addition, IPs noted that the outreaches involve government health workers who support IP staff, share experience and fosters effective collaboration between IPs and government.

However, some IPs reported that they did not do outreaches. Kumi Hospital for instance reported that they used to do outreaches in the past but now it was not necessary as there were other HIV service providers reaching different communities. Kisii Hospital reported that they had substantially reduced outreaches due to limited resources.

- (iii) **Home-Based Care model of service delivery:** Home-based care – HBC was found to be a common model of delivering care services to PHAs. HBC includes home-visits to homes of clients. AOET reported that they have a team of CRPs (community Resource Persons) who are responsible for home-visiting. Kumi Hospital reported that they had trained home care givers through whom care kits are distributed. IPs noted that this is an important service delivery model in communities. It was appreciated due to the following:
- Some clients due to various reasons for example those who lack transport, have stigma or are in denial stay quiet at homes and will never come to outreaches or health facilities. IPs noted that such clients can easily be reached through this service delivery model.
  - They reported that this model provides the opportunity to garner family support for the client at home through education of family members and information giving.

**Table 8: Service Delivery Models in Use**

	Frequency	Percentage
Model of service delivery through which PHAs receive services		
Client visits agency	311	78.1
Agency staff sometimes visits client	81	20.4
Strictly agency visits client	2	0.5
It depends	4	1.0
Clients' preference in relation to delivery model		
Happy to be visited at home by agency	89	80.9
Not comfortable to be visited	1	0.9
No preference	20	18.2

- (iv) **Use of community volunteers:** IPs appreciate IRCU support to involvement of community volunteers / care givers that include; religious leaders, home-based care workers, expert clients, community counselors and or educators. Nyapea hospital has network leaders who were trained with IRCU support and given bicycles to visit clients in the villages. In case they find clients who are bedridden and cannot come to the hospital, they inform hospital staff who go and pick them up using the Ambulance.

They appreciate the model because of the following;

- They provide a strong linkage between health facilities and communities through mobilization, awareness creation, referrals and monitoring adherence.
- They fill gaps which technical staff cannot fill because of challenges of human resources at health facilities.

However, the major limitations reported were that (i) community caregivers were not well motivated to boost their morale during implementation of activities and (ii) They dropped out frequently when IPs have already invested in them through training.

- (v) **Health Systems strengthening model:** Findings from key informants revealed that IRCU interventions strengthens health systems through the following:
- Training of IP health facility staff
  - Establishment / strengthening HIV and AIDS clinics that were not there or were weak before
  - Laboratory strengthening and other infrastructural improvement through refurbishment (electing client sheds, expansion of rooms etc)
  - Partnership with PACE which provides a very essential HBC package to ART/Palliative clients.
  - IPs commended IRCU for allowing them flexibility to modify and adopt the Basic care kit to the needs of the clients and their caregivers. For example, Mengo Hospital kit includes: dettol soap, ordinary soap for washing, gloves, tooth brush, towel, jik, omo etc.
  - Increasing human resources for IPs, some of whom are recruited on permanent basis and are absorbed by the respective IPs in their health systems.
  - IPs involvement of public health works during outreaches strengthens their capacity in service delivery.
- (vi) **Referral** – Referrals were used where IPs did not have the services needed by certain clients. Several IPs reported that they referred clients elsewhere for needed services. IPs such as AOET (Jinja District) which do not provide ART and CD4 count tests referred their clients to hospitals and other facilities that provide these services such as Kakira where JCRC has a facility and Jinja Hospital. Kumi Hospital reported that it referred clients to Soroti and Mbale for CD4 count tests. The referral model was important because:
- It enabled service users to access additional needed services
  - It enabled facilities to concentrate on providing a few services that they can manage – expertise remains concentrated where it is optimally utilized.
  - Where coordination is working well, it enables provision of a comprehensive package of services.

Only 14.4% of the respondents interviewed reported that they had ever been referred to get services from elsewhere. The services commonly referred for were ART, TB services and laboratory services. Table 9 shows the results.

**Table 9: Client’s Experiences with Referral Services**

	Frequency	Percentage
Ever been referred to get services from elsewhere		
Yes	58	14.4
No	346	85.6
Services for which clients were referred		
Information/health education	2	3.4
HCT	3	5.2
Facility based care package	2	3.4
Home based care package	1	1.7
Palliative care	7	12.1
ART care	24	41.4
TB/HIV management	14	24.1
Laboratory services	13	22.4
Pain control and management	5	8.6
Other	6	10.3
The last you were referred elsewhere, did you obtain the services/products for which you were referred?		
Got all services/products	45	78.9
Got partial assistance	10	17.6
Did not go	2	3.5

Majority of the PHA respondents (78.9%) that had ever been referred reported that they obtained the services they needed.

- (vii) **Faith-Based model of service delivery:** Key informants remarked that the faith-based model is a very essential element of IRCU programming at IP level across IRCU supported interventions because of the following strengths that it has:
- Working through religious structures and leaders widens quick geographical coverage through various religious denominations,
  - Strengthens community mobilization and personal commitment implementation of programs and accountability. They said that prayers give hope and belief in services they receive. Among some IPs, there are billboards with phrases such as *“We treat; God heals”*. One key informant said that in the Muslim faith before an injection is given, the following prayer is encouraged *“Bismillah Rahaman Rahim”* a prayer request for drugs treatment to work effectively and not to attract adverse side effects.
  - Self control skills foster beneficiaries to adhere to treatment guidelines.
  - The evaluation team noted the when Christians and Moslems quote the bible and *quoran* reflecting when Jesus and Mohammad respectively were giving care to the sick, service providers and beneficiaries become more committed to these programs because it reduces stigma among.

As part of the faith-based model, most organizations work with religious leaders. AOET for instance reported that they work with religious leaders who visit their PHA clients to offer spiritual support. The aspect of inter-faith is reflected in the fact that organizations such as AOET work with religious leaders of different denominations. The specific roles played by religious leaders included:

- Home visiting to pray and offer spiritual support
- Praying and visiting patients on wards (in facility based services)
- Follow ups
- Mobilization

Kumi Hospital for instance reported that spiritual counseling is part and parcel of the hospitals’ work. The hospital has a public address system connected with speakers to all parts of the hospital. Prayers and sermons are aired through this system to reach everybody in the hospital. In Nyapea Hospital, IRCU trained religious leaders who do home visits. They also offer spiritual care in form of morning prayers. There is a Parish Priest for the Catholics, an Imam for the Moslems and a Reverend for the Protestants. These religious leaders come to the hospital to offer spiritual support every Tuesday.

## 2.10 Factors Contributing to Quality Service Provision through FBOs

Some of the factors contributing to high quality of services through FBOs were found to include:

- Commitment of staff – staff of FBOs provide services as part of their call. It is considered as part of their apostolate and their desire to fulfill their religious belief of serving and caring for others. As a result, staff put in extra effort, work overtime or go that extra mile to meet the needs of their clients.
- Use of volunteers – Use of volunteers was found to be an effective mechanism of reaching the clients while at the same time cutting down costs. In AOET, they have CRPs who do the home-visits. In Kumi Hospital they have trained home care givers. In Kisii, they have expert client volunteers.
- Honesty and transparency – FBOs were reported to be more honest and transparent than non-faith-based organizations. They endeavor to deliver what they promise, and they ensure that the support reaches the intended beneficiaries.

- FBOs also have a network of structures from the national level down to the grassroots. Through these, they are able to mobilize, to disseminate information, to monitor and to follow up the services provided.
- Some IPs such as Kiwoko Hospital have additional facilities such as child play centres stocked with playing tools and chairs

## **2.11 Good Practices in Service Provision**

- Some IPs use PRA to establish HIV and AIDS interventions for OVC and households in communities (Namirembe Diocese)
- Some IPs complement efforts of IRCU to fill service gaps through resource leveraging. For example they provide food supplements to clients
- Some IPs (such as Mengo Hospital, Saidana Abubaker and Kisiizi hospitals) use services of expert clients in service delivery to reduce stigma, to care for others, act as role models, and motivate them not to transmit the virus to others.
- Excellent referral network between IPs for example Kampala Diocese and Mengo Hospital (both supported by IRCU)
- Collaborations and partnerships demonstrated by IPs for example Kampala diocese partnerships with Mildmay and TASO for HIV and AIDS Management and training
- At Kiwoko Hospital, arrangements are made in such a way that all clients who turn up on clinic days receive services before lunch time to enable clients embark on their activities and avoid them incurring lunch costs while seeking services.
- Introduction of user fees at Kiwoko hospital (10,000) is commended as a good practice to meet some needs of clients not met by IRCU or funds can fill gaps during the period when the financial flow is poor. Annual user-fees are considerably cheaper than fees per visit.

## **2.12 Limitations and Challenges**

- Limited space/accommodation – In some IPs, problems of working space were found. In Kumi Hospital for instance, a counseling room also served as an office, and was very close to the waiting area, thus compromising privacy.
- On some occasions, IPs receive ARVs that have a short life for example six months. However, arrangements are normally made with other IRCU supported health facilities and take them before they expire
- Blood samples taken to JCRC delay enrolment of clients on ART. Feedback takes long (a week or so)
- IPs experience frequent drug stock outs for TB including antibiotics (from MOH) which compromises adherence to treatment. Much as this is not an IRCU problem, it affects IRCU funded programs.
- Long distances to health facilities. Some clients travel as far as 50 miles away from the health facilities requiring about 10,000 shilling for transport per visit
- Delay in release of funds by IRCU affects timely implementation of planned program activities.
- At some IPs, there is little or poor facilitation of field staff to adequately follow up and monitor activities in communities. The reason is that either staff are few or motorcycles are old and have broken down without repair or placement (case of Kiwoko and Namungona Orthodox hospitals)
- Shortages of staff (case of Ishaka Adventist hospital)
- IPs complained that their proposals to IRCU were rejected and planned activities/budget items altered without consulting them.

- Use of standard prices for supplies in Kampala which are often different from the prices up-country
- Delays in disbursement of funds – some IPs reported that sometimes release of funds delays for more than 3 months, thus affecting planned activities.
- Lack of transport means - The bicycles got old and some religious leaders who got bicycles to do palliative care have since been transferred, while some volunteers were reported to have died.
- Inadequate stocks of ITNs to give to all clients
- IPs in Northern region which used to do CD4 count at the referral hospital in Arua reported limits on the number of samples they could send per month (20 samples a month, at times 10) yet the number of clients that needed the tests were many.
- Lack of facilities to do laboratory monitoring – IPs in the North have to do CD4, PCR, LFTs, RFTs tests in Arua regional referral hospital which is 140kms away. The manpower is available to do the work but there is lack of machines.
- Lack of facilities to do pediatric tests such as PCR. Previous arrangements to send samples to MoH through the post office have since ceased.
- Lack of needed services at the places of referral

### 3.0 SUPPORT TO OVC FOR FORMAL EDUCATION

#### 3.1 Introduction

This chapter presents the findings about the IRCU-supported services for OVC in formal education. The team found out that IRCU supports the following integrated services under this program area to complement formal education: provision of scholastic materials; access to medical care; psycho-social support; training in cognitive and life skills; child protection and paralegal training.

#### 3.2 Socio-Demographic Characteristics of the Respondents

The socio-demographic characteristics of the child respondents supported in formal education are presented in Table 10 below.

**Table 10: Socio-demographic characteristics of OVCs in formal education**

Characteristics	Respondents	
	%	N
<b>Sex</b>		
Female	242	53.9
Male	207	46.1
<b>Age</b>		
<12	147	32.7
13-15	218	48.6
16-18	76	16.9
19+	8	1.8
<b>Class Attended</b>		
P1-P4	107	23.8
P5-P7	262	58.3
S1-S4	72	16.0
S5-S6	8	1.8
<b>Relationship with caretaker/guardian</b>		
Parent	255	56.8
Uncle	11	2.4
Aunt	34	7.6
Grandparent	103	22.9
Sibling	11	2.4
Other relative	4	0.9
Not related by blood	31	6.9
No response		
<b>Source of income</b>		
Nothing	9	2.0
Business	7	1.6
Informal skilled	5	1.1
Informal unskilled	10	2.2
Still a student	417	92.9
Other	1	0.2

The sample of OVC supported in formal education consisted of slightly more females(53.9%) than males (46.1%). The biggest proportion was aged 13-15. Majority of the children supported were in primary school, with only a few in secondary level. Majority of the children were under the care of a surviving parent or a grandparent.

### 3.3 Needs and Expectations of Clients

OVC supported in formal education were asked to mention their needs for which they commonly needed external support. These were mentioned to include educational related needs, feeding, health care, and housing. Unfortunately, some of these needs were not within the scope of the programs and therefore could not be met by the IRCU-supported agencies.

**Table 11: Needs of OVC in relation to Services Provided**

	Frequency	Percentage
Common Needs of OVC as identified by OVC		
Education	289	64.4
Food and nutrition	149	33.2
Housing	68	15.1
Health care	117	26.1
Employment	10	2.2
Socialization/psycho-social	21	4.7
Others	182	40.5
OVC's assessment of services/products provided to them by IPs in relation to OVC needs		
Agency fully meets needs	204	46.0
Needs only partially met	237	53.5
Needs not met	2	0.5
Critical needs of OVC insufficiently met		
School fees (primary)	74	16.7
Bedding/sleeping materials	59	13.2
Scholastic materials	53	11.9
Clothing	36	8.1
Health care	33	7.4
Food at home	33	7.4
Food at school	19	4.3
School fees (secondary)	15	3.4
Start-up capital/tools/materials	5	1.1
Others	45	10.0

The needs and expectations of children supported for formal education cannot be divorced from the expectations of their caregivers about the needs of those children. These needs and expectations related both directly to the schooling of the children (such as school fees and supplies) as well as to the social, physical and other needs of the children.

Some IPs (e.g. Jinja Diocese) mentioned that they had carried out needs assessments through which they identified the critical needs of OVC. Jinja Diocese however reported that they were not fully meeting the needs of OVC – meeting only about 70% of the needs for formal schooling because they were not providing lunch and shoes, yet the had been identified as being among the critical needs.

With respect to school charges, it was reported that although schools are not meant to charge fees under the UPE scheme, most schools charged what they call ‘development fund’ and ‘academic fund’ ranging between Uganda Shillings 5,000 to 20,000. The academic fund is meant to cover costs of tests and examinations. As a result of this, some children are often sent home due to failure to pay. The table below summarizes these needs and expectations as reported by the IPs.

### Box 3: Needs and Expectations in relation to OVC in Formal Education as reported by IPs

<i>Schooling related needs</i>	<i>Families expect that all children in a vulnerable family should be helped, and not just one. Where only one child is supported e.g. with shoes, this creates conflict with other children.</i>
	<i>Need to increase the number of scholastic materials. Some time they (one dozen) are not enough for the term in schools were the need 18 exercise books. In secondary schools, students need black books and not exercise books</i>
	<i>Need for support in tuition fees and or development fund in schools</i>
	<i>Need for regular provision of meals (supplementary feeding) at schools where this support is provided. Where support is given, it is regular Introduce nutrition support where this support is not provided</i>
<i>Other complementary needs</i>	<i>Need for ITNs</i>
	<i>Need for better facilitation of child rights monitors to actively follow up OVC in communities</i>
	<i>Beddings such as mattresses and blankets - Some have no clothes, beddings, they sleep on the floor, they also don't have blankets they sleep in the cold.</i>
	<i>The need for paraffin is high because power is either irregular or not in available at all</i>
	<i>Need for a more organized mechanism for treating OVC. Medical access to OVC is not adequate. Most OVC are referred and there is no control regarding whether they receive services, what service they receive or not</i>
	<i>There is need for holiday programs for children. These are however not supported by IRCU</i>

### 3.4 Type of Support Provided to OVC in Formal Education

OVC interviewees supported in formal education were asked to mention the types of services they had received from the IPs. Table 12 shows the responses from these children.

**Table 12: Type of Support and Training Received by OVC supported in Formal Education**

	Frequency	Percentage
Type of support ever received by OVC from IRCU IPs		
Support for formal education	449	100.0
Counseling/psycho-social support	176	39.2
Support to access health care	160	35.6
HIV/AIDS education/BCC	156	34.7
Food & Nutrition Support	134	29.8
Care and support	81	18.0
Child rights/protection	76	16.9
Training	59	13.1
Support for IGAs	24	5.3
Referral	9	2.0
Other	41	9.1
Type of support received under Formal Education		
Scholastic materials	434	97.5
School uniform	374	84.0
School visits	310	69.7
Home visits	194	43.6
Counseling/Psycho-social support	258	58.0
Other	45	10.1
Other Types of training received		
Counselor training (peer to peer)	19	4.2
Psycho-social support training	29	6.5
Life and cognitive skills training	31	6.9
IGAs training	22	4.9
Child rights training	39	8.7
Other	9	2.0

Most IPs reported that at primary school level, they provided scholastic materials to the children. Almost all the children in the sample (97.5%) reported that they had received scholastic materials; 84% reported that they had received uniforms. Common items given out include:

- School uniform
- Exercise Books

- Pens
- Pencils
- Mathematical Sets (for upper primary classes)
- Duplicating Paper (for upper primary)
- Sanitary pads (for girls in upper classes)
- School bag
- Underwear (for girls)

A few IPs also gave out shoes. In some projects/schools, support also covered midday meals (e.g. Busota) while in others it did not. Some IPs also supported children in secondary schools (e.g. Jinja Diocese, Kumi Diocese, Agape Nyakibale) – In Jinja Diocese, it was reported that IRCU support covered a top up of 50,000/= per term – but the average school charges for most schools was 200,000/= to 250,000/= meaning that needs were only partially met and some children got chased from school.

**Table 13: Number of Children Supported by IPs in Primary and Secondary Schools**

Implementing Partner	Number of OVC supported in Formal Education		
	Number supported in Primary schools	Number supported in Secondary schools	Total number of OVC supported in formal education
Jinja Diocese	210	40	250
Busota OVC Project	200	0	200
Namisambya OVC Project	190	10	200
Islamic Outreach Centre	159	21	180
Kumi Diocese	173	30	203
Kakinga Development Centre	200	0	200
Agape Nyakibare	441	59	500
Karera Ecumenical	170	0	170
Bweranyangi	420	0	420

Many IPs also supported the medical care of children by referring the supported children elsewhere for medical care and meeting their transport costs. The challenge with this was that the facilitation for transport covered only one person, yet under normal circumstances, the child would need to go with an adult to accompany him/her. Another limitation was that the transport was paid as a refund not in advance of seeking medical treatment. As such it meant that children/caregivers had to look for money, go for treatment and ask for a refund later. Implementers also reported that in some cases, the referred child did not obtain the service referred for. In Islamic Outreach Centre, there was no system of feedback to know whether referred children got the service or not and what type of service was got. No referral form was used. Others used referral forms (Kumi Diocese, Kakinga Child Development Centre). Some projects such as the Caritas OVC project in Ulepi, Nebbi Catholic Diocese provided curative health services at the selected FBO facility at Ulepi Parish.

On the frequency of service provision, two thirds of the OVC supported in formal education (66%) reported that they received scholastic materials about once every quarter of a year. Only 3% reported that they received scholastic materials once a year and only 4.2% reported that they ever received only once. See Table 14 below for details.

**Table 14: Frequency of Service Provision to OVC supported in Formal Education**

	Once a week	Once a month	Once a quarter	Once every half a year	Once a year	Only once ever	Only a few times	Other
Visited at school	13.2	22.3	31.6	2.9	2.9	3.2	7.1	16.8
Visited at home	22.6	21.1	21.1	6.8	6.8	12.0	9.8	0.0
Offered counseling/PSS	20.2	23.6	19.4	0.8	4.3	5.8	4.7	21.3
Received scholastic materials	1.9	7.9	66.0	4.9	3.0	4.2	2.6	9.5

### 3.5 Perceptions of Quality of Services

Key informants were asked to comment on what they considered to constitute quality services in the provision of formal education. Findings indicate that the quality of support for formal education was rated highly. Key informants rated quality high basing on a number of parameters that included the following:

- The quality and quantity of scholastic materials bought. Most schools purchase *Picfare* exercise books and sufficient enough to take the supported child through the term.
- If the support helps to keep most children in school
- The support covers items that children not get elsewhere like books, pens, sanitary towels, sets; they only give them school fees, social support, HIV/AIDS support like sensitization, transport facilitation food support, visitation, health screening.
- KIs considered training of teachers and parents in child care and support and parenting skills as essential ingredients of OVC support. They improve care, relationship and communication between OVC and guardians and teachers which enhance their learning environment. Above all, they enhance behavior change among OVC.
- Participants remarked that school visits and home visits conducted by staff form critical components of the education model. They provide an excellent linkage between schools, IPs, guardians and OVC. They are avenues where children challenges including those of caretakers are identified discussed and solutions sought. They also motivate them to work hard and improve relation ship between guardians and schools

### 3.6 Levels of Satisfaction with Services

OVC respondents were asked to comment on a number of aspects in relation to the services provided. The results are shown in the table below. The results show that more than half (56.9%) thought that the services received had helped them a lot to deal with their problems as OVC. Majority (55.7%) rated the quality of services as very good, while 31.8% considered the quality to be satisfactory.

**Table 15: Aspects of client Satisfaction**

	Frequency	Percentage	
Has the service you have received helped you to deal more effectively with your problems as an OVC	Yes, helped a great deal	251	56.9
	Yes helped	153	34.7
	Helped somehow	32	7.3
	No, not helped	5	1.1
Overall rating of the quality of services received from IP	Very good	249	55.7
	Satisfactory	142	31.8
	Fair	48	10.7
	Poor	8	1.8
Overall rating of range of services received from IP	Very good	226	50.6

	Satisfactory	156	34.9
	Fair	54	12.1
	Poor	11	2.4
Attributes of services particularly liked by the OVC			
	Package/content of services	247	55.0
	Services meet my needs	73	16.3
	Amount of services/support	43	9.6
	Quality of services	36	8.0
	Timeliness of services	8	1.8
	Gained skills	4	0.9
	Enabled me to work/earn a living	1	0.2
	Others	34	7.6
Services needed by OVC but not provided by IP			
	Food and nutrition support	108	24.5
	Support for formal education/School fees	102	23.0
	Support to access health care	54	12.2
	IGA support/start up capital	41	9.3
	Skills training/apprenticeship	15	3.4
	Counseling/psycho-social support	8	1.8
	HIV/AIDS education	8	1.8
	Other forms of training	3	0.7
	Others	163	36.8

Service gaps were identified from the services needed by the OVC but not provided by the IRCU-supported agencies. Up to 72.7% (n=319) of the OVC supported in formal education reported that there were certain services that they would have wanted but which were not provided to them by the IRCU supported agencies. These were reported to include food and nutrition support, school fees, and support for health care.

OVC interviewees also provided a ranking of their levels of satisfaction with the different services provided by the IRCU implementing partners. See Table 16.

**Table 16: OVC Level of Satisfaction with IRCU Supported Services**

IRCU Supported Services	Highly satisfied	Fairly satisfied	Not satisfied	Don't know
Support to formal education (scholastic materials, uniforms etc)	82.7	13.9	3.4	0.0
Support to access health care	60.1	16.1	17.9	5.9
HIV/AIDS education	69.2	15.8	9.3	5.7
Food and nutritional support	45.8	19.0	28.6	6.6
School visits	70.0	22.3	5.8	1.9
Home visits	61.0	18.4	17.5	3.1
Training OVCs in IGAs	41.2	16.5	16.5	25.8
Training in life and cognitive skills	62.5	13.5	9.0	15.0
Training OVC in children's rights	58.5	13.7	11.9	15.9
Training in psycho-social support	51.9	18.6	13.1	16.4
Training in counseling (peer to peer)	49.7	13.4	18.8	18.1

The services for which there were high levels of satisfaction included provision of scholastic materials and school visits. Those for which the OVC were not satisfied included food and nutrition support, support to access health care, home visits, and training in IGAs.

Variations also existed in the extent of meeting OVC needs depending on the levels of education at which they were attending. Implementers themselves thought they had met the needs of clients for primary education to a large extent, and only to a small extent for those in secondary school. This was because the demands for secondary were higher and more costly, and the support only covered a small proportion of that. Overall, some of the beneficiaries were reported to be happy with the support, others had mixed feelings, while others were dissatisfied.

*The main satisfaction is with the children because we are able to see it. These children are now smart; we are able to give them uniforms, enough exercise books unlike before when they would use one book for all the subjects. At least the children are able to remain in school all the time. That is our big achievement. The care takers are now relieved as most of them are widows (Nebbi COU OVC Project Coordinator).*

IP representatives were asked to comment on beneficiary satisfaction with formal education support to OVC.

*They are happy with the program given the situation where we got these OVCs, they were studying in torn clothes, others did not have uniforms, some of them were bedridden especially those on ARVs and others were discriminated in their homes (Lango Diocese OVC Project Coordinator).*

*...as the person implementing, they are satisfied but as the implementer, I wish I had done more (Amuca SDA OVC Project Coordinator).*

*The community has liked the programme but they are complaining that it is not reaching very far.....the chairperson of Apac district was asking us why we are not having activities in Apac (Amuca SDA OVC Project Coordinator).*

School authorities talked to judged the type of support given to children to be relevant and appropriate because it was meeting real needs. A deputy headmistress in one school in Jinja commented that the support with scholastic materials was relevant because some children used to go to school without books. On the other hand, implementers reported that sometimes funds did not come in time, and the clients would be asking what happened to the expected support.

*The money comes late which makes procurement late like this term money for buying books came when they were beginning exams. Ideally, we are supposed to give books when the term is beginning but for us it is either in middle of term or end. This term we were only able to give out books once instead of two – it has created suspicion among parents. Money for uniforms was split into 2 quarters, we got money for 1<sup>st</sup> quarter but 2<sup>nd</sup> quarter, we have not got it yet, we don't know whether it will come (Staff member, Bweranyangi OVC project).*

Others were concerned that the support offered does not meet all the children's costs for schooling, yet their families cannot raise the cost of these needs.

*We get funds for only scholastic materials, it does not keep OVCs in school. They are always chased for school dues so they lose a lot of time for learning. You cannot guarantee their staying in school. (Staff member, Karera Ecumenical).*

At secondary school level, some children are forced to change schools when school fees are increased in the school they have been attending (Jinja diocese).

Dissatisfaction was also reported with regard to provision of medical support. Most implementing organizations for OVCs only offer transport to public health facilities. Some of the facilities to which the OVCs are referred not provide the appropriate care service. The case of one child under Amuca SDA OVC Project who had passed away on the day the Research team visited served to underline the difficulties in addressing needs of vulnerable members. Similarly, implementing partners in northern Uganda are concerned at the biting challenge of food insecurity especially among families with OVCs and PLHAs which are only struggling to resettle in their natal communities after years of insurgency. The current projects mainly focus at the school level needs of OVCs and nearly leave out the broader issues at family level. The Table 17 summarizes the responses of implementers towards aspects that they were particularly satisfied and not satisfied with:

**Table 17: Satisfaction towards services among service beneficiaries**

<i>Common area of satisfaction</i>	<i>Reasons</i>
<i>Provision scholastic materials</i>	<i>They are regular and essential / basic requirements at school and are of good quality and supplied in enough quantities for OVC.</i>
<i>OVC identification process</i>	<i>The process is very involving and participatory at all levels</i>
<i>Home and school visits</i>	<i>It improves relationship/ reduces gap between guardians, OVC and the institution. Changes are identified and solution sought together, fosters referral for children where applicable</i>
<i>Child protection</i>	<i>OVC know where, when and how to seek support when abused in any form. Cases of abuse by step mothers or greedy uncles are minimal</i>
<i>Access to medical care</i>	<i>Keeps OVC at school which would not be possible if not supported. Caregivers are poor</i>
<i>Training of religious leader in guidance, communication, stress management and psycho-social support</i>	<i>Trained religious leaders are very committed to OVC programs, provide better care to OVC and carry out effective mobilization</i>
<i>Common area of dissatisfaction</i>	<i>Reasons</i>
<i>Training of teachers in OVC care and support</i>	<i>This has never been done or training happened once early in the beginning of the program. Many teachers are not trained</i>
<i>Food and nutrition support</i>	<i>Not prioritized by IRCU</i>
<i>Paralegal training</i>	<i>Hazy or had never been conducted</i>

### 3.7 Relevance, Appropriateness and Acceptability of Service Delivery Models

In supporting the formal education of OVC, the key models of support considered were the provision of scholastic materials in-kind (rather than paying fees or supporting IGAs and the family-based approach – whereby all children in a vulnerable family are supported. The principles of faith-based approach were found to cut across these models.

- (a) **Provision of Scholastic materials** – The provision of scholastic materials as opposed to payment of fees or provision of other forms of support was assessed to have both strengths and weaknesses. The approach was justified because under the UPE policy, the fees of children are presumed to be covered by government. In reality however, a range of charges still exist in schools. Provision of scholastic materials therefore helps to fill a critical gap that many vulnerable children would not fill on their own, but they do not take away the biggest burden on vulnerable households. The other limitation of this form of support is that it may create dependency, rather than build capacity. In cases where it is not accompanied by other support to meet other needs such as for feeding, clothing and medical care, children may still fail to regularly attend school.
- (b) **The Family Based Approach** - In many cases, it was found that the IPs did not adopt the family-based approach recommended by the MGLSD. The family-based approach would entail supporting all OVC from any one selected household, i.e., if an OVC from a household was identified for support, all the children in that household would be reached with support. The advantage of this would be that it would minimize intra-household conflicts, jealous and discrimination as all children in the same household would be treated in the same way. In practice, many IPs reported that this approach proved problematic to implement. It would mean concentrating the few available resources in a few households. Instead, the community members themselves preferred that the support be spread out to reach many households even if it meant supporting only 1 or 2 children per family. For most projects visited, they reported that the maximum number of OVC that could be supported from any one household was 2. As a consequence of this, it was in some cases reported that children in a family shared the support given to one child (e.g. the 12 exercise books given to one child ended up being shared among many). The

difficulty in implementing the family-based approach was reported by many agencies including Jinja Diocese, Namisambya OVC Project, Kakinga Child Development Centre, among others.

Failure to implement a family approach also had its problems. For instance in projects which gave out shoes to OVC (e.g. Busota during Year 1), it was reported that if one child was given shoes and other children in the family never got, this would create problems amongst children in that household.

- (c) The faith-based approach and principles - As part of their faith-based model, some IPs reported that they invite religious leaders to speak to the OVC. In Busota OVC project (Kamuli District), it was reported that religious leaders of all denominations are invited to talk to the children. Reflecting the inter-faith approach, this project reported that they supported more Christian children than Muslim ones, although the project was Muslim-based.

Use of faith based approach to OVC is important. It gives them hope and personal commitment to studies as they it gives them a new look at themselves line non-orphans. One key informant (Namirembe Diocese) remarked ***“life cannot be in its fullness without God...John chapter 10 verse 10”***. Such scriptures give hope to OVC

*Religious leaders do special counseling especially for those we are difficult to change but they generally offer prayers. They visit other school probably once a month or twice depending on the programmes they have. Then if there are extreme cases they follow up like abuse, children that are not cared for. They also help us get primary data that the children take long to reveal but come up through counseling (Amuca SDA OVC Project Coordinator).*

### **3.8 Factors Contributing to Quality Service Provision through FBOs**

- Identification and selection process for OCV education support is excellent. It involves PRAs, a series of community consultative meetings, establishment of committees to verify and vet OVC for support at household level and then carryout needs assessment exercises. Participants noted that these procedures and process involve religious leaders, community members and leaders, households and PHAs. This representation maximizes transparency, accountability and ownership of OVC supported activities
- The model integrates psycho-social support to OVC, social protection and rights of OVC and life skills in the formal education of the child. They noted that these important aspects of the model that supplement formal education. It enhances partnership and service complementarity where for example the government through probation officers and police play their part. OVC and guardians know when and where to get the support when their children are abused and enhance personal responsibility and behavior change among OVC.
- Most OVC are supported up to senior 4 or when they make 18 years. This was highly commended In the first place; supported OVC would no be in school if IRCU had not provided this support. Thus, the model provides the future to OVC which would remain uncertain if they had not been supported.
- Most IPs do home and school visits during which they provide counseling, education on HIV/AIDS and monitor children school attendance and performance.

### **3.9 Good Practices in Service Provision**

*Balancing for gender* - In most IPs visited (e.g. Jinja Diocese), equal numbers of male and female children were being supported in school to ensure gender balance.

*Participatory selection of beneficiaries* – Selection of beneficiary children was reported to be participatory. One IP described their selection process as follows: “We first sensitize the community, we tell them we have a program on OVCs and we are going to support them in this parish, we shall design a method on recruitment. We want a total orphan or an orphan who has lost one parent. We can also recruit an OVC from a needy family when the two parents are alive. When they were recruited we called all the caretakers of the OVCs with the OVCs and the local authorities for a meeting. We use the family approach where we would recruit two to four OVCs from one family. The community participates in the screening and those who are supported really deserve the support” (Lango Diocese OVC Project Coordinator). Another one had this to say: If a child should be considered, the community decides since they know which OVC is needier compared (Nebbi COU OVC Project Coordinator).

*Support to OVC in secondary education* – it was found that in some cases, IPs supported OVC for secondary education. This mostly happened where IPs had supported OVC in primary 7 in the previous year, whereby they continued the support as they entered secondary level. This was considered a good practice by the Consultants team, unlike in the case of many NGOs where support ceases at P.7 leaving OVC stranded without further support beyond P.7.

*School and Home Visits* – Incorporating school and home visits in the support was found to be important for ensuring effective use of the support and for providing complementary services such as psycho-social support.

### **3.10 Limitations and Challenges**

Most IPs and schools visited reported that the number of children supported was very small compared to those in need.

*“Supporting only 50 children here in a school of 988 pupils is just a drop in the ocean. About half of all the children in this school are vulnerable, because they come from families that came from Northern Uganda escaping the war. Some caregivers whose children are not supported come here and complain” (Deputy Headmistress, Kimasa Primary School – OVC supported by Jinja Diocese)*

The support extended to children in school did not cover meals for some schools (e.g. Kimasa PS in Jinja). OVC see other children (who have paid for meals) take porridge at lunch time, while the themselves have no midday meal.

One of the unintended consequences of the support is that schools that host supported OVC have experienced increasing enrolments because parents know that there is a project supporting children in such and such a school.

Many IPs reported limited staff – and yet have a big number of people to reach out to. Though religious leaders have come in to help, there is often inadequate facilitation for them such as lunch while in the field.

Other agencies (E.g. Islamic Outreach centre – Kumi) reported that their clients were dispersed over a big geographical areas with the effect that monitoring and home visits are very costly or difficult to do without effective means of transport.

Some IPs thought that by distributing books and other hand-outs, they could have been creating dependency. They preferred an approach that builds more capacity of households rather than distributing items. Other challenges/limitations reported include:

- The value of education in some communities still low. This affects mobilization for the neediest OVC and enrollment in schools
- Most caretakers are poor and fail to make contribution to supported OVC.
- Late disbursement of funds affect purchase of the scholastic materials in time which affects OVC at school
- The escalating costs of scholastic materials affects the quality of scholastic materials for supported OVC
- Supported OVC are still being chased out of schools and miss out lessons due to other fares not supported by IRCU. These include for example uniforms, development fund, inadequate scholastic materials and tuition fees
- Poor communication / linkages between the school administration and some IPs affects OVC learning
- There is a problem of school dues, even government schools charge some fees, so you find they have changed to another school because of school fees, actually we are supposed to get Report cards from them but they don't get them because of fees. We make school uniform then you find the child changed school.
- In many cases, the support does not pay for secondary school once an OVC completes P.7, the project stops supporting him/her.
- Some IPs do not give ITNs, school bags, mattresses
- Most IPs give uniforms but not sweaters yet in some schools, children are not allowed to wear something also other than school sweeter.

## 4.0 SUPPORT TO OVC THROUGH APPRENTICESHIPS

### 4.1 Introduction

Skills training of OVC mainly targeted those children who were out-of-school or unable to continue with formal schooling. Skills training consisted of both training through attachments to local artisans (apprenticeships) and enrolment in vocational institutes. Data was collected from the managers/representatives of IPs, the trainers, and the trainee children.

### 4.2 Socio-Demographic Characteristics of the Respondents

Table 18 below presents the socio-demographic characteristics of the OVC interviewees that were supported for skills training.

**Table 18: Socio-demographic characteristics of OVCs in formal education**

Characteristics	Respondents	
	%	n
<b>Sex</b>		
Female	68.5	146
Male	31.5	67
<b>Age</b>		
10-12	5.2	11
13-15	11.7	25
16-18	53.5	114
19+	29.6	63
<b>Highest level of education attained</b>		
Primary	25.9	54
Secondary	15.0	32
Post secondary	0.0	0
Vocational	59.2	126
<b>Relationship with caretaker/guardian</b>		
Parent	48.4	103
Uncle	8.5	18
Aunt	8.5	18
Grandparent	14.1	30
Sibling	9.4	20
Other relative	1.9	4
Not related by blood	6.6	14
No response	2.8	6
<b>Source of income</b>		
Nothing	11.3	24
Business	7.0	15
Vending	0.5	1
Formal skilled	23.9	51
Formal unskilled	0.5	1
Informal skilled	22.5	48
Informal unskilled	4.7	10
Still a student	27.7	59
Other	1.9	4

As can be observed from the Table above, majority of the interviewees in this category consisted of females (68.5%), compared to males (31.5%). Over half were in the age range 16-18. It is also evident that a substantial proportion of these OVC (29.6%) were aged 19 and above at the time of the interview. This is explained by two factors. First, majority of the interviewees had completed their training programs by the time of this study and had graduated. This means that they most likely got enrolled for training when they

were still under 18, but had turned 19 or more by the time they completed the training. Secondly, by virtue of the nature of skills training, it is considered more suited to older rather than younger children. Trades such as carpentry, brick-laying and so on are more likely to attract relatively older youths compared to formal education. Moreover, most of the youths targeted for skills training had dropped out of school. In any case, vulnerability does not necessarily end when one turns 18, despite the legal/official definition of an OVC.

It is worthwhile to note that 23.9% and 22.5% of the sample children trained in skills reported their main sources of income to be formal and informal skilled work respectively. This skilled work no doubt was a function of the skills they had acquired through the training offered by IRCU partner agencies (comparison with sources of income for children in formal education in previous chapter confirms this point). As already pointed out, in many of the IPs visited, the children trained in skills through vocational training and apprenticeship had completed their courses, graduated and gone away. This was also related to the fact that the funding for skills training had ended in June 2009, and no extension had been made for this component, unlike other components.

### 4.3 Type and Extent of Support Provided/Received

Table 19 shows the types of support that OVC supported in skills training had received. It should be pointed out that some of the OVC who benefited from skills training had previously been supported in formal education, thus 66.7% of the interviewees reported having received support for formal education. This linking of formal education with skills training or put differently – the continuation of support from one level of education to another is a good practice necessary for ensuring that children are not abandoned half way during their schooling.

**Table 19: Type of Support and Training Received by OVC supported for Skills Training**

	Frequency	Percentage
Type of support ever received by OVC from IRCU IPs		
Support for formal education	142	66.7
Apprenticeship	213	100.0
Training	93	43.7
Counseling/psycho-social support	90	42.3
Support for IGAs	51	23.9
Food & Nutrition Support	55	25.8
HIV/AIDS education/BCC	77	36.2
Support to access health care	64	30.0
Child rights/protection	27	12.7
Care and support	37	17.4
Referral	1	0.5
Other	19	8.9
Type of Skills Training received by OVC		
Tailoring	165	77.5
Carpentry	24	11.3
Knitting	19	8.9
Brick laying	10	4.7
Mechanics and repair	5	2.3
Others	54	25.4
Received Start-up Kit after training		
Yes	153	71.8
No	28	13.1
Not yet, still training	32	15.0
Other Types of training received		
Counselor training (peer to peer)	49	23.0
Psycho-social support training	52	24.4
Life and cognitive skills training	68	31.9
IGAs training	88	41.3
Child rights training	47	22.1
Other	15	7.0

In terms of skill trades, tailoring was the most popular trade in which OVC were trained, reported by 77.5% of the trainees. This was followed by carpentry (11.3%). The category “others” included hair-dressing, plumbing, electrical installation, welding and metal work, poultry farming, animal husbandry, among others. From interviews with IPs, the major types of trades or skill areas for which children were trained included carpentry and joinery; tailoring; bakery; saloon; metal works and fabrication/welding; and hair dressing. The table below shows the trades reported by different IPs.

**Table 20: Types of Trades Supported by IPs**

Implementing Partner	Carpentry	Tailoring	Hairdressing	Brick laying	Welding & Metal fabrication	Bike Mechanics	
Jinja Diocese	X	X					
Busota OVC Project	X	X			X		
Alqodus Centre	X	X	X				
Namisambya OVC Project		X					
Kumi Diocese	X	X		X			
Bweranyangi	X	X		X			
Mbarara Arch-Diocese		X	X			X	

Some IPs also supported the boarding fees of OVC who were enrolled in vocational schools. Otherwise, the common costs paid for by the IPs included the training fees, training materials and start up kits. It is also important to draw attention to the finding that 71.8% of the interviewees reported that they had received a start-up kit upon completion of their training. Only 13.1% reported that they never received start up kits, while 15% were still training. As will be shown later, the provision of start-up kits constitutes a good practice that helps to ease the transition of trainees from school to work.

#### 4.4 Needs and Expectations of Clients

OVC interviewees supported in skills training were asked to mention their common needs for which they often require IP support. They were also asked to comment on the extent to which these needs were met. See Table 21.

**Table 21: OVC Needs in relation to the Services Provided by IPs**

	Frequency	Percentage
Common Needs of OVC as identified by OVC		
Education	87	40.8
Food and nutrition	32	15.0
Housing	32	15.0
Employment	31	14.6
Health care	22	10.3
Socialization/psycho-social	20	9.4
Others	107	50.3
OVC's assessment of services/products provided to them by IP		
Agency fully meets needs	85	39.9
Needs only partially met	123	57.7
Needs not met	5	2.4
Critical needs of OVC insufficiently met		
Start-up capital/tools/materials	59	27.7
Clothing	14	6.6
Scholastic materials	10	4.7

Bedding/sleeping materials	8	3.8
School fees	7	3.3
Food at home	5	2.3
Health care	1	0.5
Food at school	0	0.0
Others	46	21.6

The reported needs of OVC ranged from education to health care. Important to note that is that the need for employment featured highly, reflecting the demand for jobs sparked off by the skills acquisition. More than half of the interviewees had their needs only partially met. The needs that were insufficiently met were mainly in form of start up capital in form of cash, tools, or materials. It was reported for instance that whereas trainees who graduate in tailoring are given a sewing machine as a start up tool, they would also need some cloth materials and money for rent in order to start work. They would also need a tape measure, a pair of scissors and perhaps a chair/stool. Some IPs were able to give out the tape measure and a pair of scissors as part of the kit, while others did not. To corroborate the needs enumerated by OVCs, views were also sought from the agency staff. The reported needs for IPs in relation to this service varied from IP to IP. Common expectations that emerged out of the survey are shown in Box 4.

**Box 4: Needs and Expectations in Relation to Skills Training**

<ul style="list-style-type: none"> <li>• <i>Extend training support from one year to two years – the one year (9 months) programs were reported to be too short to impart sufficient skills</i></li> </ul>
<ul style="list-style-type: none"> <li>• <i>Support a revolving fund to facilitate a post vocational program.</i></li> </ul>
<ul style="list-style-type: none"> <li>• <i>Start up tools are not enough; for instance girls trained in tailoring wanted the start up capital to include a piece of cloth, with which they could start tailoring (Jinja Diocese).</i></li> </ul>
<ul style="list-style-type: none"> <li>• <i>To maximize quality of training, IRCU to support institutions to replace old or acquire new machines used for instructions other than providing maintenance support</i></li> </ul>
<ul style="list-style-type: none"> <li>• <i>IRCU to balance capacity building of OVC and the institution (service provider). At present, the institutions that train OVC are not supported to enhance their training function and this affects the quality of vocational training</i></li> </ul>
<ul style="list-style-type: none"> <li>• <i>Expose vocational training in primary and secondary before they complete to enable students appreciate this course other than turning to it after failing primary 7 or senior 4 or after dropping out of school</i></li> </ul>
<ul style="list-style-type: none"> <li>• <i>Introduce additional courses such as cosmetology, brick making and concrete practice for support by IRCU</i></li> </ul>
<ul style="list-style-type: none"> <li>• <i>To increase production, IPs need showrooms that facilitate marketing of products produced by OVC</i></li> </ul>
<ul style="list-style-type: none"> <li>• <i>Some IPs wanted to be supported to open up community workshops in the villages (e.g. Jinja Diocese)</i></li> </ul>

**4.5 Perceptions of Quality of Services**

Most OVC’s and IPs’ perception of quality services under this program area was characterized or linked to the following;

- Availability of adequate equipment and tools used for instructions during the training
- Employment/use of skilled trainers
- Enrolment of manageable numbers of OVC which facilitates OVC to obtain adequate access to machines and instructors
- The courses offered offer opportunities for self employment quickly. OVC are involved in the production industry.
- Trainees being able to acquire a wide range of skills e.g. with regard to tailoring, being able to sew different designs to meet market demands
- The institution provides sufficient induction on various courses at the beginning. This enables OVC make informed decisions / choices about courses they need as opposed to selecting course for OVC. This translates into better commitment and performance

- Trainings are nourished with religious values which instill a sense of humanity, fear of God and personal respect and respect for others among the supported OVC. These religious values provide a platform for behavior change and hard work among OVC

#### 4.6 Levels of Client Satisfaction with Services

To assess levels of satisfaction with services, skills trainees were asked a number of questions aimed at judging the quality and usefulness of services received. The Table below presents the responses.

**Table 22: Aspects of Client Satisfaction with Services**

	Frequency	Percentage
Has the service you have received helped you to deal more effectively with your problems as an OVC		
Yes, helped a great deal	97	46.6
Yes helped	83	39.9
Helped somehow	24	11.5
No, not helped	4	1.9
Overall rating of the quality of services received from IP		
Very good	97	46.6
Satisfactory	84	40.4
Fair	27	13.0
Poor	0	0.0
Overall rating of range of services received from IP		
Very good	91	42.7
Satisfactory	99	46.5
Fair	21	9.9
Poor	2	0.9
Attributes of services particularly liked by the OVC		
Package/content of services	87	40.8
Gained skills	58	27.2
Enabled me to work/earn a living	28	13.1
Services meet my needs	25	11.7
Quality of services	17	8.0
Amount of services/support	17	8.0
Timeliness of services	1	0.5
Others	9	4.2
Services needed by OVC but not provided by IP		
Start up capital/IGA support	27	12.7
Support for formal education/School fees	20	9.4
Other forms of training	19	8.9
Support to access health care	17	8.0
Skills training in particular trades	16	7.5
Food and nutrition support	15	7.0
Counseling/psycho-social support	7	3.3
HIV/AIDS education	5	2.3
Others	93	43.7

From the above table, close to half of the interviewees (46.6%) reported that the services had helped them to deal with their problems as OVCs. A similar proportion rated the quality of services as very good. The attributes of services most liked by the OVC were: the package/content of services; the fact that they gained skills, and the fact that the trained enabled them to work and earn a living. The latter was mentioned by 13.1% of the interviewees. It should be pointed out that the study team came across a number of graduates from the skills training, who were gainfully employed, putting the newly acquired skills to good use. In a number of other cases, similar graduates were reported to have gone to work in Kampala and other urban areas.

At the same time, however, interviewees pointed out the support that they needed but which was not provided or was insufficiently provided by their support agencies. Such support was mostly in form of start up capital, but also included other forms of support such as access to health care and food. Indeed, some agencies reported the difficulties that their trainees were facing. Kumi Diocese for instance reported that the training centres were located in Kumi town, yet some of the trainees were drawn from far off places – meaning that the children had to look for accommodation and meet the costs of upkeep in a town setting. In such cases, being enrolled for training came a long with a range of other demands to the OVC, most of which the support agency would not meet. The OVCs further assessed the quality of services provided by rating the different services on a scale as shown in the following Table.

**Table 23: OVC’s Level of Satisfaction with IRCU Supported Services**

IRCUC Supported Services	Highly satisfied	Fairly satisfied	Not satisfied	Don’t know
Support in vocational/apprenticeship/skills training	72.4	24.1	3.0	0.5
Provision of start up kits after training	64.9	27.3	7.1	0.7
Support to access health care	57.0	17.1	14.6	11.4
HIV/AIDS education	66.3	12.7	12.2	8.8
Food and nutritional support	37.7	25.2	24.5	12.6
School visits	72.7	17.2	8.9	1.2
Home visits	58.4	16.9	20.8	3.9
Training OVCs in IGAs	59.6	25.5	12.1	2.8
Training in life and cognitive skills	54.5	19.4	10.4	15.7
Training OVC in children’s rights	43.1	23.8	17.9	15.2
Training in psycho-social support	41.4	26.2	16.6	15.8
Training in counseling (peer to peer)	38.5	23.1	22.3	16.1

The service components that scored highly on this rating scale were: skills training, provision of start up kits, HIV&AIDS education and school visits. Those for which the OVC were most unsatisfied included food and nutritional support, home visits, and trainings in counseling and in children’s rights.

The views of the implementers were also sought regarding their satisfaction with services. Most implementers were satisfied with the quality and range of skills training that they offered. Jinja Diocese for instance reported that among the OVC supported for apprenticeships, it met about 90% of the needs. Some differences were found however with regard to levels of satisfaction for different skill areas. Overall, the boys trained in carpentry seemed more satisfied with their kits compared to the girls trained in tailoring (Jinja Diocese) because kits were more complete for the former. The reasons for satisfaction or lack of it differed and a synthesis of these is provided in Box 5.

**Box 6: Reasons for Satisfaction/Dissatisfaction with services**

<b>Common area of satisfaction</b>	<b>Reasons</b>
<i>Training in saloon and hairdressing</i>	<i>Quick income (marketable) and can be pursued by both sexes and can be completed in a year. Equipment for instruction is enough.</i>
<i>Training in carpentry</i>	<i>Quick income and can be under taken by both sexes Quick income and can be undertaken by both sexes and can be done in a year. Equipment for instruction is enough.</i>
<i>Training in welding</i>	<i>Quick income and can be under taken by both sexes and can be done in one year. Equipment for instruction are enough.</i>
<i>Training in bakery</i>	<i>Quick income and can be pursued by both sexes and can be done in one year</i>
<i>Provision of start up tools / kits upon completion of vocational training</i>	<i>They provide a basis to begin income and become economically independent ; they are provided regularly but affected by rent in the field</i>
<b>Common area of dissatisfaction</b>	<b>Reasons</b>
<i>Motor engineering</i>	<i>Not easy to finish in a year; mainly associated with boys</i>
<i>Tailoring</i>	<i>The market is thin and competes with already made clothes. In some areas e.g. Kumi, the market seems to be saturated</i>

The major source of discontent was that IRCU does not support replacement / acquisition of new equipment for training instructions when they are old or broken down.

#### **4.7 Relevance, Appropriateness and Acceptability of Service Delivery Models**

Findings from KIs indicate that overall, the vocational training model is relevant, acceptable and largely meets the need of OVC. This was demonstrated through the following reported aspects (strengths);

- The courses are practical. Little time is spent on theory and OVC are given sufficient information to make appropriate choices for their courses. The training model allows flexibility to allow OVC gain as much skill as possible within one year of IRCU support. This is done through a modularized training approach where an OVC is exposed to basic theories and concentrates on core practical aspects of the training in the year.
- Courses offered opportunities for gainful employment. For example training in saloon and hairdressing and carpentry enable OVC after graduating obtain self employment immediately. Other OVC earn while still undertaking courses. They are given opportunity to work and get pay. Feedback obtained from OVC who run saloon and hair dressing is that they can earn a minimum of 15,000 per day. Girls confess that instead of chasing money from boda-boda cyclists and other men for survival, they can now depend on their own moreover with low risk of getting infected with HIV.
- The training approach adapts to local environment for sustainability purposes. Local materials are used other than sophisticated ones to enable trainees cope easily after graduation.
- The course also allows trainees opportunities for practice especially when they make products and get sold. This also motivates them to do more and quality work.
- The courses also allow both sex (girls and boys) undertake non traditional courses as previously gender ascribed. They demystify gender issues that undermine the vocational training career. For example girls undertake non-girls traditional courses such as saloon and engage in welding. Similarly, boys engage in non-boys traditional training such as carpentry and do saloon and hairdressing. Feedback indicates that the success rate for these traditional courses is very high after graduation or in the field. They do well in these non traditional skill areas.
- In terms of OVC identification, the model allows shared responsibility and transparency. Perspectives religious leaders through their constituencies (Catholic, protestant and Islam) advertise through their religious bodies and forward OVC for training. This facilitates quick enrolment process, reduces pressure on the training intuition and allows transparency and participation of key stakeholders.
- The courses also are sensitive to needs of OVC caretakers which allow them opportunity to support families as well as attending lessons (win-win).

Another issue to consider was the choice between apprenticeship versus vocational training in formal settings – In some cases, IPs used both strategies for different types of skills. Alquodus for instance run vocational formal classes in tailoring, while they placed the OVC for carpentry with local artisans. This choice was made because training in carpentry demanded much more in terms of training equipment which the centre did not have.

In Kumi Diocese, it was reported that although they had initially planned to train OVC in skills through apprenticeships, they could not find suitable local artisans to train the children. As a result, children for

tailoring were trained from a training centre in town run by another NGO. This had implications for transportation or residence for the children as most of them were from the villages.

Skills training also incorporated the faith-based model. The roles played by religious leaders included:

- Identification of OVC to be supported
- Counseling and guidance
- Preaching on HIV/AIDS and other epidemics

#### **4.8 Factors Contributing to Quality Service Provision through FBOs**

Some of the factors contributing to quality services were reported to include:

- Availability of training facilities such as machines, workshops and training materials. At Alqudus, it was reported that they have about 13 sewing machines which they use to train about 30 children, i.e. an average of about 2 trainees per machine.
- Availability of skilled trainers
- Some IPs integrated literacy and numeracy into the training
- Provision of start up kits
- In some cases IPs were able to enroll children into formal vocational training institutions where they obtain formal and recognized qualifications

#### **4.9 Good Practices in Service Provision**

Provision of start-up kits – Provision of start-up kits was found to be a necessary element of support to enable trained OVC to enter work. In absence of start-up kits, trained OVC would possibly remain redundant after failing to find employment. Start up kits enabled them to start employing themselves, some in their homes, especially those for tailoring.

Some implementers did additional things that were not necessarily part of the project plan. In Busota project for instance, the project also taught some basic literacy and numeracy to OVC enrolled for vocational skills training. They also imparted values and emphasized discipline. The continuation of support to OVCs from primary school to vocational/apprenticeship is another good practice. Unlike many NGO interventions which cease support when a child completes primary 7, this continuation of support enables children to continue in school/training until they have a qualification.

#### **4.10 Limitations and Challenges**

**Incomplete Kits** - For some IPs, the start-up kits given to the trainees were not comprehensive enough. For instance in many projects trainees from tailoring received sewing machines only, yet they also needed other things to start, e.g. some cloth, scissors, measuring tape, and money for rent. As a result, some of the graduates were reported to be working from home (common for Busota, and Alqudus). Working from home meant that sometimes the number of customers would be limited. For a few others (e.g. Kumi Diocese), start up kits for tailoring trainees included a sewing machine, a pair of scissors and a tape measure. Related to the above, some IPs reported that the amount given OVCs to provide start up kits is little. Some projects gave only UGX 150000/= to buy tools yet this amount can purchase one equipment only for example a tool for a carpenter costs 110000shs yet a carpenter needs a tool box. For mechanics, the UGX 150000/= can only buy a set of spanners yet they need jerks and other tools.

**Short Training Period** - Several IPs thought that the training period for apprentices/vocational training which was often 9 months was not adequate to make them competent and competitive enough. Yet, with funding periods of 1 year, they had to complete the training within that period.

**Informed Career Choice?** - Some implementers also thought that most OVC being trained in skills have by that age not decided what their career paths should be, and they just join in because there is an opportunity available. Other limitations include:

- OVC miss training sessions especially in morning hours as they are supposed to provide labor input first in their families. This is especially so for the girl child. Boys also first work as porters else where to earn before they come for lessons. However, we found out that thus is a win-win situation and as such, have shifted lessons to take place in the afternoon
- There are negative perceptions about vocational training course. The major one is that vocational training is considered to be the course for those who failed in class or for the failure in life. This attitudes discourages enrolment
- Some skill areas such as tailoring are facing stiff competition in the market. People are resorting to second hand clothes that are cheaper. For tailoring to be more competitive, it requires high level innovation and creativity including fashion design; yet we cannot offer fashion design here due to the nature of trainees we have and limited training duration that IRCU supports (one year)
- Worn out or burn machines are not easily replaced. They are expensive
- Communities have a negative attitude that OVC supported should get everything free. Caregivers have developed the mentality that IRCU offers everything their OVC need for training. This is creating a dependency syndrome where by for example we provide uniforms but care takers expect us to provide other dressing needs of OC such as blouses which they would otherwise provide to OVC.
- There is a tendency to focus on numbers trained and yet the institutions want to focus on skills development of the child; transforming the child for better. Focusing on numbers only affects quality of vocational training
- Limited resources affects the number enrolled and trained in vocational training
- IRCU supports apprenticeship / vocational training for one year instead of two years. This affects the range and quality of training services offered to the OVC especially for courses are the new round of the new low and then no one in the new work on little and then that such as motor-engineering.
- OVC come from poor families and some of whom survive through provision of daily casual labor to earn for example as porters. Engaging them in training for a year (fulltime) without income affects their ability to learn due to frequent absenteeism. They see this period as a long period for them without earning.
- The training provides skills but the practice becomes complicated since there exists environmental factors that hinder the trainees from adequately putting into use skills for example failure to pay rent at the start.

The training model does not provide for a systematic follow up of how graduates perform in the field. Being young people, some times after obtaining income they develop other behaviors that affect their productivity. For example some OVC get jobs but after they get salaries, they disappear from work station. Our training models do not provide support to such young people whom we struggled to shape for a better future.

Some IPs expressed concern than the type of skills in which they are training OVC have become circulated (Kumi Diocese pointed out tailoring; Mbarara Arch-diocese pointed out hairdressing and mechanics). They therefore wanted to diversify the skills areas in which OVC are trained.

## 5.0 SUPPORT TO OVC CAREGIVERS

### 5.1 Introduction

The core interventions that IRCU supported under this service area or component were capacity building and training of OVC caregivers in IGAs and household economic security. Data on this component were collected from the IP staff and the caregivers.

### 5.2 Socio-Demographic Characteristics of the Caregivers

The Table below show the socio-demographic characteristics of the caregivers who participated in the study.

**Table 24: Socio-Demographic Characteristics of Caregiver Respondents**

	Frequency (N=401)	Percentage (%)
Sex of respondent		
Male	82	20.4
Female	319	79.6
Age of respondent		
Under 18	12	3.0
18-29	34	8.5
30-39	105	26.2
40-49	121	30.2
50-59	66	16.5
60+	63	15.7
Highest level of education attained		
No education	105	26.1
Primary	212	52.9
Secondary	76	19.0
Post Secondary	4	1.0
Vocational	4	1.0
Main occupation/source of income		
Peasant farmer	254	63.3
Business	60	15.0
Vending	6	1.5
Formal skilled	10	2.5
Formal unskilled	6	1.5
Informal skilled	4	1.0
Informal unskilled	37	9.2
Unemployed	22	5.5
Student	2	0.5
OVC relationship to Caregiver		
Biological son/daughter	220	54.9
Grand child	93	23.2
Nephew	34	8.5
Niece	25	6.4
Cousin/brother/sister	8	2.0
Other relative	13	3.2
Not related by blood	8	2.0

The data in the Table show that majority of the caregivers (79.6%) were females compared to males (20.4%); were middle and old-aged; and majority had attained a primary level of education. Peasant farming and petty business were their main sources of income. Consistent with the findings from the OVC, majority of the caregivers were the biological parents of the OVC under their care (54.9%), followed by those who were grand-parents (23.2%).

### 5.3 Type of Support Provided:

The support to caregivers was mainly in form of trainings which covered different aspects including:

- Agriculture/food security
- Child protection/child rights
- Psycho-social support and Will-making
- Training of religious leaders in child protection (*see table below*)

**Table 25: Type of Support and Training Received by Caregivers**

	Frequency	Percentage
Type of support ever received by caregivers from IRCU IPs		
Training	291	72.6
Food & Nutrition Support	86	21.4
Increasing HH economic security	101	25.2
HIV/AIDS education prevention	117	29.2
Support for referral for family	30	7.5
Other	42	10.5
Type of Training received by caregivers		
Training in IGAs/social economic security	264	65.8
Training in Parenting skills	220	54.9
Training in succession planning	65	16.2
Will making/memory book writing	74	18.5
Psycho-social support	79	19.7
Child protection	117	29.2
Para-legal	14	3.5
Other	18	4.4

For the majority of caregivers, no materials support was provided to the caregivers by most IPs apart from the trainings. For instance with respect to IGAs, caregivers were trained in IGA management skills and group formation but no cash or material support was extended to enable them implement IGAs.

*We train the caretakers in income generating activities, yet these people have just been resettled after years of displacement and do not have capital to begin with...we only give them the knowledge that they may not utilize* (Lango Diocese OVC Project Coordinator).

IPs reported that they were meant to link the caregivers to micro-finance institutions where caregivers could obtain loans to start up IGAs. In practice, this was hampered by the stringent conditions (including high interest rates) imposed by micro-finance institutions. In a few cases, such as in Kamuli (Namisambya OVC Project), some caregivers had been able to translate their knowledge in agriculture into improved farming practices. This was enabled by the existence of other programmes that supported them to implement what they had been taught. These included Africa Network 2000, VEDCO and NAADS.

#### **Box 6: Harnessing the benefits of networking: Kiroba Tweyambe Community Group**

*Kiroba Tweyambe Community Group consists of members who received training in agriculture and food security by Namisambya project. The members formed a group and linked up with other programs such as NAADS and Africa 2000 Network. They have got from these organization improved planting materials of bananas and planted 300 suckers of bananas as a mother field from which they will distribute suckers to the 33 members so that each plants their won garden. They have also planted 2 acres of sweet potatoes. Members say that they want to eradicate hunger from their homes.*

It was found that most of the trainings were facilitated by other organizations contracted either by IRCU or by the IPs themselves. For instance it was found that training in Entrepreneurship was facilitated by FIT Uganda contracted by IRCU; Will making by FIDA; Food security by NAADS, VEDCO and Africa 2000 Network; Social Economics security by Uganda Finance Trust; Child Protection by the Probation Office and

the Police Child and Family Protection unit; Psycho-social counseling by Kamuli HIV/AIDS Program and District HIV Information Office. It can be considered a good practice that different specialized organizations were brought in to facilitate these trainings.

In very few cases, some IPs had given out support for IGAs to caregivers. From the statistical data, only 10.2% (n=41) of the caregivers who had received training in IGAs reported that they had also received support in form of start-up capital to start up IGAs. For instance Agape Nyakibale had given out goats, piglets and chicken to caregivers to start IGAs. A few IPs such as Mbarara Arch-Diocese also gave seeds and tarpaulins (for drying crops) after training the caregivers in improved farming methods. The table below shows the responses about type of support received by the caregivers.

### 5.3 Needs and Expectations of Clients

Whereas most caregivers appreciated the trainings received, the major concern was that the training was not accompanied by materials of cash support. Most caregivers expected to be supported with start up capital for instance to run IGAs. Caregivers also expected to be helped with other forms of support to meet the needs of OVC under their care. The table below presents the needs of OVC as identified by caregivers and the extent to which they were met by the services provided.

**Table 26: Needs Identified by Caregivers and Assessment of their Fulfillment**

	Frequency	Percentage
Common Needs of OVC as identified by Caregivers		
Education	211	52.6
Food and nutrition	153	38.2
Housing	90	22.4
Health care	89	22.2
Employment	17	4.2
Socialization/psycho-social	14	3.5
Others	102	24.7
Caregivers' assessment of services/products provided to OVC		
Agency fully meets needs	132	33.0
Needs only partially met	264	66.0
Needs not met	4	1.0
Critical needs of OVC insufficiently met		
School fees	73	18.2
Bedding/sleeping materials	76	19.0
Food at home	53	13.2
Food at school	35	8.7
Health care	38	9.5
Clothing	34	8.5
Start-up capital	9	2.2
Others	98	24.4

The needs of OVC identified by caregivers related to schooling, feeding, housing and health care; all, being basic needs for the welfare, growth and development of children. Two thirds of the caregivers thought the support provided only partially met these needs. The needs insufficiently met were mentioned to include school fees, bedding materials, food, clothing, health care and start-up capital. Thus whereas support had been provided in form of scholastic materials, other costs of education – notably school charges remain. And beyond education, other basic needs of children remain a great challenge for caregivers.

From the implementer point of view, the needs / expectations vary from IP to IP but those which commonly featured among all IPs visited were as follows:

### Box 7: Needs and Expectations in relation to services for Caregivers

• <i>Linkages to micro credit schemes such as SACCOs to access loans</i>
• <i>Training in general health; hygiene, HIV and AIDS etc</i>
• <i>Those involved in agriculture need agricultural inputs</i>
• <i>More support needed to access medical care because when they are weak, they cannot support OVC in their homes</i>
• <i>More investment in the guardians / caretakers to channel support to OVC e.g. paying fees and provision of scholastic materials rather than this being done by the schools</i>
• <i>Establish a community revolving fund for OVC caretakers / guardians to empower them economically</i>
• <i>Trained caregivers in IGAs need start up funds which in most cases they are not provided</i>
• <i>Organize / conduct refresher training for OVC caretakers.</i>
• <i>Form caregivers groups at community level and build their capacity to monitor support to OVC by themselves</i>

## 5.4 Perceptions of Quality of Services

Findings from IPs indicate that caregivers appreciated the role being played by IRCU to address OVC needs. They were aware that if these services were not provided, they would find it difficult to access them because they are costly. They are being relieved of this burden to concentrate on other development issues. IPs reported that the quality of support towards caretakers is perceived by what they are able to do by themselves after the training. They reported that the training given to caregivers had been appreciated greatly because it empowers them with skills to identify and carry out feasible and lucrative business for themselves. Feedback obtained from caregivers indicates that some of them have been able to start income generating activities as a result of the training. These include piggery, mushroom growing, poultry, animal husbandry, beads making, selling yellow bananas, charcoal selling and retail shops.

IPs noted these IGAs increase household income and they have the potential to enable caregivers / households sustain themselves beyond the IRCU. The quality of the training itself was judged to be good – many of the trainings having been facilitated by competent trainers hired directly by IRCU or by the IPs themselves. The quality of services to caregivers was mainly perceived in terms of:

- Use of skilled and experienced trainers
- Provision of relevant, practical and context-specific training
- Potential to translate training into practical actions
- Enabling long-term empowerment

## 5.5 Levels of Client Satisfaction with Services

A big proportion (45.6%) of the caregivers reported that the services had helped them to deal with their problems. The Table below presents the rest of the findings from the caregivers' assessment of services.

**Table 27: Aspects of Client Satisfaction**

	Frequency	Percentage
Has the service/product you have received helped you to deal more effectively with your problems as a caregiver		
Yes, helped a great deal	139	45.6
Yes helped	139	45.6
Helped somehow	21	6.9
No, not helped	6	2.0
Overall rating of the quality of services received from IP		
Very good	126	40.4
Satisfactory	144	46.2
Fair	33	10.6
Poor	9	2.9

Services needed by Caregiver but not provided by IP			
Food and nutrition support	87	21.7	
Support for increasing HH economic security	75	18.7	
Support to access health care	56	14.0	
Training	20	5.0	
Support for referral to family	11	2.7	
HIV/AIDS education	7	1.7	
Others	159	39.7	

Similarly, 40.4% of the caregivers rated the quality of services received as very good and 46.2% as satisfactory. Up to 68.1% (n=273) of the caregivers reported that there were certain services that they needed but which were not provided by the IRCU implementing partner. These mainly included food and nutrition support, support for IGAs, and support for health care.

Further, the table below shows the caregivers rating of their satisfaction with various forms of support received from the IPs. It can be observed that aspects for which there was very high satisfaction include training in IGAs, and training in parenting skills and succession planning. On the other hand, the aspects with very low satisfaction included provision of start up capital for IGAs, support for referral, and food and nutrition support.

**Table 28: Caregiver's Level of Satisfaction with IRCU Supported Services**

IRCUC Supported Services	Highly satisfied	Fairly satisfied	Not satisfied	Don't know
Psycho-social support training	69.9	15.7	11.1	3.3
Training in IGAs	78.8	19.4	1.4	0.4
Provision of Start-up capital for IGAs	24.8	16.1	57.7	1.3
Training in parenting skills & succession planning	80.8	15.9	2.5	0.8
Training in Will making & memory book writing	57.5	18.7	11.9	11.9
Training in HIV/AIDS prevention	77.8	16.9	4.8	0.5
Increasing HH economic security	59.1	26.2	11.6	3.1
Support of referral for OVC & family	38.6	18.2	30.7	12.5
Child protection	75.4	17.5	4.9	2.2
Home visits	67.9	15.6	15.1	1.4
Food and nutritional support	39.5	31.6	24.3	4.6

IP representatives were asked to comment on the feedback from beneficiaries about satisfaction of caregivers' services. Findings regarding aspects they are satisfied and / or not stratified with were as follows:

**Box 8: Reasons for Satisfaction/Dissatisfaction in relation to support to Caregivers**

Common area of satisfaction	Reasons
<i>Training of caregivers in IGAs</i>	<i>This empowers caregivers to increase household income. Over 70% succeed after training</i>
<i>Training of caregivers in parenting skills and succession planning</i>	<i>Guardians communicate better with OVC, they become free with each other and provide better care for them</i>
Common area of dissatisfaction	Reasons
<i>Training of caregivers on prevention of acquiring HIV and AIDS</i>	<i>This is rarely done or supported in communities</i>
<i>Training in will making and memory book writing</i>	<i>This is not done regularly and it is not easy to know whether wills are being made or not. Others still fear to make wills</i>
<i>Increasing household and economic security</i>	<i>IRCUC does not support this area and where it is done, training is not regularly done. IRCVU does support provision of business or farm inputs</i>
<i>Provision of startup capital for OVC caretakers trained in IGAs</i>	<i>This is not supported by IRCUC</i>

## **5.6 Relevance, Appropriateness and Acceptability of Service Delivery Models**

The models of service delivery considered here include (i) Training (ii) Collaboration and Networking (iii) the Faith-Based Model.

- (i) Training - Findings from IP showed that the caregivers training model of giving them skills for carrying out IGAs is relevant and appropriate. The major strengths are that:
  - The trainings obtained empower them to be economically better through bringing more income in the household. When they are given adequate knowledge, they decide on what feasible IGAs they can do for themselves without being influenced to do what is perhaps not feasible for them.
  - Some IPs have established demonstration units as learning points for others. This is important in terms of knowledge sharing and rapid scaling up of benefits across caregivers in communities.
- (ii) Networking and referrals – IPs who do not provide clinical services reported that they worked in collaboration with other agencies, whereby for instance they referred OVC and caregivers to receive services from those other agencies. Jinja Diocese for instance reported that they referred their clients to AIC for HIV testing, and to Uganda Cares for ART services.
- (iii) Inter-faith/FB Model- Where IPs received funds to support training of religious leaders, they trained religious leaders of all faiths. Specific roles played by religious leaders were listed to include:
  - Talking to caregivers to care for OVC
  - Serving as a go-between (link) between the project and the community
  - Strengthening marital relationships
  - Offering psycho-social support

## **5.7 Factors Contributing to Quality Service Provision through FBOs**

The major factors contributing to quality of services were reported to include:

- Training was facilitated by specialized agencies competent in the respective areas of training. As a result good quality of training was achieved.
- Where good networking was available, caregivers benefitted from additional advice, support and inputs from other agencies to undertake IGAs and improve their agricultural production

## **5.8 Good Practices in Service Provision**

- Some IPs have trained drama groups that are facilitated to go out the community to sensitize people about the importance of OVC care and support (e.g. Amuca SDA OVC Project Coordinator)
- Use of competent and skilled trainers
- Where trained caregivers were facilitated to form groups and linked to other service providers, this enabled them to translate their acquired skills into profitable actions.

## 5.9 Limitations and Challenges

One of the limitations of the support to caregivers is that the support was limited to trainings, while no material support was given. For instance caregivers were trained in IGAs but no support was extended to enable them start up or run IGAs. To a large extent, translating the acquired knowledge into practice remained problematic – especially given that most such caregivers are old and vulnerable. Whereas it had been advised that the trained caregivers should be linked to micro-finance institutions, in many cases the terms and conditions (such as the interest rates) put by micro-finance institutions were reported to be prohibitive (reported in Jinja Diocese). Other major barriers to caregivers' support identified include;

- They were not well linked to micro credit schemes to access loans. The skills they obtain are not well put into practice
- Limited medical access is given to OVC caregivers who look after the OVC. They are not considered for treatment support
- Some care givers decline to provide the little support they were giving to OVC in anticipation the IRCU will provide everything for free
- Some trained caregivers fail to access loans / credit services not because they are not linked but they do not meet requirements of accessing it.
- Limited or no refresher training courses for caregivers
- A significant number of caregivers are old and sickly. They do not merit trainings and IGAs
- In Northern Uganda, caretakers were training in IGAs, but yet they have just been resettled and do not have start up capital (Lango Diocese)

## 6.0 CONCLUSIONS AND RECOMMENDATIONS

### 6.1 Introduction

This study aimed at assessing client satisfaction with the services provided by various agencies in the areas of ART, Palliative care and OVC support, with support from IRCU. The findings of the study have been presented and discussed in the previous chapter. This last chapter draws some conclusions and makes some recommendations for future planning and programming.

### 6.2 Conclusions

The results of the Client Survey largely reveal that IRCU interventions are not only appreciated but also yield satisfaction among clients and IPs. All the beneficiaries can be categorized as living on the margins of society and who would have had tremendous challenges to cope with the demands of life if services were not availed to them by IRCU partners. Although there are still several client needs that are unmet and challenges varying from IP to IP, 100% of IPs visited rated the quality of services between 60%-80%. Not only clients are satisfied with what is provided, but also IRCU HIV&AIDS interventions have led to boosting of IPs by making them visible in the response towards HIV&AIDS. It is important to note that the faith-based principles and approaches provide unique and value adding opportunities for enhanced behavior change and over all program impact.

As noted earlier, challenges facing IPs were identified in this Client Satisfaction Survey. For all the different types of support provided, one of the biggest challenges facing the IPs is the uncertainty about future support. For instance some IPs started supporting children in P.7 who have now moved to S.1 and hence not sure if they would be able to support them until they complete S.4. On the other hand, caregiver trainings imparted knowledge and skills but these were in many cases not translated into practical improvements. Exceptions happened where there were other active agencies that supported caregivers to implement what they were taught. Further, IPs expressed concern about the funding mechanisms by which they are funded for contract periods of only one year. They argued that this made their planning difficult. It was also difficult to keep staff in such an atmosphere of uncertainty about future funding.

Apart from challenges which IPs face, the findings have revealed in overall terms that OVCs, their caretakers and PHAs have an overwhelming number of needs for which they require more support. The needs range from basic requirements to meet minimum health care especially drugs and tests for appropriate diagnosis, to counseling and mitigation to address emotional and psychosocial inadequacies. School going children require all the essential items necessary for good learning. At the family level, both for OVCs and PHAs, there are a plethora of debilitating conditions affecting the ability of families to care for their members. Families need to be supported to play their roles more effectively, to enhance the social functioning of individual members facing difficult circumstances. Ongoing projects supported by IRCU are engaged in addressing some of the above needs but cannot fully meet all the requirements for OVCs, PHAs and affected families. The projects are able to pick out some of the critical areas for support, depending on the level of funding available.

### 5.3 Recommendations

#### *Overall IRCU HIV&AIDS programming*

- Findings show that IRCU programming is generalized between rural and urban areas and hence not well contextualized. These differences need to be put into considerations to guide future support and programmes.

### ***ART and palliative care***

- Nutrition interventions for people on treatment are missing but are considered critical among IPs for funding. IRCU needs to explore support into this intervention.
- Of the ART service delivery IPs visited, most of them (close to 100%) were delivering this service at facility level. Given that people served are poor and experience transport barriers, outreach model is critical to bring services closer to communities. The team found out that IPs would be willing to introduce this model but they lack experience on how this should be done. IRCU should support this process.
- At some IPs health facilities such as Mengo Hospital, the client waiting time is still high; an average of 5 hours due to high turn up (congestion) of clients and limited personnel especially counselors. Models/strategies for addressing this challenge such as appointment system should be put in place.
- There is an urgent need for pediatric ART at facilities, which government is unable to provide to children who need this support. IRCU could consider complementing the government of Uganda in this area.

### ***OVC programming***

- IRCU does not support a uniform package of same interventions among IPs especially for OVC interventions. This may imply that guidelines for application to access OVC funding are not understood. IRCU should consider developing standard service packages for funding to eliminate unnecessary complaints from IPs.
- IRCU support to OVC does not necessarily match with key requirements of children in schools where they study from. As a result, schools where IRCU supported OVC attend continue to be dismissed due to failure to meet their requirements. There should be a deliberate attempt to align IRCU support with basic school requirements to avoid frequent dismissal of OVC from schools.
- The working relationship between IPs and schools hosting IRCU supported OCV contributes to better learning environment of OVC. IPs need to workout and maintain good relations to minimize or eliminate unnecessary dismissals that would have been avoided.
- IRCU should consider extending financial support to OVC undertaking courses that take longer time such as motor engineering for two years and not one year
- Funding from IRCU came at the time when some IPs were already implementing OVC project which was not guided by the household approach. A mechanism to support such IPs is needed to redirect OVC program using the household approach.
- IPs community entry creates a dependence syndrome especially among OVC caretakers who perceive IRCU not as the organization complementing their efforts but rather taking over their responsibilities towards OVC. There is need to sensitize caregivers to continuously play a key role to OVC regardless of IRCU or not.

### ***Capacity-building and training***

- IRCU has not deliberately organized capacity building for the clergy or the ordained. IRCU should support them in areas such as HIV&AIDS programming, leadership, monitoring and evaluation, advocacy issues and other pertinent courses to appreciate HIV&AIDS programming and or mainstreaming.
- IRCU needs to establish mechanisms through IRBs to ensure that this gap is fixed
- The training of caregivers is essential especially in IGAs but little or no support is given to them as start up tools to put their skills into practice. IRCU should make deliberate efforts to link them to other players to fill this gap.
- There is limited computer infrastructural support at IP level to facilitate timely generation of data and report consolidation. IRCU should strengthen this area

### ***Partnerships, advocacy and networking***

- IRCU need to strengthen the capacity of religious leaders to interpret government policies on HIV&AIDS.
- There is overwhelming demand for HIV& AIDS services. The needs and expectations of IPs and clients are so high. IRCU should organize a stakeholders meeting to clarify what can be funded and what is not possible. In the same sprit, IRCU should emphasize partnerships by developing the partnerships strategy for HIV& AIDS at IP level to address the above unmet and expected needs.
- Findings indicate that there are frequent drugs stock-outs for TB and other antibiotics. IRCU need to approach the MoH through appropriate offices and advocacy machinery to advocate for regular / constant supplies of these drugs because they affect HIV&AIDS programming

### ***Sub-granting***

- Close to 100% IPs visited complained that sub grants delay. It is recommended that IRCU diversifies her funding base for HIV&AIDS programs to increase funding certainty.
- Some IPs obtain funds through their Secretariat offices, which at times causes some delays. Possibilities for such IPs to obtain funds directly from IRCU could be explored.

### ***Inter-faith planning, co-ordination and sustainability***

- IRCU supports HIV&AIDS services in the project mode; rather than taking it as a program. The life of religious institutions and their services are continuous and not like secular organizations. IRCU should support establishment or institutionalization of HIV&AIDS units to become life activities in the main stream religious activities.
- While IRCU involves religious leaders in service delivery; it does not adequately involve strategic religious leaders (mainly the clergy/ordained) who influence key decisions making and policies in the religious institutions. IRCU should strategically map out and involve strategic religious leaders from all denominations to quickly embrace matters of HIV&AIDS development work.
- The findings indicate that the clergy and other religious leaders are not well updated on government policies related to HIV&AIDS. IRCU should embark on this to facilitate the religious leaders adequately support HIV&AIDS programs
- IRCU should diversify its funding base and support IPs in resource mobilization to reduce over dependence on USAID for her HIV&AIDS programs. They should tap non-USAID resources for HIV&AIDS.