EVALUATION REPORT

USAID/UGANDA FAITH-BASED HIV AND AIDS PROGRAM

November 2013

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AOET	AIDS Orphans Education Trust H/C III
ART	Antiretroviral Therapy
ARV	Antiretroviral(s)
CDC	Communicable Disease Control
COP	Council of Presidents
COU	Church of Uganda
COR	Continuum of Response
CPHL	Central Public Health Laboratory
FBM	Faith Based Model
FBO	Faith Based Organization
GIS	Geographical Information Systems
GLP	Good Laboratory Practices
GOU	Government of Uganda
HTC	HIV Counseling and Counseling
HEP	Health educational Promotion
HFs	Health Facilities
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information Systems
HWs	Health Workers
IDI	Infectious Diseases Institute
IECs	Information Education and Communication Materials
IRB	Institutionalized Religious Body
IRCU	Inter Religious council of Uganda
JCRC	Joint Clinical Research Centre
LQMS	Laboratory Quality Management Systems
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MMC	Medical Male Circumcision
MOH	Ministry of Health
MSH	Management Sciences for Health

NACWOLA	National Community of Women living with HIV/AIDS
NCD	Non Communicable Diseases
OVC	Orphans and other Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan AIDS Relief
PLHIV	Persons Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission of HIV
RCC	Roman Catholic Church
RFA	Request for Applications
SCMS	Supply Chain Management Systems
SDA	Seventh Day Adventist Church
SLMTA	Strengthening Laboratory Management Towards Accreditation
SOPs	Standard Operating Procedures
STIs	Sexual Transmitted Infection (S)
TASO	The AIDS Support Organization
TB	Tuberculosis
UCMB	Uganda Catholic Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UMSC	Uganda Muslim Supreme Council
UNMHCP	Uganda National Minimum Health Care Package
UPMB	Uganda Protestant Medical Bureau
USAID	United States Agency for International Development
UOC	Uganda Orthodox Church
VCT	Voluntary Counseling and Testing
VHTs	Village Health Teams
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION GOALS AND OBJECTIVES

The five major faiths in Uganda – Catholic, Church of Uganda (Anglican), Seventh Day Adventists, Orthodox, and Muslim – formed the Inter Religious Council of Uganda (IRCU) in 2001. A major function of the Inter Religious Council of Uganda (IRCU) has been to bring the major faiths together to more effectively coordinate HIV/AIDS programs, and to mobilize the religious structures in the fight against HIV/AIDS. IRCU has been consistently encouraged by USAID in this function. The Chief religious leader in each faith represents that faith on the governing Council of Presidents. An Executive Board composed of the Secretary Generals (or equivalent) of each of the faiths provides implementation oversight. A Secretary General of IRCU is effectively the Managing Director of IRCU, which has programs in both HIV/AIDS-Public Health and Conflict Mitigation. USAID is the major funding agency for IRCU and has been so since its founding.

USAID has been the leader in HIV/AIDS programming in Uganda since the first identification of the disease. This included support to programs with the individual faith groups such as Catholic, Church of Uganda, Seventh Day Adventist, and Muslim, as well as others. Other donors provide individual funding for these specific faiths. Partly because of these and secular HIV/AIDs programs, the infection rate in Uganda declined from approximately 16% in 1992 to 6.4% in 2006.

Following twenty-five years of progress, HIV/AIDS in Uganda has now begun to rise again; the infection rate is now 7.3% – primarily because of: a) complacency about AIDS – resulting in high risk behavior, b) negative changes in the social/economic environment including increased population growth, rapid urbanization, unemployment, and c) decline in political support.

USAID commissioned this Evaluation to explore the unique role of Ugandan faith-based groups in responding to the HIV/AIDS epidemic, assess the potential of IRCU in bringing the faith-groups together to play this role and to determine progress made by IRCU to date. Findings from this evaluation will inform the design of future interventions. The scope of work asked three key questions concerning IRCU:

(i) What are IRCU's uniqueness and strengths?
(ii) How effectively has IRCU mobilized those strengths to address HIV/AIDS?
(iii) What is the contribution of IRCU to the overall HIV/AIDS program in Uganda?

METHODOLOGY

The Evaluation Team's methodology started with content analysis of three elements. The first element consisted of a basic review of IRCU management documents. These included: (i) The IRCU Performance Management Plan (PMP) agreed to between IRCU and USAID. We used this plan to establish the degree to which IRCU is meeting its targets with an emphasis on the extent of coverage and numbers of persons served. (ii) The IRCU quarterly reports for all 19 primary implementation sites became the primary means of determining why IRCU is, or is not, meeting its targets. (iii) The IRCU internal evaluation conducted in October/November 2012 and annual audit reports became the basis of determining managerial capacity and responsiveness.

The second element was Key Informant Interviews. This element included interviews at all levels of those participating in the program, including the IRCU Council of Presidents, implementation managers, and program participants. It also included site visits to five sites of

IRCU supported health facilities. During the site visits, we crosschecked whether the data reported quarterly was reflected in visible program performance.

The third element of our methodology was Focus Groups and individual interviews with persons participating in either treatment or prevention programs. This element was the primary means of establishing the quality of the services on offer at IRCU supported facilities, that is, 'what the program participants say about the services they are receiving?'

All interviews started with questions from a Checklist prepared by the Evaluation consultants and reviewed by both USAID and IRCU. The Evaluation team crosschecked data from all three elements, which were then collectively analyzed. For example, review of the quarterly reports showed that the majorly reported reason for not meeting quarterly targets for testing was the lack of kits and operational money. The evaluation team checked this assertion with IRCU management, which confirmed the assertion. IRCU also stated that the shortfall was the result of USAID changing its disbursement system consequently resulting in limited disbursements in the second quarter to field sites.

KEY FINDINGS

(i) The five major Instutionalized Faith Based Organizations (IFBOs) who currently comprise IRCU are a significant segment of the Ugandan power and civil society sectors. IRCU's unique strength is its success in bringing together those faiths to work as a group to address HIV/AIDS and other social economic challenges of mutual concern.

(ii) IRCU delivers its services through 19 faith-based health facilities that offer HIV/AIDS care and treatment, 40 religious structures (dioceses, Muslim districts, deaneries and churches) addressing HIV prevention, and 37 community based FBOs offering care and support to OVC. All of these organizations are collectively meeting their PMP targets. IRCU also assists its five (5) parent IFBOs for coordination of HIV/AIDS programs delivered through their respective structures and affiliated FBOs.

(iii) IRCU is a major – and a critical - player in the National Response to HIV/AIDS. Considering geographic coverage, population served, PEPFAR funding, PMP targets and national influence, IRCU ranks among the top three local Health non-governmental organizations getting PEPFAR funding and among the top ten, including all PEPFAR-funded international organizations/consortiums

CONCLUSION

IRCU is performing satisfactorily in terms of mobilizing the strengths of the faith based community to address HIV/AIDS prevention and treatment and, in doing so, is making a significant contribution to the overall HIV/AIDS program in Uganda. IRCU is contributing to the overall national HIV/AIDS program by providing religious cover at the policy level and effective HIV/AIDS prevention and treatment services throughout Uganda. Importantly, IRCU is bringing hope to those who have little of it. Critically, IRCU is performing satisfactorily in terms of meeting the major targets in its PMP. In the key intermediate result "increased availability and access to HIV/AIDS services (AB, HCT, PMTCT, OVC, ART, MMC, and PEP)", IRCU achieved an overall 100 % rating. Performance within technical areas varies. Vitally, according to interviews of actual patients receiving care and treatment, the services are the highest on offer in the rural areas.. Those persons IRCU serves are highly satisfied. While IRCU is meeting basic PMP targets, it appears to be too satisfied with its current level of achievement. Improvements are required, primarily in expansion of service coverage and targeted

testing/counseling. Specifically, there needs to be a stronger, more immediate, link between exhortation from the pulpit and counseling of couples evidenced by higher couple testing.

RECOMMENDATIONS

Based on current performance, improved capacity, and the potential (with more assertive management) for substantially greater coverage, the Evaluation team recommends continued investment in IRCU; it is a safe investment involving a key element of Ugandan society. It has a potentially high upside both in terms of preventing HIV/AIDS and in developing civil society. We recommend three program prongs: 1) Gradually expand the existing services/treatment programs with an increased emphasis on continuum of response; 2) Use existing structures to significantly expand targeted testing and counseling; 3) Increase involvement of the Executive Board in mobilization of IFBO human resources for program implementation. USAID should condition future funding levels on meeting incremental progress targets. Establish all of this in dialogue with IRCU and follow up often.

I. BACKGROUND

1.1 CONTEXT

a. Evolution of HIV/AIDS in Uganda

The evaluation process began with an analysis of the context of the disease and its evolution in Uganda – this includes perceptions of the disease, changes in the social/economic environment, and transformations in the political/policy climate. Uganda in the later 80s and early 90s was close to ground zero in terms of identification of HIV/AIDS. The impact of AIDS was devastating. The death rate from AIDS was much greater than the deaths from the wars and internal conflicts that convulsed Uganda for 20 years. Virtually every family lost someone. Fortunately, USAID responded rapidly and found a ready partner in the Museveni government.

Over the past 25 years, with the GOU–USG partnership leading the way, Uganda reduced the HIV/AIDS prevalence rate from a high of 16% in 1992, to a low of 6.4% in 2006. This major success would not have happened without the USAID leadership and financial support. Regrettably, the prevalence rate is now edging up slowly with the national figure at 7.3% for 2010 (Uganda AIDS Indicator Survey, 2011). There are large variations in the prevalence rate depending on the specific geographic region and demography.

The upward trend parallels the experience of other nations including the US, UK, and some African nations in which the initial extreme infection and death rate stimulated a very aggressive whole of nation response that brought down the infection rate. As time passed, and Uganda achieved significant success in decreasing HIV/AIDS, the sense of urgency waned. The Ugandans we interviewed expressed a multitude of reasons for this. Most importantly, AIDS is now a disease that many can live with because of ARV treatment. This is clearly a positive step but it has the effect of decreasing the fear of AIDS. Twenty years ago, almost everyone knew multiple persons who died from AIDS. Now many view AIDS as a disease like diabetes, serious but something with which one can live. Many caregivers in the field facilities believe there has been a decreased emphasis on prevention, which has resulted in an increase in incidence. (Note: while the reality maybe that more resources than ever are going to prevention, there is a widespread impression that sexual prevention is being de-emphasized, in favor of Biomedical approaches.)

b. Religious context and role of FBOs in service delivery

Uganda is a nation with a high degree of religious affiliation; over 95% of Ugandans belong to a church/mosque. Beyond attending religious services, Ugandan Christians and Muslims demonstrate a reasonable degree of behavior adherence to the principles of their specific religion. That is to say, the majority of Ugandans belong to a faith, attend services, and reasonably comport themselves to the basic code of behavior advocated by church/mosque leadership. They also, on occasion, especially the males, tend to stray and do not like to wear a condom when doing so. Because of cultural traditions, most Christian males are not circumcised and exhibit a certain reluctance to participate in MMC.

It follows that no single approach to preventing HIV infection works for every element of the total population. An overnight long-haul truck driver seeking a bed and companionship for the evening needs a different approach than a smallholder farm family of five all of whom regularly attend church/mosque. IRCU is well placed to meet the needs of the latter.

According to everyone the Evaluation team interviewed, IRCU's major achievement is bringing together the major faiths (Catholic, Church of Uganda, Seventh Day Adventist, Orthodox, and Muslim) and reaching agreement on a comprehensive HIV/AIDs program. Historically the major

faiths in Uganda have often been in conflict politically. The formation of IRCU has provided a means for collective dialogue, both between the religions, and with the highest levels of the GOU. Equally importantly, IRCU provides ready access to the medical facilities of all the faiths. Those facilities are the most extensive and most efficiently managed in Uganda. IRCU provides training to District medical facilities and to District and parish level religious structures. Each Friday through Sunday, the opportunity is available to reach up to half the population of Uganda and to follow up with individuals and couples level counseling.

Despite some doctrine impediments, IRCU has obtained significant achievements. If the Catholics do not provide condoms, they do refer clients to facilities that do provide this service. For the Catholic Church, on this issue, that is the best response one can expect anywhere in the world. Similarly, unless one is Muslim, male circumcision runs contrary to most traditional Ugandan cultural practice. All faiths in IRCU have endorsed male circumcision and launched programs to provide it. Those programs are picking up pace. The Muslims have helped by emphasizing that participating in MMC does not mean one is converting to Islam.

Faith-based organizations (FBOs) bring both sustained motivation and moral authority to the program. Through effective outreach, they have significantly influenced behavior change among the faith-based community. The faith-based community has influenced policy changes that address societal and structural factors that do impede individuals' capacity to prevent HIV infection. This influence is growing as their organized progressive inter-faith religious voice addresses governance and development issues in Uganda.

1.2 PURPOSE

This evaluation has three purposes: (i) profile the unique strengths of IRCU in addressing HIV/AIDS, (ii) assess its success in mobilizing those strengths to address the HIV/AIDS epidemic, and (iii) assess the possibilities of IRCU scaling up to increase its contribution to the overall Uganda HIV/AIDS program – informing design of any future faith-based interventions.

1.3 METHODOLOGY

The Evaluation Team's basic methodology consisted of a desk review and content analysis of basic documents, field visits, key informant interviews, and focus groups discussions with service providers and recipients. Analysis of each data source was used to crosscheck quantitative data from the PMP. Annex 2 contains the summary reports on each interview and focus group. The universe in which IRCU operates includes 101 health facilities (entities) and programs of one type or another owned by the participating partners. IRCU delivers its services through 19 faith-based health facilities that offer HIV/AIDS care and treatment, 40 religious structures (Dioceses, Muslim districts, Deaneries and Churches) addressing HIV prevention, and 37 community based FBOs offering care and support to OVC. All of these organizations are collectively meeting IRCU performance targets. IRCU also assists its five (5) parent IFBOs for coordination of HIV/AIDS programs delivered through their structures and affiliated FBOs. Of these, the evaluation team visited five of the care/treatment facilities, three OVC sites, conducted 30 key informant interviews and held three (3) focus group discussions. In addition, the team talked to 20 persons living with AIDS concerning the quality of the services provided. We reviewed and conducted content analysis on the quarterly reports of all 19 care/treatment facilities. We compared these data with the results projected in the IRCU PMP and, finally, compared the ambitions articulated in the work plan with the actual achievements documented in the PMP and in quarterly reports to USAID.

Based on the three key evaluation questions, the key findings are documented below.

2. UNIQUENESS, STRENGTHS, AND WEAKNESSESS OF IRCU

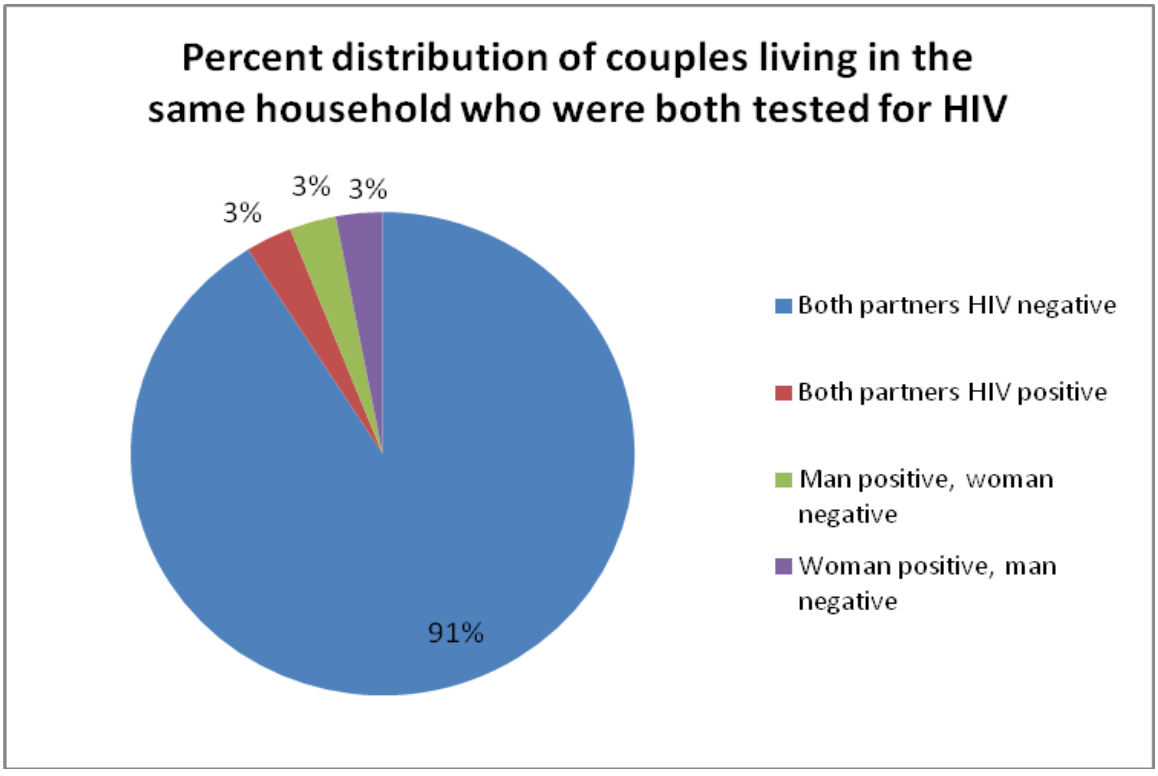
2.1 UNIQUENESS AND STRENGTHS

a. Nationwide access to the faith based community

The IRCU constituency contains over 95 percent of Uganda's population. IRCU claims that, each week, between Friday and Sunday, approximately 15 million people attend church/mosque. There are approximately 27,800 Church of Uganda, Orthodox and Seventh Day Adventists churches, 3,800 catholic sub-parishes with over 10,000 congregations and 7,290 mosques, which provide a ready audience and forum for educating and engaging communities on a variety of health, economic, and political issues. For instance, churches and mosques provide an excellent avenue for disseminating HIV prevention models such as partner reduction and couple testing and counseling for prevention as well as promoting other approaches such as HCT, SMC, and PMTCT. These structures have the potential for self-sustainability. IRCU service providers typically tend to be in hard-to-reach areas.

IRCU has a comparative advantage in its ready access to couples, either to prevent or treat HIV/AIDS. The religious setting increases the receptivity to the message for many couples. It also tends to improve compliance with treatment/prevention protocols. All faiths supported by IRCU have organized training programs for clergy and laity in Health Testing and Counseling (HTC). To date these programs have reached 70,548 couples. It should be possible for IRCU to increase that number by 10 to 15 percent compounded annually.

There are very many discordant couples (one person is HIV+ while the other one is not) in Uganda. 9% of the couples tested in UAIS 2011, approximately 66% were discordant. These couples continue to have sex regularly, many times oblivious of the discordant status.



b. Trust of the faith-based community in the clergy

In Uganda, the clergy are highly respected by their followers as prime directors and interceders in spiritual and social issues. Continuous interactions through home visits and officiating at important events such as marriages, funerals, and confirmations built this respect and the spiritual authority to influence behavior. Churches and mosques are often primary points of reference for individuals and communities faced with challenges. For many people, mainstreaming HIV/AIDS prevention and treatment through the church/mosque can be a key driving force towards effective response. Values such as transparency, accountability, and trust associated with "faith" are seen as a foundation for the community's confidence in the clergy, thus empowering clergy to respond to HIV/AIDS and civic education at community level. In our interactions with respondents, this fact was stated throughout the interviews.

c. Ability of the Council of Presidents (COP) to engage in dialogue with the highest levels of the GOU.

IRCU, through its Council of Presidents (COP) is potentially an excellent vehicle for providing an additional alternative for effective dialogue in terms of HIV/AIDS. The COP composed of the supreme leaders of the five IRCU constituent faiths act as trustees of IRCU. Over time, they have built trust among the senior leadership of the GOU concerning a range of health issues. Their non-competitive approach to addressing HIV/AIDS stands out as a "best practice" in the Eastern Africa region. Their collective voice on health matters and other issues attracts the attention of government and the President. This positions IRCU as a key interlocutor in national policy, an assertion confirmed by World Vision Uganda. In addition, due to the influence of the COP, IRCU facilitates each of the faith based organizations and facilities to engage the Ministry of Health (MoH) at national and regional levels.

d. Holistic treatment protocols involving service providers and priests

Those Ugandans participating in IRCU-supported HIV/AIDS programs greatly appreciate the holistic approach IRCU takes to service delivery. IRCU integrates clergy into service delivery program to counsel and pray for patients. Reports from patients and service providers at the Ishaka Seventh Day Adventist Hospital, St. Francis in Jinja, in Kiwoko, and in Luwero, confirm that this contribution adds value to total treatment experience. The clientele served confirmed IRCU is a people-centered godly program. IRCU's training of the clergy builds capacity and enables different religious leaders to expand their spiritual calling by delivering culturally appropriate effective messages that develop positive attitudes in the patients.

e. Ability to mobilize and train large amounts of volunteers

Parish-level churches/mosques provide a ready source for thousands of volunteers motivated by faith to help those in need. The churches/mosques are also ready training sites. However, our interviews and observations indicate that there is minimal training for volunteers, and competency varies substantially.

f. Potential for local level dialogue and mobilization through the District Interfaith Committees

District Interfaith Committees (DIC) represent IRCU at the District level and provide a forum for local religious leaders to dialogue concerning HIV/AIDS programs. The Evaluation team visited five forums of which four were functioning effectively. While IRCU has five members at national level, evidence in two of the five committees interviewed show integration of other faiths e.g. Pentecostals and Methodists. Thus, all faiths through IRCU provide a common forum to engage districts in matters affecting community development including HIV/AIDS. The continued presence of these structures provides more personalized engagements with the communities.

g. Ability to manage critical resources for health services

At every place that the team visited, there was unanimous agreement that staff serving in the communities and in health facilities were the most critical resource. Availability of medicines and other health commodities was the second. Clients perceive IRCU as providing quality services due to higher staff commitment, minimal stock-outs, customer focus, and continuous capacity building of staff.

h. Identification of champion clergy and service providers

Future success of FBOs and community services would benefit from identification of champion clergy and service providers to push increased service delivery. In our visits and interviews, we met individuals highly charged and excited about what they are doing. We are confident that many more of these champions exist since we only covered a sample of the 101 structures with which IRCU works. These champions should form anchors in the community driving the response to HIV/AIDS..

2.2 WEAKNESSES

A review of internal IRCU documents including the internal evaluation report of November 2012, key informant interviews, and observation, revealed several areas of weaknesses. These include:

(i) With respect to communications, flow of information from top to down is working well. However, it works less well from the bottom up, and even less well horizontally between the District Interfaith Committees and the implementing FBOs.

(ii) The Council of Presidents and Executive Board are excellent advocates for IRCU and are on top of policy matters. They are, however, inadequately informed about implementation issues, and insufficiently involved in mobilizing IFBO structural and network resources to assist implementation. They appear too often to concentrate on high-level theological discussions instead of coming to grips with the major implementation issues. Dialogue does not often result in action. Inadequate participation and involvement at local levels denies them the opportunity to interact with processes that would equip them with information that would empower them accordingly.

(iii) There is inadequate engagement with the Catholic and Church of Uganda medical bureaus. Interviews with these medical bureaus indicated the need for more active engagement with IRCU. This is especially because each of the bureaus plays a key role in the structures that IRCU potentially works with. This is important because the bureaus positively acknowledge the unique position of IRCU in facilitating interfaith collaborations.

(iv) The District-level interfaith committees (DIC) seem to have an inadequate understanding of their role with local level implementing FBOs. In their potential role, if well developed, owned and effectively performed, the DIC would have more impact in enhancing HIV/AIDS response at local levels.

(v) There has been inadequate coordination with the GOU at the district level. IRCU complies with the national HIV/AIDS plan but in several local locations is insufficiently coordinated with District-level government programs. Coordination at the local level with other NGO programs occasionally causes competition for clients/patients.

(vi) Local-level FBO staff and volunteers in some places are less qualified, and less trained than required to perform assigned tasks.

The future of IRCU rests squarely on its ability to build on the above uniqueness and strengths while candidly addressing the weaknesses. Its uniqueness is a nationwide institutional presence that the majority of the Uganda people trust. Its strengths are the capacities it has built to deliver services through faith-based medical facilities. A more active, hands-on, management

approach can mobilize that capacity to increase geographical coverage and number of persons served. In particular, there should be substantial expansion of the couples counseling programs. It is the belief of the evaluation team that when this happens, performance against potential - not just targets - will significantly improve.

3. STRUCTURES

The functioning of the structure of IRCU is an essential element in achieving higher levels of performance.

a. Council of Presidents (COP)

Each of the five major faiths is represented on the IRCU Council of Presidents by its patriarch or the equivalent. The COP functions in a high level – strategic role, rather like a Presidential Advisory Board in the US. The COP has been supportive of the interfaith dialogue, a key factor in a nation in which religious competition among major faiths has been a major and often negative factor. Council members have been very useful in issuing pastoral letters – typically the vehicle that the patriarch uses as an accepted means of issuing policy guidelines –such as outlining general support for the HIV/AIDS program. The evidence of this flow down communication is seen in the statements/actions of subordinate levels of the various faiths. The COP has been less actively involved in detailing specific steps for their subordinates to take in mobilizing to address specific HIV/AIDS issues. As a practical matter, the patriarchs follow a heavy work schedule with significant international travel, which sometimes makes scheduling of meetings difficult.

Several IRCU partners stated that they believe the Council of Presidents could also have a positive effect in high-level policy dialogue. The Secretary General of IRCU is hopeful that the USAID leadership would support the Council Presidents in this dialogue.

b. The Executive Board

This Board functions rather like a corporate board in the US. Working through the Secretary General, they provide oversight to ensure implementation of policy. Membership is composed of the Secretary Generals or equivalent of the respective faiths. They oversee policy articulated by the COP and relate with management through the IRCU Secretary General. They seem less informed than desirable and a little too dependent on information provided by the IRCU Secretariat. A greater overall understanding of the program would empower them to play a more effective role that demonstrates a level of control as a board. Both the COP and the Executive Board are excellent in top down policy statements, such as pastoral letters, but are less involved with mobilizing resources for specific programs. The IRCU internal evaluation of November 2012 has a similar finding.

While the Board is effective in providing a high level of political/religious support, they could further increase their impact with a greater understanding of grassroots problems. IRCU should institute a short, one to three day, field visit program on a quarterly or semi-annual basis. Observation suggests that both the COP and Executive Board would benefit from the Secretary General taking a more proactive role in establishing the agenda and mobilizing the Council/Board to act.

Similarly, district-level interfaith councils are less involved with horizontal communication concerning actual program implementation.

c. Secretary General

Effectively the Secretary General is the IRCU CEO who supervises the Secretariat. The IRCU Secretary General seems well suited to maintaining positive relations between the senior religious leaders. He does not seem to be overly involved in daily operations. He is the official spokesperson for IRCU. Like any CEO of an organization dependent on outside funds, the Secretary General appropriately spends a large amount of his time on fundraising. This has, upon occasion, led IRCU to accept funds for activities which they are unprepared to implement.

d. IRCU Secretariat

The IRCU Secretariat is the managerial element of IRCU. It is composed of two directorates: 1) HIV/AIDS and Public Health Directorate, and 2) Peace, Justice and Good Governance Directorate. Each has demonstrated significant gains in capacity over the past three years. The HIV/AIDS/Public Health Directorate has improved logistics, training, and field reporting. In addition, the District Interreligious Committees are functioning effectively in terms of interfaith dialogue.

e. IFBO Facilities

The individual IFBO own the facilities, which IRCU supports (See table in section (i) below) . A continuing issue concerns funding of the major IFBOs, who in many cases have access to sources of funding other than IRCU. There is need for more dialogue between IRCU and the IFBO's to resolve disputes over funding sources.

f. Dioceses, Muslim Districts, Deaneries or the equivalent

The secretariats or equivalents of the faiths oversee the actual implementation of activities. Except for the orthodox church, the Church of Uganda, the Catholic Church, SDA, and the Muslims have active divisions for HIV/AIDS, which implement the IRCU program. From interviews at parish and district level facilities, it is clear that the instructions from the highest level accurately reach the field operations facilities.

g. District/ Parish level

The Parish clergy state they provide the same information to their congregations that the priests and imams obtained through training. They also state they train congregation-level counselors who provide both individual and small group level counseling.

While we did not see parish-level counseling take place, we interviewed a number of the volunteer counselors. Their emphasis is on "sensitization". While this is an important part of the overall prevalence reduction message, IRCU needs to upgrade volunteer skills to achieve counseling that results in parishioners following community level prevention and treatment protocols.

With one exception, the District Interfaith Coordination Committees (DICs) that the team visited seem to be functioning effectively. These committees share two goals: they actively support programs from the pulpit, and they conduct effective interreligious dialogues. The smaller religious groups, Muslims, SDA, and Orthodox are particularly pleased to be included in these local level coordination structures. Informally in some districts so, too, are the Pentecostals and Methodists. The one dysfunctional DIC was Bushenyi. We recommend that IRCU follow up.

h. Clergy

The clergy are enthusiastically participating in the interfaith committees. They are also being trained in HIV/AIDS and passing the information on to their parishioners. Most state they are training local counselors. Counseling is occurring and IFBOs may be under-reporting to IRCU. For the most part, these efforts seem to be general exhortation. There is the need to move beyond admonitions to a mode focused on facilitating sustained behavior change. There is also need for a protocol/curriculum that is evidence-based and one that complies with PEPFAR requirement for training and community education.

i. Networks

The referral networks are a critical factor in the overall structure. All of the FBOs that we interviewed reported that whenever they could not meet the clients' needs, they followed the practice of referring them to a facility that has the required commodity. At the local level, most

follow the practice of informally providing the clients with adequate information to make an informed choice.

STRUCTURES AND INFRASTRUCTURES OWNED BY IRCU MEMBER-FAITHS

	Seventh-Day Adventists	Church of Uganda	Catholic Church	Uganda Muslim Council	Uganda Orthodox Church	Totals	Comments
Hospitals	1	6	36	5	1	49	
Health Centers, Clinics and Dispensaries	19	207	286	56	17	585	
Congregations	2,714	25,000	10,000	7,290	90	35,094	The Catholic church has 3,800 sub-parishes with an estimated 10,000 congregations
Regional structures /Dioceses	6	34	19	54	-	113	Information not available for Orthodox
Parishes		4,000	500	-	9	4509	Information not available for Muslims
Schools: Primary Secondary	296 98	5,118 460	4,781 582	1,114 130	26 15	11,335 1,285	
Vocational Training	9	50	148	-	8	215	
Universities	1	6	4	5	-	16	
Radio Stations		1	2	4	-	6	
Bank	-	-	1	-	-	1	

SOURCE: IRCU Records /Diary

j. Facilities

Individual IFBOs own and operate health facilities. Most of the facilities were built in the early missionary era, 60-80 years ago, and many are in a state of disrepair. However, they continue to handle high client volumes and the staffs are doing an excellent job of providing quality services especially in rural areas where access to quality care is limited.

k. Constituencies

The total constituency of IRCU reaches 15 million people on a weekly basis. The main faith organizations constituting IRCU meet on Friday, Saturday and Sunday bring together a ready audience that can reach 7 million – 8 million persons. Based on active levels of participation in

weekly church/mosque activities, the Evaluation Team estimates that from two to three million people are open to changing their behavior in a healthier direction. The clergy are in a position to acquire skills to provide and supervise counseling. Technical support would be helpful. Such a scale-up campaign would need to have small groups (no more than 25 persons per group) as per PEPFAR Next Generation Indicators (NGI) definitions. A structured follow-up program involving both IRCU and the churches/mosques is required to ensure quality control focusing on effectively addressing HIV/AIDS.

4. EFFECTIVENESS OF IRCU IN MOBILIZING TO ADDRESS HIV/AIDS

4.1 EFFECTIVENESS IN MOBILIZING

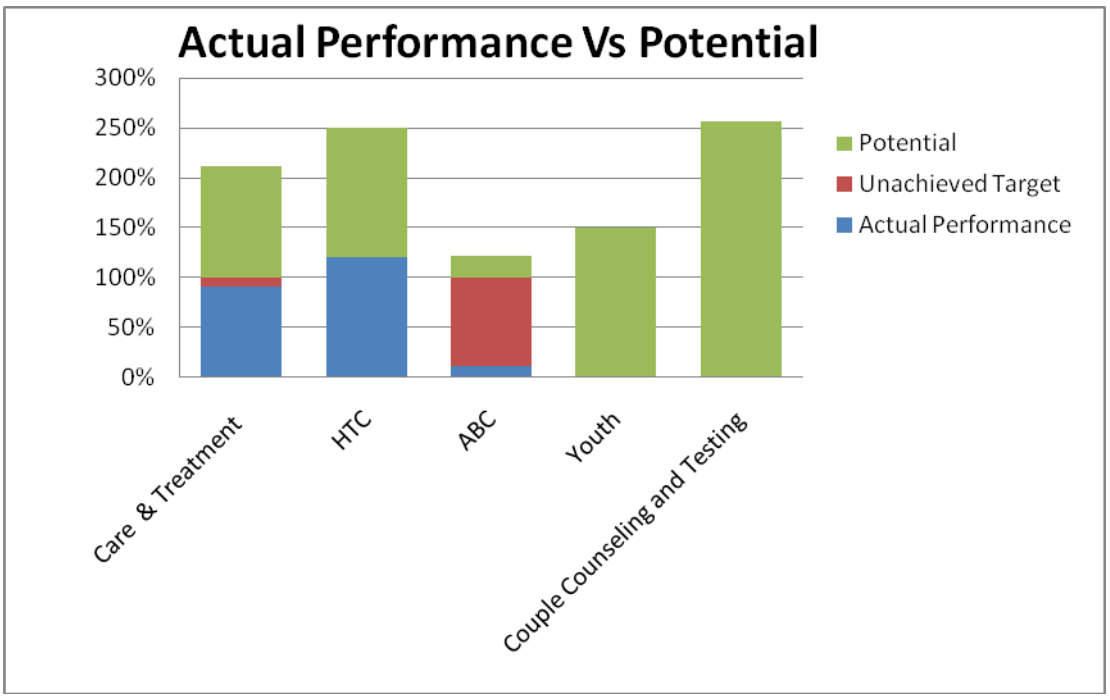
a. Major factors in determining the quality in IRCU performance

Primary emphasis was on a review of performance as tracked by the PMP. This data was spot-checked against the contents of monthly FBO reports, in particular looking at numbers served and statements of problems. We spot-checked patients in hospitals. We conducted focus group discussions with OVCs and people living with AIDS.

We conducted both group and individual interviews with FBOs on the quality of IRCU support. The consistent answer was that IRCU is hands-on in its support, providing relevant training (and repeating that training as required for replacements), giving specific guidance at the field level, and being available in the field to answer questions. This is increasing capacity as measured by improved work plans, monthly reporting, and better use of the supply system, clean audit report, and obvious high morale.

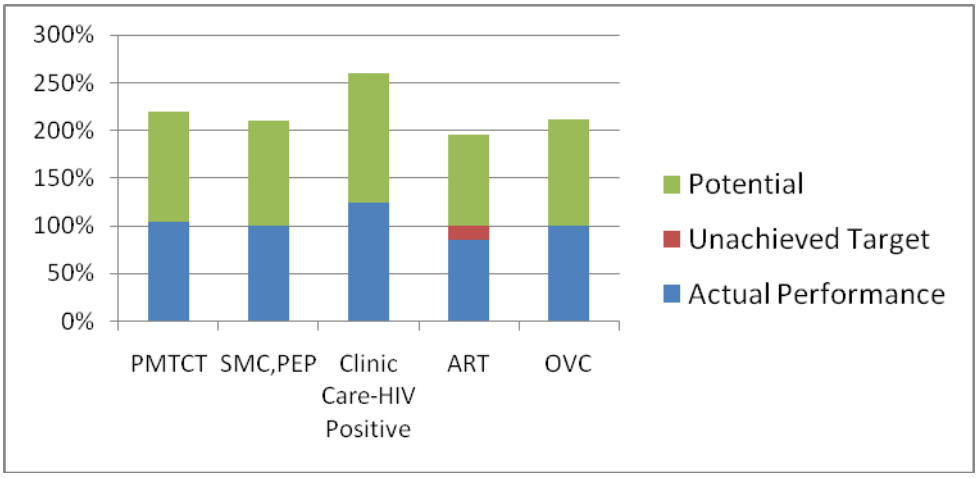
The responses were consistently positive about the quality of services. Patients appreciate the positive relationship with staff, the availability of medicine, and the whole-person approach. (Particularly appreciated was the availability of the clergy to pray with the patients during treatment.). Also appreciated was the continuum of response in terms of treatment. IRCU facilities do a better job of following up on patients. (For more details see section 4.2 (a))

In contrast to public facilities, IRCU facilities are open continuously from morning to night. However, IRCU faces challenges: 1) maintaining the standard of care while expanding services beyond the current 19 facilities, 2) increasing the numbers of people served, and 3) improving the counseling linkage between health facility, parish church/mosque, and parishioner. The following bar chart demonstrates current performance versus evaluation team's perception of potential performance over the next five years.



Increased availability and access to HIV/AIDS Service

(PMTCT, OVC, ART, MMC, PEP & Clinic Care-HIV positive)



We held focus group discussions at two OVC facilities and visited a third. They are functioning effectively with a number of graduates obtaining employment. It is very basic but the success of the program is generating hope. But we also learnt that IRCU reaches out to vulnerable children using a family based model and community-wide approaches. The family based model which IRCU adopts recognizes that when a household is vulnerable, then each and every member in this household is vulnerable hence interventions target all members. A family is the unit of concern for IRCU member institutions hence IRCU is well placed to provide services at this level.

From the data that the IRCU staff availed the evaluators, we learnt that the original project target for OVC was 15,000. This target was exceeded when IRCU reached 15, 212 (7,289 males and 7923 females), by September 2012. In the year 2012/2013, IRCU planned to reach 45,000. By December 2012, they had supported 22,210 (10,722 males and 11,488 females). By the end of March 2013, they had supported 32, 695 people (15,969 males and 16,726 females). This means that they are on track towards achieving their targets, with a little effort added.

b. Methodology for assessing actual versus potential performance

The y-axis represents a percentage of the current PMP target. The Evaluation team projected potential based on a three-step approach. 1) We looked at the progression of the indicator targets over the five-year period of the PMP. 2) We projected this rate forward for five years at the same rate of the initial five years and then added 10 percent per year - six to ten percent being the perceived annual improvement in management capacity. 3) Finally, we matched the indicator fit with the IRCU structure. Some integrate better than others did. This yielded the final projection. (Note, we believe that IRCU has performed well; it is in the top third of similar USAID funded projects. We also believe that IRCU can perform significantly better. They have had ten years of USAID support; now is the time to improve results significantly. USAID needs to be part of this process by providing strong oversight/encouragement. The following table summarizes performance against set targets.

PMP BLOCK RESULT AREAS: AVERAGE ACHIEVEMENT AS A PERCENT OF PMP TARGET

INTERMEDIATE AND SUB-IR	# OF INDICATORS	AVERAGE PERFORMANCE	COMMENTARY
INTERMEDIATE RESULT 1.0: Faith based HIV/AIDS response in Uganda Strengthened	2	83%	Performance in this area is satisfactory
SUB-INTERMEDIATE RESULT 1.1: To improve coordination at district and national level	3	848%	The number of interfaith workshops proved highly popular. IRCU responded by holding a total of 47 workshops exceeding the original target of 2
SUB-INTERMEDIATE RESULT 1.2: To enhance capacity of FBO to deliver HIV/AIDS services	2	148%	# of religious leaders trained in HIV/AIDS education and adherence support targets were 250 but actual was 1616 hence exceptional performance in this indicator
Health system strengthening	4	105%	Performance in the individual indicators ranges from 89% to 119%
INTERMEDIATE RESULT 2.0: Increased availability and access to HIV/AIDS Service (AB, HCT, PMTCT, OVC, ART, MMC, PEP)	9	100%	Performance in this PMP area ranges from 70% to 125%. This does represent a good performance all round. An examination of sub-indicators does reveal a serious underperformance on the # reached with Abstinence and Be Faithful messages (as defined in PEPFAR Guidance)where achievement was only 12% on sub-indicator #12
INTERMEDIATE RESULT 3.0: Increased demand and utilization of reproductive health and HIV/AIDS services	6	196%	Average performance appears excellent. However, a close scrutiny does reveal some areas that need attention. For example, sub-indicator #55 (# of individuals who receive testing and counseling services for HIV) performance is at 46%.

There are program indicators that show less than expected performance in the table above. These include:

(i) Abstinence/Be Faithful married individual or small groups' message - target 612,000 actual 70,548 representing a 12% achievement. This is far below planned achievement. More regular performance monitoring should have identified and stimulated corrective action.

(ii) Number of HIV-positive patients in HIV care or treatment who started TB treatment. The 2012 target was 2,700, while the actual was 904, representing a 33% achievement.

(iii) Number of OVC who completed IRCU-supported vocational/apprenticeship training. The 2012 target was 3418, while actual was 1711.

(iv) Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results disaggregated by type of counseling (individual or couple). The 2012 target was 12,600 and actual was 5,829.

The above selected program indicators where performance was less than expected primarily relate to results expected following improved capacities – for example, training of clergy and other religious leaders in order to enhance coordination in HIV/AIDS response. The underperformance points to a gap between capacities built – primarily through training – and delivery of results. For example, under Abstinence/Be Faithful, IRCU reached 291 percent of the projected training target for religious leaders as trainers in HIV prevention. Outreach was much less successful; preliminary results reaching only 12% of the overall target.

This implies that training does not automatically translate into effective outreach. There should be greater emphasis on preparation for outreach during training. IRCU in conjunction with its faith partners needs to strengthen management oversight of the link between clergy, volunteer counselors, and parishioners. The Evaluation Team believes this is beginning to happen and, if the IRCU sustains the tempo it should achieve significantly greater results by the end of this year.

Another area with less than expected performance is the number of HIV-positive patients in HIV care/treatment who started TB treatment. Actual performance seems to decrease on the third year of the program (See PMP Analysis summary table above). The evaluation team observed the integrated approach at the SDA Hospital Ishaka. This observation confirms that screening for TB is adequate for years one and two. It may be a bit too high for years three and four. They seem to have set the targets too high for both third and fourth years.

Further analysis of performance for the period January-March, 2013 for the 19 sites have been included in the annexes.

The Evaluation Team believes that the overall PMP targets are appropriate for the current level of IRCU's implementation capacity and funding. We also believe that IRCU, in coordination with assertive oversight from USAID, needs to significantly increase this capacity. For IRCU to be a forceful role model for the faith-based approach to health and HIV/AIDS challenges, increased performance as measured by meeting challenging quantitative targets is required. . Thus, the Evaluation Team believes it would be useful for USAID to review with IRCU the PMP and the data reported. We note that according to USAID, IRCU has significantly improved the quality of the PMP. The next six months is the appropriate time for IRCU to review with USAID field to headquarters reporting procedures and ensure reporting of complete data. The process should result in mutually-agreed targets for existing indicators that IRCU believes it can reach.

4.2 MAJOR MOBILIZATION CHALLENGES

a. Continuum of Care

Under the Care and Treatment Program, IRCU health facilities embrace the Continuum of Response (COR) concept. However, the orthodox church program has a challenge in this respect. While they provide the total care and treatment, including psychosocial support, basic packages, spiritual support, and support for the clients to form and belong to "adherence groups", they have not totally embraced the COR concept. At St Francis Health Care Services Center, for example, we learned that clients not only receive care and treatment, but also get their psychosocial and economic needs met. That enables the clients to live positively, both as individuals and within their communities.

IRCU applies the concept of COR liberally, emphasizing increasing intensity of care specific to the patient needs rather than a specific and unvarying list of services. It is impressive that IRCU

is rolling out the continuum of care model in several of their facilities. Besides St. Francis Center, we interviewed patients who are experiencing this approach first hand, at Kiwoko hospital, in Nakaseke District. From one of key informants, we learned that continuum of response approach is being applied at Kisiizi hospital, in South West Uganda.

At Mityana-Mubende Orthodox HIV Prevention Project, the volunteers told the Evaluation Team, they require material support to be effective. The support the volunteers require is money and food for both themselves and the clients. As such, the volunteers tend to develop "cold feet" when they know they cannot meet the demands of the clients.

Quality of care indicators that also demonstrate continuum of response for all IRCU sites include:

(i) % of HIV+ pregnant women started on treatment- 87%
(ii) % of infants of HIV+ mothers tested for HIV – 97.8%
(iii) % of HIV+ babies put on treatment – 97%
(iv) % of clients identified as HIV positive at HTC who are enrolled on care or treatment – 25% (this value improved drastically in FY 2013)
(v) % of HTC clients who are uncircumcised HIV- men offered circumcision? – Not currently collected by M&E

Note: Government hospitals, accredited Health Centre IVs and IIIs are providing Option B+. They are rolling it out in phases as guided by MOH policy.

b. Retention of professional personnel

IRCU provides job-specific training to the personnel serving in its facilities. This appears to be enough for those persons to do their jobs effectively. Over time, IRCU personnel become attractive to government facilities that have higher salaries and greater benefits. The IRCU-supported facilities report attrition rate of up to 30% per annum. Given the relatively modest investment in training, (and high return on investment) this problem seems manageable. It is unlikely that IRCU can increase staff salaries and benefits to the level needed to compete with government. As stated by the USAID/Uganda Mission Director, one could consider the migration of IRCU trained personnel to government service as an ancillary benefit of indirectly improving the competence of the GOU health facilities.

c. Quality of care - Follow up of clients /patients (Testing and counseling dropouts)

Following the specific questions in the questionnaire on testing and counseling, we queried both staff and patients at the facilities we visited and received a variety of answers. The OVC Centre at Iganga does not track its graduates beyond immediate placement. The health facilities do, at least initially. Only the SDA hospital at Ishaka appears to aggressively follow up on patients failing to report for scheduled treatment appointments. At Ishaka, management is utilizing both the Provider Initiated Counseling as well as the Voluntary Counseling and Testing approaches.

d. The evaluation team observed that Ishaka follows a strict protocol on the Continuum of Response (COR).

The Continuum of Response (COR) is not easy for most facilities that are not as organized as Ishaka. It requires the right staff, structures and capacity to integrate services in each clinic/unit. In Ishaka for example, the health worker at ANC initiates HTC for all first-visit clients. Before being tested for HIV, all pregnant women receive counseling. Women who test positive are escorted to the registration hall, where Ishaka enrolls them in a treatment program. All women receive an appointment for six weeks post-birth. The Evaluation Team learnt from Ishaka hospital that the infants who test positive are put on pediatric treatment.

e. Prevention

This is a key area where IRCU has comparative advantage given its wide constituency. Even where the religious doctrine of some faiths restricts delivery of some types of services, such as the use of the condom, none of the faiths "de-campaign" the others. For example, Catholic facilities provide referrals to those wanting to use condoms. Pre-marital counseling seems to be working well. Marital counseling is vital, both to prevent adult and child infections. There seem to be some excellent ongoing programs that can serve as models for extension. But this needs expansion.

Similarly, USAID and IRCU need to take a fresh look at youth programs to ensure that they are youth-friendly and that they actually address youth concerns.

Within their catchment area, the parishes and health facilities are making a concerted effort at prevention. Almost without exception, they are in hotspot areas experiencing higher prevalence rates than the national average. Measurement of the overall impact by looking at the local prevalence rate will not yield an entirely accurate picture because a number of the parishes/field facilities are along the major transport routes that attract transient high risk populations such as truck drivers and lading sites that are frequented by migrant fisher-folk. Record-keeping for persons receiving sexual prevention interventions like BCC need improvement.

5. CONTRIBUTIONS TO OVERALL HIV/AIDS PROGRAM IN UGANDA

5.1 QUANTITATIVE INDICATORS

Quantitatively, the PEPFAR indicators best represent USAID's primary contribution to country-wide effectiveness in combating HIV/AIDS in Uganda. This is the best available way to assess IRCU contribution to the national response as PEPFAR contribution in many instances equals, and sometimes exceeds, what is given as the national data. Listed below by program area are the IRCU contributions. At 10 percent or greater, IRCU does particularly well in sexual prevention and number of persons provided with PEP. (See table below)

IRCU's contribution to the overall PEPFAR HIV/AIDS response in Uganda
(Annual period ending September 30, 2012)

Indicator	PEPFAR	IRCU	IRCU% contribution
Sexual Prevention			
Number reached with AB Interventions	722,635	70,548	10%
Number of MARPs reached with sexual prevention interventions	217,761	10,400	5%
Biomedical HIV Prevention			
Number of males circumcised	348,099	2,833	0.8%
Number of people provided with PEP	2,080	225	11%
Number of HIV positive pregnant women given ARV Prophylaxis	68,123	1,464	2.1%
Unique Individuals Counseled, Tested & Received Results	3,628,640	125,837	3.5%
Clinical Care			
Number of HIV-positive adults and children receiving a minimum of one clinical service	717,205	41,432*	5.8%
Number of HIV-positive persons receiving Cotrimoxazole/Dapsone prophylaxis	671,175	41,432*	6.2%
Number of HIV+ve in HIV care or treatment (pre-ART or ART) started on TB treatment	15,094	904	6%
Treatment (ARV Services)			
Number of adults and children with advanced HIV infection receiving antiretroviral (ART) Current/Active	364,207	13,718	3.8%
Number of adults and children with advanced HIV infection newly enrolled on ART	82,113	2,958	3.6%
OVC Care and Support			
Number of orphans and vulnerable children (OVC) served	288,650	12,485	4.3%

Health Systems Strengthening			
Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests according to national standards	747	16	2.1%

*These two numbers are the same because the above provides overall active clients who were on care by that time. The one below shows that all those clients (above) were provided with Cotrimozazole / Dapsone as one of the clinical services.

5.2 QUALITATIVE INDICATORS

a. Hope to the hard-to-reach - the poor in both rural and urban areas

Qualitatively, IRCU, through mobilization of the faith community, is a vital element in the national HIV/AIDS program. IRCU provides USAID a ready link with the largest and most productive demographic in Uganda, the faith community. Through that community, IRCU is bringing hope to those who have little of it. Critically, hope comes in the form of concrete services. IRCU is bringing first-class services to its community, as shown by documented data on meeting the major targets in its PMP. In the key intermediate result "increased availability and access to HIV/AIDS services (AB, HCT, PMTCT, OVC, ART, MMC, and PEP)", IRCU achieved an overall 100 % rating. Vitally, according to interviews of actual patients receiving care and treatment, the services are the highest on offer in the rural areas being served. Those IRCU is serving are highly satisfied. The Government agrees, "This organization has implemented a number of important and relevant strategies and activities" (*Assistant Commissioner Health Services, Ministry of Health*). IRCU targets to contribute approximately 6% in terms of meeting PEPFAR overall targets.

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b. What is the most appropriate role for IRCU? What is their area of strategic advantage?

The Evaluation Team recommends a three-prong approach for IRCU:

1. Continue to provide the range of services, which USAID now supports. Strengthen coordination with the Catholic and Protestant Medical Bureaus. (It is worth noting that when one combines the results from IRCU, and the Catholic and Protestant Medical Bureaus those results are in the top three in all indicators.
2. Mainstream HIV/AIDS activities into the education programs /ministries of the congregations by expanding the testing and counseling programs to all 101 health facilities and programs supported by IRCU. Similarly, target a comparable number of independent churches/mosques. Target both youth and couples. The groups should meet in numbers not to exceed 25, at least once a month, for a minimum of three months. Ideally, they should adopt some type of sponsor system. Start with the existing structures such as Mothers Union, Madrasas, and Youth Clubs;
3. Encourage the Council of Presidents, and particularly the Executive Board to see their role more expansively; specifically mobilize the human resources in their IFBOs to support the Testing/Counseling program, more actively oversee the secretariat, and engage more actively in the national level dialogue concerning the prevention – care of HIV/AIDS.

Families are the fundamental building-block of society. Research in the US demonstrates the quality of family support is a critical factor in achieving positive outcomes. The adolescent children of strong families do better in school, have fewer disciplinary problems, start sexual activity later, generally do not get pregnant, and obtain better jobs in adulthood. Children seem to influence their parents to adhere to positive behavior patterns. IRCU is of the view this is true

for Uganda as well. Parish-level churches/mosques are in a strong position to positively influence the growth of strong families.

USAID should actively engage IRCU in dialogue on the most appropriate target areas for these interventions.

6. SYNOPSIS OF KEY FINDINGS

a) IRCU has successfully mobilized the major faiths in a campaign to address the challenges of HIV/AIDS - Evidence Key informant interviews, meeting PMP targets.
b) IRCU has a nationwide reach in terms of church/mosque presence but a limited reach in terms of actual health facilities- Evidence – field observation and documentation of field presence.
c) The IRCU secretariat has the managerial capacity to implement its existing program and to expand while maintaining existing quality- Evidence - Preparation of work plans, PMP reporting, Internal Evaluation, FBO reporting, reports on quality of services, clean audit report, and field site visits.
d) The Council of Presidents and Executive Board are effective in providing high-level political/religious support in addressing HIV/AIDS. "This is good, given that we need to have one voice representing our different interests. With this, we are in a better position to drive our agenda" Robert Kanwagi, Director Health &AIDS – World Vision Uganda. They are less effective in mobilizing implementation resources. Key informant interviews –
e) Personnel retention is a problem with up to 30% turnover per year at field health facilities. The major reason for the high turnover is superior salaries/benefits at government facilities. The FBOs seem to be managing this challenge by repeatedly training new personnel and providing non- monetary incentives. Evidence – Key informant interviews supported by field reporting.
f) Utilizing the improved national supply chain management system, the IRCU logistics system seems to be supplying the vital eight (8) drugs to IRCU assisted facilities with relatively few stock- outs. Evidence key informant interviews, quarterly reports from facilities, confirmation from living with AIDS patients.
g) Several field sites are potential models for expansion. Specifically SDA – Ishaka and Mityana, St. Francis – Jinja and Luweero interfaith provide excellent services as measured by their monthly reports and observed by the Evaluation Team.

7. SUPPLEMENTARY FINDINGS

a) IRCU is like a large elephant. Properly trained and motivated, the elephant can lift a heavy load but it will never successfully learn to dance. IRCU provides excellent health services by reaching down to the family level, more effectively than any one national organization. However, like the elephant, it has its limitations. Within the religious scope that IRCU provides service, USAID needs to work within the theological constraints of IRCU. Similarly, USAID needs to recognize its own limitations in implementation/supervision/monitoring.
b) IRCU is meeting its major PMP targets, demonstrating a major improvement between 2011 and 2012. In general, IRCU is contributing to meeting PEPFAR goals in proportion to its budget for each activity.
c) Core managerial competency at the field level is improving as demonstrated by preparation of work plans, monthly reporting and quality surveys.
d) Morale is high both within the IRCU secretariat and in the field posts.
e) Stable married couples are a new and critical MARP. Economically, they are the most productive of threatened groups. The Evaluation Team believes IRCU is the organization best able to address this need.
f) Perception at the field implementation level is that prevention is being de-emphasized in favor of treatment. The field level believes that the public is tuning out previous messages. Perception from many is that many people now believe that AIDS is a disease like diabetes or cancer that one can live with through sustained treatment and this is effecting behavior.
g) Capacity building of religious leaders through training is reaching from the Bishops to the local counselors, as demonstrated by the use of very similar language to describe HIV/AIDs programs and challenges
h) A whole of life approach to treatment is proving to be an effective treatment protocol. IRCU should expand this approach across the entire faith based community - system. (Prayer by the priests during treatment, continued support, counseling and exhortation)
i) Similarly, complete family approach is proving more effective in OVC implementation. Changing to reporting entire numbers in families greatly improve the IRCU OVC numbers.
j) The higher the level of religious adherence the lower the prevalence rate (Evidence: IMAU research findings on Religiosity and behavior among the youth age 15 to 24 years).
k) Examples of low-level prevalence exist among University students attributed to early exposure to preventive messages for behavior change. Primary education sensitization seems to have an impact that extends through University (Dr. Apuuli, Director General, Uganda AIDS Commission).
l) The supply logistics system seems to be supplying the vital AIDS drugs to IRCU facilities with relatively few stock-outs. Contrastingly, the supply of drugs for treating opportunistic infections is often in short supply. For many patients, purchasing the drugs is too expensive. A service fee from 1000 to 2000 Ush is affordable for most persons.
m) The parishes have been successful in recruiting local counselors; however, compensation of the counselors, who generally are living below the poverty line, is an issue. Typically the counselors receive a bicycle and a cell phone (air time).

9. CONCLUSIONS

Any accurate evaluation of IRCU should take into account the core beliefs that motivate IRCU and its church/mosque components. That is, IRCU is structured along religious lines, motivated by a strong ethic of religious service, and in some cases limited by theological concerns. This ethic is at the core of their success. It also imposes limitations. (See section 8 (a) above).

IRCU has been successful in mobilizing the major faiths to address the challenge of HIV/AIDS. All of the major religions are working together on addressing HIV/AIDS. In particular, they are taking common training offered by IRCU, training that teaches their clergy and lay leaders the same lessons, and following, within the constraints of their religious culture, similar implementation protocols. (Evidence – shared articulation during interviews, similar observed implementation patterns.) This inclusiveness and shared vision, is a major accomplishment that USAID can build upon. In all of our interviews, respondents always mentioned this accomplishment first.

The component faiths, especially the Catholic Church and the Church of Uganda, are fundamental institutions in Uganda that have passed the test of time by adapting to changing circumstances. They see themselves as the creators of IRCU. They also see the facilities as those of the churches/mosques even as IRCU supports those facilities. That theological reality places both restrictions on scaling up, as well as presenting increased potential for sustainability.

The Council of Presidents, represented by the Princes of their faiths, is the de facto owners of IRCU. The Executive Board provides oversight. The Council and the Board offer USAID an opening for dialogue not available any other way.

There are limitations. While the reach of IRCU through the churches/mosques is nationwide, actual facilities reach only a small fraction of Ugandans. Clients highly rate the services IRCU provides significantly higher than government facilities. (Evidence – statements by clients during focus groups) Significantly the restraints placed on services by theology or cultural custom, are to a degree addressed by a reasonable referral network.

IRCU significantly improved its performance in 2012 over previous years at meeting its PMP targets. The semiannual PMP report for 2013 indicates this trend is continuing. (Evidence 2012 PMP) This indicates that improved capacity is turning out greater performance. There are problems, especially finances, retention of personnel, and logistics, but for the most part the IRCU supported facilities seem to be managing those problems. Within the range of its 101 supported entities IRCU has the potential to significantly scale up but that potential is not unlimited. They can reach many, and many of those will respond positively to a message of prudent self-discipline within the context of a strong religious faith. However, many are by no means all.

Behavior change is an inherent part of religious faiths and an essential component to any long term solution to the HIV/AIDS epidemic. The weekly sermon supported by grass roots parishioner counseling and follow up offers vital advantages, especially in such a sensitive culturally bounded area as sexual behavior. Behavior change is an emphasis of IRCU and its constituent partners. USAID is justifiably proud of its role in providing life sustaining drugs; however, over the long run Uganda cannot afford those drugs for everyone. The only long-term solution is to reduce the infection rate. That will require sustained positive behavior change. IRCU offers an opportunity to try a variety of approaches, tailored to the varied demographic groups and then to extend the most successful approaches nationwide to what is likely to be the most productive and receptive elements of the population.

Overall IRCU is a vital element in the total Uganda HIV/AIDS program. It has the most comprehensive access to youth and couples both married and unmarried. Addressing the needs of this demographic should be a priority in any comprehensive HIV/AIDS program

10. MAJOR RECOMMENDATIONS

a. STRENGTHS AND POTENTIALS

(i) Involve the Council of Presidents and Executive Board in a program of active advocate dialogue and parish level resource mobilization.
(ii) To maintain commitment, IRCU should limit membership in the Council of Presidents and Executive Board to its current core of the major religions.
(iii) IRCU is the most effective option for engaging the main line religions in support of any comprehensive HIV/AIDS program.

b. CONTRIBUTION TO HIV RESPONSE

(i) Emphasize prevention programs that address behavior change with two specific target groups: 1) youth, and 2) couples.
(ii) The IRCU Secretariat has strengthened its ability to disseminate lessons learned and best practice to all levels. For example, the model at Ishaka should be replicated to expand application of the COR approach.

c. IMPROVED QUALITY THROUGH FBOS

(i) IRCU should utilize the USAID health communications program to experiment, test, standardize and deliver messages to the specific target groups.
(ii) IRCU should permit affiliated membership for smaller groups and manage the grants to those groups. This would reduce the management burden on USAID, and increase the coverage of IRCU.

II. SUPPORTING RECOMMENDATIONS

a. STRENGTHS AND POTENTIALS

(i) Use the Council of Presidents and Executive Board of Directors to provide specific direction to their dioceses (or equivalent) and parishes to form counseling groups for youth, pre-married, and married couples. Support this recommendation with the active involvement of the USAID Senior Management by periodic attendance at COP and Executive Board meetings. Ensure the USAID Project Manager has sufficient time to actively engage with all levels of IRCU. If IRCU is to achieve a high level of performance increased active USAID engagement at all levels is required.

(ii) While the Council of Presidents and Board of Directors are effective in providing a political level of support, they do not appear knowledgeable about the grass roots program. On a quarterly or semiannual basis, IRCU should institute a program of short, one to three day, field visits for the COP and Executive Board.

b. CONTRIBUTION TO HIV RESPONSE

(i) Emphasize coordination of prevention work between the parish priests – local counselors and youth, couples, pre and post marital.

(ii) In conjunction with the USAID Health Communication project, review message protocols and support research – experimentation in updating the messages for specific target groups – youth, pre-married, married stable couple. Coordinate with the government oversight group.

(iii) Explore how to best use social media to create a youth friendly environment. This should include an interactive network through which youth can communicate concerns, receive advice and get real guidance on how to access services.

(iv) Encourage IRCU to strengthen its federal approach in which IRCU would perform a range of staff functions including advocacy, research, oversight, finance, reporting, auditing, and technical support but actual implementation would be conducted by the individual faith organizations.

c. IMPROVED QUALITY THROUGH FBOS

(i) Review condom distribution channels and ensure wide spread availability. As part of this review, analyze the reasons for opposition to the condom. In an informal group discussion, commercial sex workers stated condoms are sometimes in short supply and not always readily available.

(ii) Review the literature and conduct necessary new research on why couples remain faithful and sexually satisfied within marriages. Update data within the specific context of Uganda.

(iii) Support development of starter packages for district level interfaith offices at an existing church/mosque facility.

(iv) Review the reception and follow up plans of the OVC - especially the linkages between the OVC and other support networks.

(v) IRCU should establish a credentialing program for adding facilities and affiliated organizations. The IDI program for upgrading laboratories may be a useful example achieving this objective.

(vi) Identify champions, especially parish clergy. Research why they do especially well. Provide tailored training to further upgrade their skills.

ANNEXES

ANNEX-1

IRCU'S SELF-STATED UNIQUENESS AND COMPARATIVE ADVANTAGES

N.B.: This is a letter from Mr. Johnson Masiko, the Director of HIV/AIDS and Public Health IRCU, on what IRCU sees as its uniqueness and comparative advantages. The substance of the letter is widely reflective of views within IRCU and of IRCU's partners.

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Inter-Religious Council of Uganda
Religions for Peace

UNIQUENESS AND COMPARATIVE ADVANTAGES

OF THE INTER-RELIGIOUS COUNCIL OF UGANDA

1.0 INTRODUCTION

The Inter-Religious Council of Uganda (IRCU), established in 2001 is a network that brings together different religious organizations including Church of Uganda, the Roman Catholic Church, the Uganda Muslim Supreme Council, the Seventh-day Adventist Church Uganda Union, and the Uganda Orthodox Church, to work together along areas of common interest. IRCU also works with other faith based organizations notably the Baha'i Faith, the Pentecostal and Evangelical churches.

One of the cardinal goals of IRCU is to provide a mechanism for enhanced faith based involvement in addressing developmental issues through coordinated approaches, coherence of effort, maximization of synergy and sharing of resources.

1.1 IRCU Vision

A divinely peaceful, united, prosperous Uganda where all people enjoy full health and freedoms for the common good

1.2 IRCU Mission

To promote peace, reconciliation, good governance, and Holistic human development through interfaith action and collaboration, advocating for the empowerment of member bodies for the common good.

Implementation of IRCU programmes is hinged on the principles of the faith-based approach (FBA) and these include:

(i) Belief in God

(ii) Application of religious structures

(iii) Working with Religious leaders

(iv) Self-control

(v) Application of scientific knowledge

2.0 UNIQUENESS OF IRCU

2.1 Vast and Available structures

IRCU is endowed with structures that run from national to the grass root which enhance communication and service delivery. However, the available resources are inadequate to enable them exploit this great potential. For example:

(i) The Seventh-day Adventist Church has 6 Dioceses, 296 Primary Schools, 98 Secondary Schools, 9 Vocational Institutes, 1 University, 1 Hospital, 19 Clinics and Dispensaries country-wide;
(ii) Church of Uganda has 34 Dioceses, 213 Hospitals and Health Centres, 6 Universities, 5,118 Primary Schools, 460 Secondary Schools, 50 Post-Secondary/Vocational Schools, 1 Radio Station;
(iii) The Uganda Orthodox Church has 9 deaneries, 90 Churches, 18 Hospitals, Health Centers and Clinics, 50 Pre-Primary Schools, 26 Primary Schools, 15 Secondary Schools, and 8 Post-Secondary Schools.
(iv) The Catholic Church has 19 Dioceses, 36 Hospitals, 286 Health Centers, 4781 Primary Schools, 582 Secondary Schools, 148 Technical/Vocational Institutes, 4 Universities, 2 Radio Stations, 1 Bank;
(v) The Uganda Muslim Supreme Council has 54 Districts, 7,290 Mosques, 5 Hospitals, 56 Health Centers, 5 Universities, 6 Post-Secondary Institutes, 130 Secondary Schools, 1,114 Primary Schools, and 4 Radio Stations.

Other faith structures that can be tapped into include: Associations of professionals like Lawyers, Doctors, Engineers, Teachers; Mothers' and Fathers' Unions; Students' Unions; Scripture Unions; and Networks for Women, Youth and Children.

2.2 Enhanced Coordination

The IRCU Secretariat and the Institutionalized Faith Based Organizations (IFBOs) that are in-fact the membership of IRCU are strategically positioned to coordinate the faith based fraternity at the national level and beyond using their established systems and structures.

2.3 Platform for influencing policy and consensus building

Religious institutions and Religious leaders are highly influential, respected and trusted. This provides a platform for advocacy. They are a trusted source of information by most Ugandans, and they reach many people from diverse backgrounds.

2.4 Accessibility to congregations

Religious leaders have regular forum every Fridays or Saturdays or Sundays during which they can communicate with people of all walks of life.

3.0 COMPARATIVE ADVANTAGES OF IRCU

3.1 Behavior Change interventions

Religious leaders are custodians of morals in society. They retain and restore morals. IRCU is best suited to implement behavioral HIV prevention interventions focusing on youth and couples. Religious institutions own vast structures for youths and couples including youth camps, Madrasa classes, mothers and fathers unions, among others. The couples and youths form a family, a unit of focus by religious leaders. Religious leaders provide pre-marriage counseling, and are a stop point for couples and families troubled. This position places IRCU as a better choice for behavior change interventions for youths, children and the general public.

3.2 HIV/AIDS mobilization, communication and messaging

IRCU presence in every village represented by churches and mosques, and the highly organized leadership structures from national to grass root level makes community mobilization, communication and messaging pretty easy. The formation of District interfaith committees makes IRCU HIV/AIDS mobilization at district and lower levels well-coordinated.

3.3 Care and Treatment

The already existing network of health facilities and the experience in HIV/AIDS management so far built by IRCU is adequate to continue providing quality HIV/AIDS care and services, as well as scaling up to other faith based health facilities. The experience in supporting facility-community linkage and referral using a pool of volunteers/linkage facilitators provides enormous opportunity for IRCU to provide comprehensive facility and community based care/treatment services.

3.4 Child support interventions using family based model and community-wide approaches

The family based model which IRCU adopts recognizes that when a household is vulnerable, then each and every member in this household is vulnerable hence interventions target all members. A family is the unit of concern for IRCU member institutions hence IRCU is well placed to provide services at this level.

3.5 Capacity Building and Empowerment for faith based HIV/AIDS programming

Religious leaders have vast potential that can be tapped into to deliver services, however, this potential needs to be developed through knowledge and skill enhancement to enable FBOs integrate HIV/AIDS services in routine religious activities while ensuring quality service delivery. IRCU's experience in FBO HIV/AIDS programming put her in a unique and strategic position to provide capacity strengthening interventions through training, mentoring and other forms. The Inter-Religious Institute for Peace (IRIP) is a structure established by IRCU to provide practical skill training for religious leaders in a number of social and development areas.

3.6 Bio-medical HIV prevention

As in care and treatment, IRCU's net-work of health facilities provides vast opportunities for the provision of HCT including couple HCT and PMTCT. IRCU potential to provide Voluntary Medical Male Circumcision is unquestionable given the initial test IRCU has given to this intervention. A few activities will have to be conducted to correct the wrong approach initiated by the different implementers and targeted interventions to a few religious leaders whose personal attitude towards VMMC is negative.

4.0 BASIC ISSUES TO SUPPORT THE ABOVE-HIGLIGHTED FEATURES

(i) System strengthening including human resource, finance, and organizational (governance and leadership) at FBO level
(ii) Supporting infrastructural development including laboratory space, clinical and counseling infrastructure
(iii) Well consulted implementation strategy/model
(iv) Sustained and well nurtured action based networks and partnership.
(v) Prudent use of IRCU assets including spiritual, moral, equipment and other structures.

ANNEX-2.0 DATA SETS

ANNEX-2.1 PERSONS INTERVIEWED

The Evaluation Team conducted 28 interviews and 5 focus groups. As listed in Data Set A: Persons Interviewed, 183 persons participated in the interviews or focus groups. What follows are summaries of those interviews. The format for the interviews follows the questionnaire approved by USAID at the beginning of the evaluation. The questionnaire has an open-ended component to encourage participation and to identify achievements, issues, and recommendations that the Evaluation Team did not initially anticipate. For the most part, the summaries follow the questionnaire format unless the actual discussion took another direction. For example, during the focus group with the HIV/AIDS patients, the Evaluation team asked the patients to describe their experiences. The write-up of those discussions provides a brief summary of each patient's experience rather than strictly following the questionnaire format. Similarly, the Evaluation Team found that when asked about IRCU's contribution to the overall HIV/AIDS program almost universally the answer was "they brought us together" followed by suggestions for improvements in the programs. We have included many of those suggestions. In the interest of increasing understanding on the part of the reader, depending on the interview we have used both narrative and bullet point styles.

1. **Secretary General IRCU –** Joshua Kitakule. April 23, 2013.
2. **Secretary General IRCU –** Joshua Kitakule. April 29, 2013.
3. **Director of HIV/AIDS IRCU –** Johnson Masiko. April 29, 2013.
4. **Uganda AIDS Commission –** Dr. David Kihumuro Apuuli, Director General; Enid Wamani, Partnership Director; Stella Watia, Civil Society Organization (CSO) Coordinator. April 23, 2013.
5. **IRCU staff –** Charles Serwanja, HIV / AIDS & Public Health Specialist; Jackie Katana, Project Manager HIV / AIDS prevention project; Stella M. Nakaggwa, SCMS; Florence Aliba Ediu, HIV / AIDS Prevention Specialist; Denis Nuwagaba, OVC Program Specialist. April 17, 2013.
6. **KIWOKO C.O.U HOSPITAL, LUWEERO –** Buwembo, Joseph, Finance Manager; James Nyonyintono, Surgeon; William Kiwanuka, Manager. April 17, 2013.
7. **KANSANA-LUWEERO DISTRICT INTERFAITH COMMITTEE –** Rev. Fr. Gerald Wamala, Chair of the Committee; Pastor Kairaga, SDA; Sheik Umar Mukus, Muslim; Rev. Fr. Surugunda, Orthodox; Rev. Samson Karwani, Full Gospel Churches of Uganda, representing Pentecostals. April 24, 2013.
8. **SAIDINA ISLAMIC MEDICAL ASSOCIATION OF UGANDA (IMAU), WAKISO DISTRICT –** Dr. Yusuf Walakira; Prof Majid Kagimu; Dr. Anwar, Medical Officer; Hajjat Sarah Kaye, Accounts Officer; Ibrahim Sebuta, Midwife; Wandago Fazali, Laboratory Technician; Kwimbi Muzamior, Data Officer. April 24, 2013.
9. **IGANGA MUSLIM DISTRICT HIV PREVENTION PROJECT –** Waiswa Umar Juma, Coordinator; S. Muhamadi Kirimwira, County Kadhi-Bukoyo; Kakande Hassan, Deputy Country Kadhi. April 25, 2013.
10. **KANSANA-LUWEERO DISTRICT INTERFAITH COMMITTEE –** Rev. Fr. Gerald Wamala, Chair of the Committee; Pastor Kairaga, SDA; Sheik Umar Mukus, Muslim; Rev. Fr. Surugunda, Orthodox; Rev. Samson Karwani, Full Gospel Churches of Uganda, Representing Pentecostals. April 24, 2013.
11. **IGANGA MUSLIM LEADERS –** Sheik Waiswa Juma, HIV protection coordinator, key stake holders and partners; Sheik Mohammad Monika, Muslim Leader. April 25, 2013.
12. **IGANGA DISTRICT INTERFAITH COMMITTEE –** Reverend Daniel Wejuli Token. April 25, 2013.

13. **JINJA DIOCESAN HEALTH MANGEMENT TEAM –** Felix Kajura, Accountant; Angella Nairuba, Secretary; Richard Isike, Accountant; Patrick Omogi , Data Clerk. April 26, 2013.
14. **JINJA DISTRICT INTERFAITH COMMITTEE –** Rev. E. Amooti Bagambi, Chairperson; Rev. Patrick Wakula Treasure; Ord. Aggrey Muttebe, Member; Sheikh Ahmad Izzv-DiKibirige, Member. April 26, 2013.
15. **WORLD VISION –** Robert Kanwagi, Associate Director, Health and HIV/AIDS. April 29, 2013.
16. **ISHAKA ADVENTIST HOSPITAL –** Mugabe Geoffrey, Treasurer; Enock Begumisa, HIV/AIDS Programme Officer; Tumwesigye Asaph, Human Resource Manager. May 2, 2013.
17. **BUSHENYI DISTRICT INTERFAITH COMMITTEE –** Canon Norbert Tibinome, Chairperson of the Committee; Rev. Fr. Richard D. Ssebugwawo, Secretary of the Committee; Sheikh Mubarak Barvamuiura, Treasurer of the Committee; Sheikh Nsubuga A., Deputy Kadhi. May 2, 2013.
18. **CARITAS MADDO –** Andrew Peter Tamale, Program Officer; Mulindwa Jude, Program Accountant; Namiiro Immaculate, Social Worker. May 3, 2013.
19. **UGANDA PROTESTANT MEDICAL BUREAU (UPMB) –** Dr. Tonny Tumwesigye, Executive Director of the UPMB. May 6, 2013.
20. **PACANet (PAN AFRICAN CHRISTIAN AIDS NETWORK) –** Rev. Edward Balaremwa, Executive Director of PACANet. May 6, 2013.
21. **UGANDA MUSLIMS MEDICAL BUREAU (UMMB) –** Dr.Karama Saud, Executive Secretary of the UMMB. May 6, 2013.
22. **UGANDA CATHOLIC MEDICAL BUREAU (UCMB) –** Dr. Samuel Orach, Executive Secretary of the UCMB; Dr. GambaIsinga, IRCU liaison; Dr. Peter Paul Opatat, Non-Clinical Services. May 7, 2013.
23. **INSTITUTE OF INFECTIOUS DISEASES (IDI) –** Sam Anguria, Project Coordinator; Dr. Richard Mwesigwa, Project Manager; Dr. Umaru Ssekabira, Deputy Head of Training; Judith Kyokushaba, Lab Specialist; Sumaya Nakibuuka, Grants Officer; Milly Namalwa, Training Operations Manager. April 23, 2013.
24. **KIWOKO HOSPITAL LUWEERO -** April 24
25. **KANSANA – LUWEERO DISTRICT INTERFAITH COMMITTEE**
26. **IGANGA MUSLIM DISTRICT HIV PREVENTION PROJECT, IGANGA**
27. **HIV/AIDS PROGRAM IN JINJA - CATHOLIC DIOCESE OF JINJA**
28. **ORTHODOX HIV/AIDS PREVENTION PROGRAM – MITYANA DISTRICT**
29. **SEVENTH DAY ADVENTIST CHURCH IN MITYANA**

ANNEX-2.2 INTERVIEWS CONDUCTED - SUMMARIES OF NOTES

1. FIRST INTERVIEW OF IRCU'S SECRETARY GENERAL – APRIL 23RD

- **Interviewers:** Peter Okaalet, Samuel Irungu, and Norman L. Olsen
- Person(s) interviewed: Joshua Kitakule
- Element of IRCU: Administration
- **Position:** Secretary General
- **Date/Time/Location:** April 23rd 2013, IRCU Secretariat Offices in Namirembe Hill Morning: 30 minutes; afternoon: 40 minutes

a) What are the actual and potential strengths of the IRCU?

Uganda has approximately 30 million people, of which 15 million attend church/mosque Friday to Sunday. Somewhere between 95 and 97 percent of Ugandans believe in some form of religion. Forty percent know their HIV/AIDS status. Mr. Kitakule has two visions for IRCU: 1) test five million Ugandans for their HIV/AIDS status over the next three years; and 2) offer IRCU as a vehicle to lead a transition to faith-based facilities as an alternative to the GOU facilities. IRCU is planning a UN supported conference on this theme in the next year.

IRCU has a nationwide reach, working through 101 faith-based organizations. (Note: that reach is nationwide geographically, but the number of active facilities is very limited in terms of reaching the patient population.) People trust the churches even if some individual churches misbehave.

IRCU has an M&E framework and conducted an internal evaluation in late 2012 using the framework. The quality of the evaluation was excellent although IRCU does not seem to have acted on many of the findings.

The Secretary General's vision also includes a new strategy in which the IRCU would scale back its secretariat and the Faith Based Organizations (FBOs) would do most basic management.

b) How effectively has IRCU mobilized those strengths?

IRCU has 1000 health facilities, of which it actively supports 19. Stockage of medicines and retention of personnel are major issues. Stockage is important because if medicines are not available patients do not come back and need to be re-recruited. Problems in retention require a constant training effort.

The quality of care in these facilities is superior to GOU facilities. The IRCU vision is to increase the number of active facilities to 250 or approximately 25% in five years.

Eight million Ugandan children are in the at-risk categories. IRCU is now helping approximately 40,000 children, up from 10,000.

c) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

Breakdown of Government services is occurring. ICRU sees itself as an alternative to government facilities in terms of service delivery. IRCU believes it can scale up rapidly if given greater resources. (It is not clear whether, given present salary levels, even enhanced funds would be sufficient to recruit, train, and retain adequate numbers of skilled personnel.)

The Catholic pre-marriage counseling training to the Muslims for their pre-marriage counseling program is an excellent example of inter-faith cooperation. This inter-faith exchange needs to increase.

Summary

The Secretary General has a realistic vision for IRCU. Contacts with other IRCU staff indicate that his vision and enthusiasm are widely shared. IRCU has done an excellent job in bringing together the major religious groups to work together both on HIV/AIDS and other initiatives such as peace and reconciliation. The Secretary General believes IRCU can readily scale up and serve as an alternative service delivery structure to government. (Note - Some scaling up is possible but is unlikely to be either easy or entirely sufficient.)

2. SECOND INTERVIEW OF IRCU'S SECRETARY GENERAL – APRIL 29TH

- **Interviewers**: Dr. Peter Okaalet, Norman L Olsen and Samuel Irungu
- **Person interviewed:** Mr. Joshua Kitakule – Secretary General
- **Element of IRCU:** Administration
- **Position**: Secretary General
- **Date/Time/Location:** 29th April 2013, IRCU Offices, Namirembe Hill

a) What are the actual and potential strengths of the IRCU?

The Secretary General repeated his assertions that most people in Uganda belong to a certain religion and up to 15 million Ugandans go to church/mosque from Sunday to Friday. IRCU has a nationwide reach through its Church/Mosque structures. (Note: that reach is nationwide geographically, but the number of active facilities is very limited in terms of reaching the patient population.)IRCU works through 101 Faith-based Organizations. People trust the churches even if some individual churches misbehave. IRCU has an M&E framework.

b) How effectively has IRCU mobilized those strengths?

IRCU actively supports 19 facilities in the HIV / AIDS program and reaches out to a number of people through the churches / mosques.

Local churches host home cells that provide counseling as part of the small groups. Churches / mosques encourage couple counseling and hence more Ugandans know their HIV status. This small trusted group approach is a major comparative advantage of IRCU.

c) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

It is meeting the USAID PMP target numbers.

d) Ways forward/Challenges/Recommendations

Increase coverage and ownership to 25% of all facilities by providing more services in the facilities.

Hold dialogues between the IRCU and USAID to discuss issues such as couple counseling and other related issues.

Strengthen regional structures to strengthen Inter Faith Organizations (IFO) like the Teso Efforts for Peace and Reconsolidation.

Strengthen the Human Resource staff within the IRCU Secretariat, which needs more staff.

Prioritize and concentrate on very remote and hard to reach areas because not many NGOs want to go to these areas. Start by combining the current13 regions into four.

Competitors within the church community are a big challenge, such as the $51million grant given to the Catholic Church versus the $30 million US grant given to IRCU.

There is a problem with resource allocation by USAID. This was especially noticeable in the previous quarter when USAID changed its disbursement policies and did not disburse adequate

funds effectively. That resulted in some IRCU partners not receiving adequate quarterly funds and thus, not meeting their quarterly targets.

IRCU is a giant that needs re-awakening. It needs to strengthen member organizations and to strengthen and empower regional structures. IRCU having a permanent home and not paying a monthly rent of 18 million Ugandan shillings would help.

3. INTERVIEW OF IRCU'S DIRCETOR OF HIV/AIDS AND PUBLIC HEALTH

- **Interviewer:** Dr. Peter Okaalet, Norman L Olsen and Samuel Irungu
- Person interviewed: Johnson Masiko
- Element of IRCU: Administration
- **Position:** Director of HIV /AIDS and Public Health
- **Date/Time/Location:** 29th April 2013, IRC, Namirembe Hill

a) What are the actual and potential strengths of IRCU?

IRCU was formed as an Inter Faith Based Organization to involve the Pentecostal churches and work together to deliver services to the people regardless of the challenges.

The IRCU structures bring in a well-integrated spiritual component –spiritual assets in terms of spiritual values, which the community highly believes in, and trusts. The faith based Community highly believes in the FBO to carryout HCT (HIV Counseling and Testing). For example, Bishop Katolene of western Ankole mobilized a high turnout for Voluntary Male Circumcision (VMC) in Western Uganda.

b) How effectively has IRCU mobilized those strengths?

IRCU worked with the Archbishop of Mityana to integrate issues of HIV / AIDS during the mass wedding in Mityana.

IRCU has access to both the physical church/mosque structures and to the institutional processes of the faiths. This includes schools (about 80% of schools in Uganda are faith supported) and radio stations. These institutional structures – schools and radio stations – are excellent communication platforms to a ready audience.

IRCU has a sound HIV / AIDS prevention strategy that focuses on A&B (Abstain and Be Faithful). IRCU also talks about ABC - Abstinence, Be Faithful and Character Change. There are youth groups and communities to support the HIV / AIDS prevention strategy. Mengo hospital (the largest hospital in Uganda) is IRCU's biggest partner. Together Mengo and IRCU are effectively implementing an HIV / AIDS prevention strategy.

c) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

It has mobilized the faith-based community to comprehensively address the HIV/AIDS crisis. Importantly, mobilization has resulted in none of the faiths "de-campaigning" other faiths over religious issues. For example, while Catholic facilities will not provide condoms they do not publically condemn condoms, and will provide referrals to where a person can obtain them.

d) Way forwards/Challenges/Recommendations

Religious Leaders are not readily supporting the IRCU, yet the messenger is very important.

Religious institutions are voluntary and, ideally, there is a lot of capacity building to be done among the clergy.

Field sites do not report a lot of work due to Translation issues. IRCU needs to decentralize M&E and go on-site and train in local languages. Focus on the HIV / AIDS prevention and report the numbers. Arm the Institutional Faith Based Organization (IFBO) and strengthen the small groups.

Poaching is a big challenge: namely, training people; then these newly trained medical staff employees leave the organization and therefore IRCU builds capacity of competing organizations, such as the GOU. There is now less funding due to the cut of the AB strategy budget.

Summary

Johnson Masiko rated IRCU at a scale of 3+ (70%) on a five point scale. He believes Care & Treatment service delivery is at 90%; HIV/ AIDS prevention is about 50%. In terms of M&E, systems, coordination and mobilization are good and well. He ended with the statement: "We are building the boat while sailing."

4. INTERVIEW OF IRCU STAFF

- **Interviewers:** Dr. Peter Okaalet, Samuel Irungu, and Norman L. Olsen
- **Element of IRCU:** Program Staff Members
- **Date/Time/Location:** April,17th 2013, IRCU Secretariat Offices, Namirembe Hill
- Person(s) interviewed:
    - Charles Serwanja, HIV/AIDS & Public Health Specialist
    - Jackie Katana B., Project Manager HIV/AIDS Prevention Project
    - Stella M. Nakaggwa, SCMS
    - Florence Aliba Ediu, HIV/AIDS Prevention Specialist
    - Denis Nuwagaba, OVC Program Specialist

a) What are the actual and potential strengths of IRCU?

Moral authority asserted through:

- Mobilization of faith membership
- Utilization of religious leaders
- Wider outreach to communities
- Potential to enhance Voluntary Counseling and Testing
- Religious Leaders (RL) can reach individuals on a one to one basis and in smaller church groups

This was an interview with the senior management staff of IRCU. Included were logistics, operations, and HIV/AIDS prevention staff members. The management staff sees the strengths of IRCU as its ability to sustain at all levels, from the parish priest to the Presiding Bishops, effective dialogue among the major religions in Uganda; and to give practical application to that dialogue by implementation of concrete development programs. The most important programs deal with various elements of the HIV/AIDS epidemic. They also see the linkages between the peace and reconciliation programs and the HIV/AIDS programs as being an important source of strength.

Importantly, they noted, bringing together the senior religious leadership provides IRCU with a strategic voice in a range of civil society and health issues.

They noted that while the religious institutions in Uganda have international ties and receive substantial international support (for which they are deeply grateful); the institutions are local Ugandan institutions. And, an overwhelming majority of Ugandans view IRCU and its constituent institutions as loc al.

The religious institutions provide a structure for mobilization from the basic family unit up to the national level. The religious leaders have been receptive to training in all aspects of HIV/AIDS, and receptive to spreading the messages, not only in their sermons, but, more importantly, through various church programs, such as Mothers Union. Admittedly effectiveness varies

substantially. The messages have not always kept up with the changes in cultural perceptions of HIV/AIDS, or the receptivity of the various demographic groups.

The group noted that IRCU integrates the scriptures, both biblical and Muslim, into the training. This provides for a religious approval that increases the legitimacy of the overall information for much of the Ugandan population. The faiths provide psycho/social reinforcements for health.

b) How effectively has IRCU mobilized those strengths?

IRCU's Strengths:

- Capacity building
- Enhanced structures
- Quality control
- Training of Clergy and Muslim leaders on HIV/AIDs
- Technical support and IEC materials

New Knowledge:

- Power of bringing Religious Leaders together
- Enhanced safety, security and trust in HIV/AIDS programs
- Possible alternative to GOU structures in implementing programs
- Pool of IRCU champions and consultants to spur implementation

The FBO approach has five components:

- Prayer
- Use of Holy Scriptures
- Structures and Religious Leaders
- Application of scientific knowledge
- Belief in God

IRCU health facilities exist in all 45 of the original Uganda districts. Currently there are 145 districts established as much for political reasons as administrative effectiveness. IRCU supports a total of 101 facilities, of which 19 provide care/treatment. Forty (40) facilities have prevention programs. The plan is, over five years, to increase this number of facilities providing care/treatment to 25.

In addition to the Department of HIV/AIDS prevention, IRCU has several departments dealing with the HIV/AIDS epidemic including youth, women and health.

IRCU is building the capacity of religious leaders by offering a range of training courses, seminars, and conferences. (Note, at the local level, all of the religious leaders the Evaluation team interviewed stated they had received training, and had used this training to train persons in their churches/mosques. These religious leaders also stated they regularly used the information in their sermons). The initial knowledge of the religious leaders concerning HIV/AIDS was very low. Often religious leaders considered HIV/AIDS a "sinners" disease. Now a more generous and realistic view appears to prevail. Training covers HIV/AIDS prevention, budgeting, planning, and technical support. The IRCU estimated the typical level of knowledge of the religious leaders was 20 to 30 out of 100. Now it has increased to approximately 50 out of 100. The result is mainstreaming of HIV/AIDS at all levels of the religious community.

Health facility personnel also receive training. They are tested both pre and post training. IRCU follows up with field visits to evaluate the effectiveness of the training. (Field facilities confirmed this statement and stated it was one of IRCU's greatest strengths.)

Support for events held by Mothers Union, Youth Camps, and Pathfinders (SDA) Retreats, and Married couples' seminars.

SDA has the strongest and most integrated programs. Given the small cohesive nature of SDA and the stress of faithful compliance with SDA religious practice, this is not surprising.

IRCU selects its implementing partners through a proposal review process. Proposals are invited from all participating groups. Funding is allocated in amounts approximately equal to the size of the participating group. Within the group, a competitive review occurs.

IRCU faces two major organizational challenges – retention and supply chain management. Retention. Because IRCU has an effective training program and its personnel are known for a superior work ethic, those personnel are in high demand, especially from the government, which pays substantially higher salaries and greater benefits including retirement. Thus, turnover is high, as much as 30% in some facilities.

Supply chain management. According to the supply chain manager, the system works reasonably well over all but is needlessly complicated. (Others stated the recent changes by USAID further complicated the system making it harder to manage). The supply chain manager stated that complete stock outs were rare (an assertion upon which field facilities agreed) but some specific drugs may occasionally run out. She also stated that the facilities sometimes were not proactive enough, that is actively networking with other facilities to obtain needed drugs and supply others with items that may be over stocked in their own facility.

OVC – There are 37 facilities supported by IRCU that support OVC programs. A total of 4,000 orphans and other children at risk are supported. IRCU estimates the total OVC population in Uganda at approximately 8 million. Programs in health, HIV/AIDS prevention, and vocational training are provided. (Field observation indicates the programs are working for a number of children.)

There is a need to share lessons more actively. Some of that takes place but not enough. The Evaluation team noted that the HQ staff seems to be actively seeking to find and implement better methods.

c) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

IRCU has brought together a vital element of Ugandan society – the religious institutions to address common challenges in both health and peace/reconciliation. Those institutions have often been vicious competitors. Now they are united against a common foe, and in the process, strengthen civil society.

Their activities are beginning to address the complacency issues facing the HIV/AIDS community. They have been effective in upgrading the competencies of all of the religious groups and especially the Muslims.

Within the domain of limited facilities, IRCU centers are providing quality care to the afflicted. They are addressing behavior change and having some success within specific demographic groups, specifically high school and college students and newly married Ugandans. They are beginning to address the new MAPS - stable married couples between 30 and 45 years old.

Summary

IRCU has a nationwide network of religious institutions in Uganda. The theoretical reach is up to 95% of the population. They are making a good faith effort to mobilize this community for both prevention and care/treatment.

IRCU has done an excellent job of bringing together the leadership of the major religious groups. They have demonstrated skill in forging the compromises necessary to find common ground. This has results in cooperation from the parish level on up. IRCU is represented on most of the major HIV/AIDS committees in Uganda. The result is IRCU has a strategic voice within the political as well as health domain. It also strengthens civil society.

In terms of HIV/AIDS – IRCU has done very well for a relatively modest number of OVC. They also provide solid care and treatment services in their 19 service facilities. Measuring the impact of prevention programs is difficult. It is unfair to attribute much if any of the increased HIV/AIDS infection rate to ineffective IRCU programs. What one can expect is a stronger impact on several of the religious community specific demographics.

5. INTERVIEW OF UGANDA AIDS COMMISSIONS (UAC)

- **Interviewers:** Peter Okaalet , Samuel Irungu, Norman L. Olsen and Charles Serwanja
- Element of IRCU: Partner
- **Date/Time/Location:** April 23rd , 2013, 10:30am, UAC Headquarters in Ntinda
- Person(s) interviewed:
  - Dr. David Kihumuro Apuuli, , Director General
  - Enid Wamani, Partnership Director
  - Stella Watia, Civil Society Organization (CSO) Coordinator

a) What are the actual and potential strengths of IRCU?

The Uganda AIDS Commission began in 1992. The HIV infection rate was then officially 16 – 18% and the death rate from AIDS then 200,000 per year. By 1998, the death rate had dropped to 88,000. New Infections: 200,000 (1992), dropped to 88,000 in 2006, but the number of new infections has gone up to 145,000 per year.

Dr. Apuuli emphasized that IRCU is effectively addressing behavior change and mentioned a range of Ugandan Universities in which the infection rate was between 0.6 and 1.6 %. He attributed this success to AIDS awareness programs in primary school and lamented that the donors had abandoned those programs. In contrast, in Kenya the death rate from AIDS remained much higher. He noted, that, similarly to London, New York, and San Francisco, the HIV infection rate is again climbing.

Behavior is the centerpiece of all interventions. Behavior change lacks the quantitative evidence base desired by donors. Donors seem to prefer an exclusively bio/medical approach, which is short-sighted on their part.

The Fact of Religion – Over 97% of Ugandans count themselves as religious and IRCU is that face in terms of HIV/AIDS. Religion is a unifying factor in Uganda and can be a vehicle for mobilization. Dr. Apuuli stated that 50% of treatment in Uganda is provided by FB hospitals. The supporting voices of the Religious Leaders (RL) are key in continued progress against AIDS. 60-70% of the population goes to places of worship on each Friday, Saturday and Sunday. IRCU's constituency – Religious Leaders – 'killed' the GOU's Marriage and Divorce Bill. IRCU is one of the Key Partners to UAC extensive Networks, trusted by Religious Leaders. Its multi-sectoral approach is exactly what Uganda needs. Its wide scope captures different elements of the population most of whom, within themselves, have some spark of spirituality.

Circumcision brings 60% increase in protection; however, very regrettably, many males misunderstand the implication. After circumcision many men believe their first six (6) sexual partners are risk free.

The infection rate is climbing, especially in stable couples, 30 to 35 year old women, and 40 to 45 year men. IRCU respondents blamed this rise on message fatigue, complacency, and changing hormones. They noted that this demographic is becoming a most at risk category.

b) How effectively has IRCU mobilized those strengths?

IRCU is a strong effective partner of the Uganda AIDS Commission. Its programs are working. IRCU serves on a number of AIDS Commissions committees and panels.

c) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

IRCU facilities provide excellent quality care in a range of services. In addition to direct assistance to patients, those facilities have a beneficial demonstration effect.

Summary

Going forward, Dr. Apuuli suggested doing the following:

(i) Sustain strong prevention messages so as to reverse the trends of new infections.
(ii) Support IRCU with more (additional) resources.
(iii) Carry out research to validate that behavior change does work. Evidence? (Cf. the Prevalence at the Universities...)
(iv) Critical interventions needed – with maximum impact.
(v) Mandatory Testing before marriage…?

6. INTERVIEW OF STAFF OF KIWOKO HOSPITAL, LUWEERO

- **Interviewers:** Peter Okaalet , Samuel Irungu, and Norman L Olsen
- **Element of IRCU:** Supported hospital
- **Date/Time/Location:** 24th April 2013. 10:30a.m, at Kiwoko Hospital, Luweero
- Person(s) interviewed:
  - Buwembo Joseph, Finance Manager
  - James Nyonyintono, Surgeon
  - William Kiwanuka, Manager

a) What are the actual and potential strengths of the IRCU?

IRCU's Strengths:

- Belief in God
- Respect for Religious Leaders
- Churches and Faith Communities are safe havens
- Restoration of life
- Holistic approach to health of individuals
- Inter-denominational approach

Luweero is the district of greatest activity in the civil war that brought Museveni to power. It also has higher than average HIV prevalence rate of 9%. Kiwoko is a relatively full service rural hospital that in Uganda is rated the best in the district and ninth in the nation.

IRCU has provided substantial support: first, by mobilizing the churches to address the challenges of HIV/AIDS; second, by bringing a Holistic approach including treatment, spiritual support, and healing.

b) How effectively has IRCU mobilized those strengths?

- 2,000 clients to date. Up to 179 clients seen daily.
- Partnership with ISIS Foundation to assist with nutrition.
- SMC – 20-25 operations per week, from age 12 upwards.
- Kiwoka Hospital has doctors and other staff from the US and UK

The hospital serves multiple denominations including Muslim. Pastors refer patients to the hospitals. People listen to religious leaders; the process is slowly de-stigmatizing HIV/AIDS. There is decreased labeling of AIDS as a sinner's disease. Approximately 2000 patients are served weekly in clinics. The hospital is limited by logistics, mainly in patients obtaining transport to the hospital. They have a motor cycle outreach program but are short on drivers. They are occasionally short on specific medicines. These interviewees claim a 90% adherence rate. Fifty percent is the estimated national average.

Kiwoko offers circumcision services. Approximately 20 – 25 men respond per week. Many men take the increased protection as immunity. The hospital distributes condoms but does not have a family planning program.

Retention is a problem with a 30% annual turnover. Interestingly, the three persons we interviewed had been at Kiwoko for some time – the Doctor for 30 years, the nurse for 12 years, and the finance person for four (4) years. They view Kiwoko Hospital as a calling in which the spiritual wages compensate for the modest monetary return. Also, they are looking to build accommodations. The hospital is starting an aggressive fund raising program to support compensation increases. (Conceivably USAID could help with some expert input into how to raise funds.)

The Evaluation team spot-checked patient satisfaction. We interviewed three patients (two with active AIDS being treated at hospital prior to release; the third, an HIV positive mother with a

new infant, HIV negative) with related family caregivers. The patients learned of Kiwoko through their local pastors and referrals from neighbors with favorable experiences. Each patient was very satisfied with services.

c) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

- Prevention emphasis
- Regular ABC talks
- Churches and Schools are considered safe and youth friendly
- Radio stations air messages to the community
- Utilization of markets and market days to transmit health/AIDS messages

Kiwoko is a bright spot in a dark region. IRCU support has helped to increase its light. Greater emphasis is needed on behavior change, which requires a greater sustained outreach program. Need to go to schools, develop youth centers (existed previously but no longer), and develop a radio outreach program. Talk, talk, and talk with messages specifically tailored to differing demographics.

There is a perception that USAID emphasis on ART has resulted in less emphasis on prevention. Also the perception by many is that AIDS is similar to malaria. Everyone has it; it can kill one; but you can also successfully live with it. Thus, there is less concern about prevention.

Summary

Kiwoko hospital is providing superior services in a very severely conflict affected environment. They are managing a severe turnover problem effectively. Key personnel seem highly motivated. Networking between religious leaders and the hospital is effective in terms of care provided. Outreach for prevention needs work.

7. INTERVIEW OF KANSANA LUWEERO DISTRICT INTERFAITH COMMITTEE

- **Interviewers:** Dr. Peter Okaalet, Samuel Irungu, Norman L. Olsen and Charles Serwanja
- **Element of IRCU**: Members of IRCU
- **Position**: Representatives of the Catholics, Church of Uganda, Pentecostal Church, SDA, Orthodox and Muslim
- **Date/Time/Location:** April 24, 2013, 12.30pm, Catholic Church, Kasaana, Luweero
- Persons interviewed:
  - Rev. Fr. Gerald Wamala, Chair of the Committee
  - Pastor Kairaga, SDA
  - Sheik Umar Mukus, Muslim
  - Rev. Fr. Surugunda, Orthodox
  - Rev. Samson Karwani, Full Gospel Churches of Uganda, Representing Pentecostals

a) What are the actual and potential strengths of IRCU?

- Five strong Faith Communities brought together
- National outlook and coverage is broad-based
- Structures and facilities utilized for service provision
- Attitudes of RL changed
- People listen to Pastors, Imams, and other RL

b) How effectively has IRCU mobilized those strengths?

- Capacity of RL built
- ABC approach to prevention promoted
- Networking and referral of clients
- Chief Administrative Officer supports efforts of IRCU
- Resident District Commissioner supports the work done by IRCU

c) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

- Strategic Plans for the Catholic Diocese developed for 2013-2017
- Annual Report for Kasaana Diocese produced
- Over 2,000 OVC supported

d) Dreams, Recommendations and Way Forward?

- Bring down the prevalence of HIV to less than 5% in a shorter time
- Facilitate the Interfaith District Committee
- Promote peace – the bedrock for success of all other programs and projects
- Advocate against stigma and discrimination

- Strengthen biomedical interventions
- Educate all on Live positively.
- Emphasize empowerment of girls.

8. INTERVIEW OF SAIDINA ISLAMIC MEDICAL ASSOCIATION OF UGANDA, IMAU (WAKISO DISTRICT)

- **Interviewers:** Dr. Peter Okaalet , Samuel Irungu, and Norman L. Olsen
- **Element of IRCU:** Supported implementing partner
- **Date/Time/Location:** April 24, 2013, 3:30pm, IMAU Wakiso.
- Person(s) interviewed:
  - Prof Majid Kagimu**,** Director
  - Dr. Yusuf Walakira
  - Hajjat Sarah Kaye, Accounts Officer
  - Dr.Kakeeto Anwa, Medical Officer
  - Ibrahim Sebuta, Midwife
  - Ntambi Hussein, Receptionist
  - Wandago Fazali, Laboratory Technician
  - Hajjat Sarah Namugga, Secretary
  - Nakabuye Nuriat, Accounts Assistant
  - An Yiu Walakira,
  - Kwimbi Muzamiro, Data Office

a) What are the actual and potential strengths of the IRCU?

- Faith component promotes discipline, accountability and trust
- Faith and religious values reduce the spread of HIV
- Religious unity was unheard of in Uganda
- Promotes spirit of volunteerism

USAID has supported the Muslim Medical Association since 1992, initially in the training of HIV/AIDS counselors. Professor Kagimu and Mr. Olsen who worked together on several occasions in the 1990s instantly remembered one another. Clinical outreach started in 2005.

The infection rate for the District is 8%. For Christian youth it is 3%, for Muslim youth it is 2%. (Need to examine relative commitment to the faith.)

b) How effectively has IRCU mobilized those strengths?

- FBO Health Centers supported and equipped to better provide medical and laboratory services
- Partnership with researchers like Professor Kagimu and his team yield useful scientific and administrative data
- Increased sense of motivation
- Donor emphasis on bio-medical approaches decreasing effectiveness of prevention

Combining faiths to work together displays trust and accountability. Faiths share a number of common values, especially healing the sick, faithfulness, and compassion. IRCU has led in building linkages between religious structures and health facilities.

A switch from prevention to treatment has been a cause of the increase in prevalence. (Note: this is a widespread impression, which while it ignores other, probably more causative factors, needs to be dealt with.) Similarly, the longer life span of those living with HIV/AIDS increases the prevalence rate.

Even in God's selfless health service (IMAU self-description), retention is a problem. FBOs cannot match the government salaries and benefits. Increased emphasis on revenue generation could help some, but the low economic status of most patients limits its effectiveness.

- IMAU claims that stockouts are not a problem. Orders go to IRCU and are promptly and fully filled.
- IDI provides lab training, monthly oversight visits and quarterly meetings.
- IMAU has 200 community educators.
- Breakdown in social capital is resulting in less volunteerism.
- Religious have lower infection rates and better adherence to treatment protocols.

c) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

- Structures and facilities in the hard to reach areas of Uganda
- Affordable services provided at Faith Health and Community Centers
- By use of Religious structures, sustainability can be ensured
- Sense of motivation

d) Recommendations and Way Forward

(i) Facilitation of RL needs to be enhanced. Identify where the needs are, and try to meet them.

(ii) Awaken the slumbering spirits of RL, so as to enable them to do better – develop effective messages.

(iii) Prioritize 'Prevention', without neglecting the 'Biomedical Approaches'.

(iv) Share IMAU's research findings on: 'Religiosity and Enhanced Adherence to ARVs'.

(v) Share IMAU's Evidence on Behavior Change through commitment to Religious Faith: 'Religiosity for HIV Prevention in Uganda' (Majid Kagimu, et al):

- Changing behavior is not enough; positive behavior must be sustained.
- Messaging out to be segmented – to reach various categories by age, sex, religion.
- Document "success stories" with respect to prevention.

(vi) For Prevention to succeed, we need to be deliberate with our interventions, and do so at 'Three Levels':

- Individual level ('Downstream')
- Institutional level ('Midstream')
- Policy level ('Upstream')

(vii) Learn Lessons from "Engaging the Faith Community for Public Health Advocacy: An Agenda for the Surgeon General of the US":

- Promote Primary Prevention
- The multiple determinants of population health
- Communitarianism and social justice
- A global perspective

Relative ease of mobilization through the faiths in rural areas potentially increases coverage and could cut costs. It does require a total health approach (physical, mental, and spiritual.)

Summary

The IMAU appears to be bringing both enthusiasm and competence to HIV/AIDS prevention and treatment. Professor Kagimu has some excellent ideas for future programming.

9. INTERVIEW OF IGANGA MUSLIM DISTRICT HIV PREVENTION PROJECT

- **Interviewers:** Dr. Peter Okaalet, Samuel Irungu, Norman L. Olsen, and Charles Serwanja
- **Element of IRCU:** Caregivers to OVC
- **Date/Time/Location:** April 25, 2013, 10:30am, Iganga
- Person(s) interviewed:
  - Waiswa Umar Juma, Coordinator
  - S. Muhamadi Kirimwira, County Kadhi, Bukoyo
  - Kakande Hassan, Deputy County Kadhi

a) What are the actual and potential strengths of IRCU? How effectively has IRCU mobilized those strengths?

- Organized RL under one umbrella.
- Introduced programs that they did not have before, such as on Gender Based Violence, Peace and Reconciliation, HIV/AIDS.
- Respect for the faith groups – Not proselytizing.
- Partnering with the GOU through the MOH, to reach out to Faith communities utilizing their structures.
- IRCU is the "Good Samaritan" to the FBOs that were 'left by the roadside'…!

b) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

- Channeled funding from USAID to the IPs. Their budget is approximately 99 Million for five years.
- Supported them to develop proposals and work plans, and to enhance standards.
- Supervision and evaluation of the FBOs and IPs.
- Provided equipment to IPs: bicycles, computers, and mosquito nets.
- Capacity building of staff at the Health Centre, thereby bringing them to the same footing as compared to the Christian FBOs.
- Besides the Iganga Medical Center, they have opened and equipped two other centers – Kiwanyi and Budhani.
- Safe Male Circumcision now preferred… Done by Trained Circumcisers. The healing is faster, and it is free. The pain is much less. It is accompanied by counseling.
- Integrated Services – Reproductive Health and Family Planning.

Sheikh Omar himself:

- Has benefited from IRCU through Training in Project Management.
- He has attended Annual Conferences organized by IRCU.
- Has assisted in counseling others, and pointed them to biomedical approaches.
- He now can link Scriptures (*Suras*) to HIV messaging.
- Counteracting cultural myths surrounding HIV and AIDS.
- He has trained 60 Muslim Youths and 50 Religious leaders on HIV/AIDS.
- A member of Iganga District Health Committee.
- A strong advocate for IRCU and promoter of the Role of FBOs in Healthcare.

c) Recommendations and Ways Forward

(i) The need more support to reach out to many in Iganga. The town is located on the Mombasa-Kigali Highway. Number of new infections continues to rise!

(ii) Biomedical approaches are well received; the challenge is on human resource limitations to roll out the programs.

(iii) Need to do better with respect to the biomedical strategy.

(iv) Assist them with Resources Mobilization.

(v) Need to strengthen Inter-faith Committees at national, district and grassroots levels.

(vi) Is it possible to open Regional Health facilities run by IRCU?

Quote: "Somebody who is starving does not have a sense of hearing…!" (Lusoga proverb)

We asked Sheikh Omar a question: "If you were to receive 1.0 Million US Dollars for your HIV/AIDS work, how would you distribute it? He responded, thus:

- 50% - Would go to Biomedical Strategy
- 25% - Would go to Advocacy (Read "Prevention Strategies")
- 25% - Would be directed to Networking with other partners

10. INTERVIEW OF IGANGA MUSLIM LEADERS

- **Interviewers:** Dr. Peter Okaalet, Samuel Irungu, and Norman L. Olsen
- **Element of IRCU:** District health committee
- **Position**: Muslim leaders of HIV prevention program.
- **Date/Time/Location**: April 25, 2013, Iganga
- Person(s) interviewed:
  - Sheik Waiswa Juma, HIV Protection Coordinator, Key stakeholders and partners
  - Sheik Mohammad Monika, Muslim Leader

a) What are the actual and potential strengths of the IRCU?

IRCU was essential in organizing the faiths. IRCU provided funding and capacity development. Most importantly, IRCU provided a forum for dialogue. From the point of view of the Sheik, dialogue that avoids attempts at conversion is a positive ancillary benefit. Sheik Juma noted that at the Muslim hospital and OVC center all are welcomed. (From what we observed, Christians come in significant numbers; perhaps they are even the majority) Also respondents noted that the Muslims are "equal in the boat" with other faiths.

The District has a HIV/AIDS prevalence rate of between 6.9 and 7.3 percent, in line with the national average but up some from previous years. Being on a major transport route, the district is vulnerable.

b) How effectively has IRCU mobilized those strengths?

Muslims are particularly thankful to USAID and IRCU because of their fostering managerial capacity. The Muslims now have a work plan and can draft fundable proposals. Budget is 99 million Ush for five years. IRCU started project management program. The follow up visits are especially useful. Training is available for others, such as youth. (I have figures of 60 - 50 for youth and am not sure what they mean) The Sheik suggested we be sure and look at level of achievement from the point of view of the local community. "We have a long way to go, but we have come a long way from where we started."

There are three Muslim health facilities in the District. Two have labs; one does not. IRCU has trained medical personnel in providing safe male circumcisions. The benefits of, and limitations to, are explained.

IRCU has sensitized religious leaders to HIV/AIDS. Preaching at the Mosques increases attendance at the clinic. Iganga Muslim leaders support a pre-marriage counseling program that includes HIV testing. Couples with one or more positive are not married. Approximately 1000 couples have been through the program in the past two years. (Claim 70% of the District is Muslim. Other sources indicate, while growing, the actual figure is 30 to 35%.)

Overall counseling program started three to four years ago. Linking of bio-medical program with the scriptures is especially helpful.

c) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

Jinja Muslims responded: "We need an IRCU regional referral hospital." This might not be a useful recommendation at the moment but it does reflect the faith the Muslims have in IRCU. They have been treated well, and greatly appreciate that treatment. It is a foundation upon which to build.

Summary

This site reinforced the impression that the Muslims are happiest with the program. They have significantly increased their management capacity, and they recognize it has been because of

IRCU and USAID. They are making progress in counseling pre-married couples. That progress can be expanded to married couples.

11. INTERVIEW OF IGANGA DISTRICT INTERFAITH COMMITTEE

- **Interviewers:** Dr. Peter Okaalet , Samuel Irungu, and Norman L. Olsen
- **Element of IRCU:** Member of Inter Religious Council of Uganda
- **Date/Time/Location:** April 25, 2013. 4:45pm, Iganga.
- **Person(s) interviewed:** Rev. Daniel Wejulitoken

a) What are the actual and potential strengths of the IRCU?

- Quality Services
- Promotes mainstreaming of HIV activities into the Religious Sector
- Programs are pro-People
- Information flows clear from the District Khadi, to the grassroots.

The Reverend was perhaps less enthusiastic about the interfaith dialogue than others we interviewed. Perhaps his reticence was motivated by the faster growth of Islam in the District. Still he valued the dialogue and felt the strength of the IRCU program is that it is Godly based. Because it utilizes the religious structures of the district, the penetration is potentially greater. The programs are people based and appropriately adapted to local conditions.

b) How effectively has IRCU mobilized those strengths?

- United the RL. People ready to work together for the common good, when they see their RL – Muslim and Christian – travelling in the same vehicles, and visiting their respective offices and places of Worship.
- RL are respected by/at the community level. Rev. Daniel gave an example of a Moslem man who had refused his children to receive immunization. But when talked to by a Muslim Sheik, he agreed to have them immunized – therefore, protected from communicable diseases.

c) What have you done following training by IRCU?" Rev. Daniel said he has:

- Trained Lay Readers who are now called 'AIDS Lay Readers';
- Encouraged Church leaders to briefly teach on AIDS, prior to preaching;
- Talked to the media.

IRCU has provided seminars and other training that the Reverend attended. He in turn disseminated the information to members of his church. He described this as a dynamic approach that has increased testing and compliance in taking medicine. Through church groups such as Mothers Union, the information is reaching the grass roots. This is empowering local cadres to do advocacy and counseling

In a cautionary note, the Reverend felt that in contrast to 2011 – 2012 IRCU had "removed wood from the fire." Specifically he believes there has been a too rapid shift of emphasis to "hot spots." Iganga is on a main transport route and attracts a variety of high risk demographics at the main truck stop area. The Reverend's concern is that less at risk populations can be attracted to the high risk areas. He believes this risk can be mitigated by continuing education programs.

He recommends establishing a District Interfaith Office.

d) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

- Inter-faith collaboration is more dynamic now than before.
- Teaching and training of various cadres of staff takes place at all levels.
- Utilizing structures that already exist – e.g. MU, Men, Youth Groups

e) Recommendations and Ways Forward?

- Re-awaken the Religious Leaders (RL). They must talk constantly. They must not stop 'talking'…!
- IRCU seems to have "removed some firewood from the fire that was burning brightest … so the fire is dying out".
- Rev. Daniel attributed the 'slumber' to IRCU's push for the biomedical approach, vis-à-vis ABC messaging.
- Cited four 'hot spots' where Trailer Drivers park their vehicles – Idudi, Bulango, Nalwerere, and Musita. But he went on to say that young people who frequent these places come from a 20-Km radius. Therefore, IRCU and partners need target the areas surroundings the 'hot spots', so as to prevent a flare-up of new HIV infections.
- Empower the local cadres/leaders on the ground – equip and facilitate them to do more.
- Set up an IRCU Secretariat Office at the District level. This will improve flow of communication between the District and Kampala. (Avoid crisis management…!).
- Work with the Media at District level to disseminate relevant information.
- Service provision to be based on Religion. Drawing from the 2002 National Population Census Data, Rev. Daniel shared these figures with us – for Iganga District:
- Muslims population = 31.7%
- Christian population = 68.3% (Anglicans = 31.9%; Catholics = 30.9%).

f) What about MARPS?

- Multiple Concurrent Partnerships (MCP) – This is as a result of cultural Influences.
- Per Influence – In Schools we now have 'Young Mothers' (Under Age Mothers)
- Other Hot Spots: Kosokos, Nkantu, Iganga Town.

Summary

The Reverend seemed well informed and committed to the work of the Church, including HIV/AIDs prevention. He sees himself on the front lines of both HIV/AIDS and maintaining the position of the Church of Uganda.

12. INTERVIEW OF JINJA CATHOLIC DIOCESE HIV/AIDS PROGRAM

- **Interviewers:** Dr. Peter Okaalet, Samuel Irungu, Norman L Olsen, Dan Wamanya, Joseph Mwangi, and Charles Serwanja
- Element of IRCU: Member of IRCU
- **Date/Time/Location:** April 26, 2013. 9:00am, Catholic Diocese Jinja District
- Person(s) interviewed:
  - Felix Kajura, Accountant
  - Angella Nairuba N, Secretary
  - Richard Isike, Accountant
  - Patrick Omogi, Data Clerk

(a) Description of the Program and the Staff Team

This was a unit primarily of managers. One women representative participated. The health unit has been in operation since 2005. (Health coordinator was absent.) They have a positive view of the interfaith council. Notes this is a unique arrangement for Uganda. In terms of HIV/AIDS the Diocese takes a holistic approach aimed at strengthening the family. They provide targeted education which emphasizes building up the child and family.

The Church of Uganda structures in place are trusted by the people. Also they have proven mobilization practices. Note that TESO has to use religious structures to mobilize. Basically it is a federal approach from the family/parish through the Diocese up to Kampala. Rallying cry is John 10 – have life in abundance.

HIV/AIDS Program networks involving Youth Councils, Mothers Union, Fathers Union, etc. Hold weekend seminars that are useful in identifying emerging MARPs such as couples aged 30 to 45 years who are beginning to feel a strain in their marriage and thus seek outside sexual partners. They are experiencing challenges in creating and sustaining positive behavior change. A sponsorship system similar to AA and other addiction programs could be helpful.

If support is reduced, the structures will remain but are likely to be used less.

Attributed the increase in prevalence to a variety of causes, the most importance of which is superior treatment options make it possible to live with AIDs. There is less fear. Also after 25 years of preaching, many tune out the prevention message.

(b) What are the actual and potential strengths of IRCU?

- Total – holistic - approach to the person, based on John 10:10 (I came that you may have life, and have it to the full…!")
- Garnering all to RL work for the common cause.
- Utilizing structures of the Member religious groups.

(c) How effectively has IRCU mobilized those strengths?

- Built confidence among the RL – even at the lowest level (*Kabondo*).
- Integration of HIV/AIDS work into what people do – Home-to-home visits, and at congregational level.
- Networks with relevant partners strengthened.

(d) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

- Families targeted to provide support to OVC.
- Integrated approach to programming:
  - ABC strengthened at Schools, through 'School Life Programs'.

- IGAs promoted.
- Family Life Programs.

- Youth Councils created and are now avenues for discussing HIV/AIDS.

- Wrap-up Programs – In which the Church partners with others to 'complete' what the Church started. For example: After counseling a person on AB, they are advised to go obtain the condoms from the organizations that supply them.

(e) What are MARPS?

According to Richard and his team, MARPs are: Fishing Folk, Boda Boda (Motorcycle Riders), Bar Attendants, Sex Workers, Plantation Workers (Sugar Cane and Tea Farms), and Trailer Drivers. MSM: Youth Alive Program reaching out them.

(f) Recommendations and Ways Forward?

- Deepen commitment of both individuals and Church leaders.
- Committed to sustaining the work that has started – 'Scale down' if need be, but keep on doing what we have been doing.
- Revisit and address complacency between RL and general population.
- Employ combination of strategies.
- Strengthen Networking.
- Increase uptake of HIV/AIDS services. Focus on reaching families, the basic units of an effective response to AIDS.
- Increase Local Fundraising.
- Create Accountability Teams – Sponsors.
- Parish priests are effective at mobilization. Parishes have home-visit programs. Need to strengthen organizational development at the parish – diocese level. (Recommend they look at the Jesuits in Africa.) This should start with HIV/AIDS prevention in seminary.
- Traditional Aunties no longer are sources of pre-marital sexual advice. To some degree this has been commercialized, with a largely negative impact. Could be useful in large cities.
- Need to target special events such as funerals, traditionally a source of much casual sex.

Summary

The Jinja Diocese is quite enthusiastic and seems open to new ideas. Greater emphasis on actual implementation is needed. The selected field facilities we observed seemed to be doing well. IRCU is responsible for energizing the Church of Uganda hierarchy.

13. INTERVIEW OF INTERFAITH COMMITTEE OF JINJA

- **Interviewers:** Dr. Peter Okaalet, Samuel Irungu, Norman L. Olsen, Dan Wamanya, Joseph Mwangi, and Charles Serwanja
- Element of IRCU: Member of IRCU
- **Date/Time/Location:** April 26, 2013, 12:00pm, Church of Uganda Diocese, Jinja District
- Person(s) interviewed:
  - Rev. E. Amooti Bagambi, Chairperson
  - Rev. Patrick Wakula, Treasurer
  - Ord. Aggrey. Muttebe, Member
  - Sheikh Ahmad Izzv-Di4 Kibirige, Member

a) What are the actual and potential strengths of the IRCU?

- Reaching out to 'all' – across denominations – and it doing quite well.
- Training of Trainers Course – Rev James has trained 24 Clergy under him, as well as 127 Church teachers.
- Targeted RL who are the Gatekeepers of the 'flock' under them.
- RL have the potential to tap into the Core Values of families and Parents.
- Enhancing the collaboration among RL.

Similarly to other interfaith committees, the group credits IRCU with bringing them together and to sustaining a productive dialogue. While not official members of the national interface council, the local Methodist and Pentecostal ministers serve as full members of the Jinja committee. The Methodist and Pentecostal ministers have worked with IRCU on other programs for from four to 5 years; on the Inter-Faith committee for 2 to 3 years.

They have attended IRCU training courses, seminars, and conferences. After such training, they instructed their local churches committees in the same training, leading to outreach programs. In the outreach, they emphasize looking for the gatekeepers.

They believe that the ARV treatment has changed the outlook of the youth towards HIV/AIDS. One can now live with HIV/AIDS. They believe the youth from ages 13 to 25 years are the most vulnerable group. Girls are more vulnerable than boys are. The immaturity of youth and the lack of employment opportunities lead to dangerous life choices. They believe these choices lead girls into commercial sex work.

The role of families is critical. Family support leads to better decisions and greater opportunities. In this regard, respondents see the need for a methodological change in message strategy. Currently much of what is said is tuned out; an attitude adjustment is needed. An experimental approach is needed with messages tailored to the various demographic groups. Work is seen as a punishment for academic failure.

b) How effectively has IRCU mobilized those strengths?

- Assisted the members to build capacities of health workers, and other service providers.
- Supported health centers and hospitals.

c) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

- Refocusing on the core values of the members.
- Utilized persons living with HIV (PLHIV).

d) Recommendations and Way Forward?

(i) Look for the 'Missing Link' –What is it?
(ii) Revise Methodology.
(iii) Work with couples intending to get married – whether Church Marriage, Customary Marriage, and/or State Marriage.
(iv) Economic Empowerment.
(v) Revise the Messages – Equip and Train the Messengers.
(vi) Focus on Schools.
(vii) Create and design Agricultural Programs to employ and occupy the Youth.
(viii) Work to Influence Policy – For example, GOU and other Employers to stop posting spouses to different stations.
(ix) What about MARPS? The team thought that the most at risk group were Youth, aged 13-25 years, girls more than boys.

Summary

The group talks the talk with enthusiasm. They know the vocabulary. We have a mixed impression of how well they are likely to walk the talk.

14. INTERVIEW OF ASSISTANT DIRECTOR OF WORLD VISION UGANDA

- **Interviewers:** Dr. Peter Okaalet, Norman L Olsen, Samuel Irungu, and Charles Serwanja
- Element of IRCU: Partner
- **Position:** Associate Director – Health and HIV / AIDS
- **Date/Time/Location:** April 29, 2013, 4:00pm, World Vision Office, Nakasero
- Person(s) interviewed: Robert Kanwagi

a) **What are the actual and potential strengths of IRCU?**

- IRCU is providing a stepping-stone which enables World Vision to work with the wider faith based community.
- Provides a communication platform through nationwide religious structures, which increases the World Vision audience among FBOs.
- Gradually updates HIV / AIDS materials for use with the donors and communities. The materials are effective because when IRCU speaks the communities listen.

b) **How effectively has IRCU mobilized those strengths?**

- World Vision inputs materials to use in the communities and churches and prints the materials. It also supports forums of IRCU training for churches.
- World Vision supports many of the members of the IRCU in advocacy by training the local people in churches to talk about the issues that pain them; hence, the linkage between local and national level persons.

c) **How has IRCU contributed to the overall HIV/AIDS program in Uganda?**

- IRCU should strengthen the Christian youth groups to bring the focus of HIV / AIDS prevention to young people. The young people are an underserved group in terms of HIV/AIDS messaging.
- IRCU should re-examine its HIV / AIDS intervention among young people.
- IRCU has a tendency to make a statement when political issues arise; thus, IRCU needs to have advocacy statements in issues regarding HIV / AIDS prevention.
- Happy with the linkages with IRCU although the silence affects the linkage between IRCU and World Vision.
- The IRCU should always speak out. Then when NGOs speak out, the government listens to the IRCU and goes into discussions with the IRCU.
- IRCU should become a policy platform to influence some of the protocols and policies before they come out like the OVC.
- World Vision should belong on the IRCU secretariat for technical reasons.
- Community Care Cooperation (CCC).

15. INTERVIEW OF ISHAKA ADVENTIST HOSPITAL TEAM

- **Interviewers:** Dr. Peter Okaalet, Norman L. Olsen, and Samuel Irungu, Joseph Mwangi, Catherine Muwanga, and Ronald Nyakoojo
- Element of IRCU : Partner
- **Date/Time/Location:** May 2, 2013. 09:06 am, Ishaka Adventist Hospital.
- Person(s) interviewed:
  1. Mugabe Geoffrey, Treasurer
  2. Enock Begumisa, HIV/AIDS Programme Officer
  3. Tumwesigye Asaph, Human Resource Manager

a) **What are the actual and potential strengths of IRCU?**

- Use religious leaders to mobilize communities for support for HIV / AIDS prevention strategy because people believe in religious leaders.
- Religious perspective, i.e. counseling involves prayers. HIV counseling becomes more effective and unique when it comes with a spiritual perspective like the Hospital motto "We Care God Heals".
- Approach patients with a spiritual and religious focus, unlike the other facilities.
- IRCU is interfaith and all religions come for services in the Hospital. The Muslims are the smallest group; Catholics and Anglicans are the largest in the 60km catchment area.

b) **How effectively has IRCU mobilized those strengths?**

- IRCU's work with the religious leaders has helped mobilize communities for HCT and prevention of HIV / AIDS in the ABC strategy where A is Abstinence, B is Be faithful, and C is Conduct or Character.
- IRCU should distribute condoms at the hospital but do not distribute condoms in the communities to reinforce C for Conduct, mostly among the youth.
- The facility has Community Counseling Assistants (CCA) who travel for outreach in hard to reach areas. They conduct home visits. In a month, Ishaka completes 12 community outreaches, reaching on average1200 clients.
- VHT adds religious leaders and works with them.
- Conduct quarterly CCA review meetings.
- The SMC program has attracted the youth that get the HIV testing as part of the SMC package.
- Have a good nutrition program to improve the Pediatric Care and Treatment through partnership with RUTF (Ready to Use Therapy Food).
- Mobilize children through the church, organize Pediatric days, and request mothers who are HIV positive to bring their children. Ishaka conducts pediatric days and outreaches monthly.
- Conduct nutrition, Care, HCT and PMTCT outreaches monthly to bring services closer to the communities.
- Use of CCA to know who has transferred out and follow up of Pediatric Care and Treatment.
- Community services are free but at the Ishaka Adventist Hospital the patients pay one thousand Uganda shillings only (1,000/=) as service fees.
- Reports are submitted weekly, monthly, quarterly and annually to IRCU.
- Hospital budget is 127 million Uganda shillings per year from IRCU.

c) **How has IRCU contributed to the overall HIV/AIDS program in Uganda?**

- IRCU has united the faiths and provided training and logistical support. It is showing the nation the way forward.

d) Challenges, Ways forward, and Recommendations

(i) There is no specific intervention to target the female youth.
(ii) There is no active OVC program but palliative care is available.
(iii) There is a lot of stigma concerning HIV/AIDS especially among the youth.
(iv) Retention of HIV clients in care and treatment is a big challenge in both adult and pediatric care and treatment.
(v) Competition among NGOs for clients in the community is another challenge.
(vi) There are O.I. drug stock outs.
(vii) There is high turnover of staff.
(viii) Limited space, i.e., no space for laboratory, HCT and SMC.
(ix) No patient confidentiality because of lack of infrastructure.
(x) IRCU should train all Hospital staff.
(xi) Work on how to retain staff by improving the salaries and accommodation for the staff through revision of salaries to reduce staff turnover.
(xii) Community Volunteers are 50 and should be brought on board and given salaries or a monthly allowance of Ush 50,000.
(xiii) USAID can help by improving coordination among the various health facilities so they are not wasting resources competing for the same patients. Advise the government to harmonize the services.
(xiv) Provide and ensure a safe place for the youth who are HIV positive at the hospital.

16. INTERVIEW OF BUSHENYI DISTRICT INTERFAITH COMMITTEE

- **Interviewers:** Dr. Peter Okaalet, Norman L. Olsen, Samuel Irungu, Joseph Mwangi, Catherine Muwanga, and Ronald Nyakoojo
- **Element of IRCU:** Partner
- **Date/Time/Location:** May 2, 2013, 12:00pm, St Peter Cathedral Bweranyangi, Bushenyi
- Person(s) interviewed:
  - Canon Norbert Tibinome, Chairperson of the Committee
  - Rev. Fr. Richard D Ssebugwawo, Secretary of the Committee
  - Sheikh Mubarak Baryamujura, Treasurer of the Committee
  - Sheikh Nsubuga A, Deputy Kadhi

a) What are the actual and potential strengths of IRCU?

- The IRCU brings all religions together.
- The IRCU is not business oriented but is after the lives of people.

b) How effectively has IRCU mobilized those strengths?

- The IRCU has trained church leaders and equipped them with knowledge and skills in HIV / AIDS prevention strategy.
- The churches / mosques refer people to health facilities to assess services, Ishaka Adventist Hospital, KIU, Bushenyi Medical Centre IV, Katungu Church missionary hospital.
- Mothers and Fathers Union conduct sensitization in churches / mosques. They work in the villages and with an emphasis on youth and OVC. The Muslims concentrate on the youth through organization of seminars.
- There are active youth programs that operate every Friday and Monday to strengthen the HIV / AIDS prevention Strategy.
- The Marriage and Social affairs are addressed by the Fathers Unions and Mothers Unions. These efforts penetrate into rural villages.

c) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

- There has not been any follow up by IRCU on the training organized and conducted by the IRCU in January 2012; thus, IRCU is not active now in Bushenyi.
- Many Foreigners (non-residents) arrived and night clubs opened up in Bushenyi and this has increased HIV prevalence from 4% last year to 7% this year.
- There is need for facilitation of more seminars at the grassroots to meet the people in the villages to pray and care for the communities.
- IRCU should invite people from all various religions including the Adventists who were not invited in the first training for trainings and workshops by IRCU to get more technical people.
- There should be Integration of the Local Councils (LC) in the community and the Inter faith Committee to enable better communication to the people in villages hence develop a district team and share some of the HIV / AIDS Prevention issues with them.
- There is lack of employment in the community and this increases poverty among the people in the communities.
- There are no structures to train people who go out and reach out to communities that do not come to churches / mosques.

17. INTERVIEW OF CARITAS MADDO

- **Interviewers:** Dr. Peter Okaalet, Norman L Olsen, Samuel Irungu, Joseph Mwangi, Catherine Muwanga and Ronald Nyakoojo
- Element of IRCU: Partner
- **Date/Time/Location:** May 3, 2013, 10:00am, Caritas Maddo (Masaka Diocese's development organization), Masaka District
- Person(s) interviewed:
  - Andrew Peter Tamale, Program Officer
  - Mulindwa Jude, Program Accountant
  - Namiiro Immaculate, Social Worker

a) What are the actual and potential strengths of IRCU?

- IRCU is unique in its approach towards the HIV / AIDS prevention strategy using religion to impact communities and encourage character change.
- IRCU is unique because it is Faith based.
- IRCU works with religious leaders and uses religious structures to mobilize communities.
- IRCU has superior communication compared to other partners like the HORIZON 3000.
- IRCU is unique in its constant and well-coordinated support supervision and communication to CARITAS MADDO.
- IRCU supports the whole household rather than supporting only one member in the household i.e. a child per household; thus, its uniqueness.

b) How effectively has IRCU mobilized those strengths?

- IRCU mobilizes religious leaders in different forums at the district level. Thus, more persons turn up for the mobilizations. They make phone calls to the different religious leaders.
- Churches / mosques mobilize people in the churches / mosques and in the parishes and down in the grassroots.
- IRCU provides training in counseling and psychosocial support to the caregivers in the community.
- The OVC program started in 2007 and is very active and there are OVC follows up made in the community and psychosocial support. They participate in the national OVC Coordination Committee.
- There are OVC Committees at the village level and in Kibinge sub-county. The village level OVC Committee consists of 10 people, having 200 households in Kibinge Sub County. Each person on the village level OVC Committee handles 25 households. They do documentation, follow up and reporting.
- IRCU improved the OVC program by introducing policy and made OVC in CARITAS MADDO more formal.
- There is mobilization of OVC caregivers in Income Generating Activities (IGA). This can cover over 100 households.
- IRCU organizes trainings for OVC caregivers. Fifty (50) households receive three days training.
- There is a selection of households, which involves meeting with the religious leaders and LCs at the sub county headquarters. This group selects the households after which they make follow up visits to the selected households to fill out forms. There are 17 HIV households and in

general 250 OVC households in one village. The selection criteria are HIV positive, School dropouts, and irregular incomes.

- IRCU works with core program areas including education trainings for care takers in IGA, nutritional trainings, training in agriculture, health component about reproductive health, HIV prevention, and training in OVC.
- There are 250 trained and graduated. We follow up twice in a year in a meeting but we do not do formal tracking. Over 100 have jobs, which is a big success story. The graduated OVC girls are linked with jobs.
- Conduct Child protection trainings where care takers are trained in Willing Making, Memory Book making for HIV.
- Conduct psychosocial support training for religious leaders, teachers and counselors
- There is easy access to the internet, available on the site.
- CARITAS MADDO reports quarterly informs of a progressive report aggregate in soft and hard copies to IRCU.
- CARITAS MADDO ranks its partnership with IRCU at nine on a ten point scale because of clarity and IRCU support supervision to CARITAS MADDO i.e. mentorship and monitor.

c) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

- The facility does not have national OVC tools for reporting.
- There is need for the facility to report through the National Health Management Information Systems.
- More emphasis should be put on the caregivers to depend on IRCU.
- IRCU should give a startup package to the caregivers.
- IRCU should have the time to monitor and follow up the trained and graduated caregivers.
- IRCU should have good, clear and ambitious set targets that can be realized by the partner.
- IRCU should involve government to in influencing policies like education, poverty and food security.
- IRCU should build capacity of its partners and engage the community.
- IRCU should be more relevant and more meaningful to the people in the communities.
- The Program Officer recommended that CARITAS MADDO can work even after IRCU has left through structural development, i.e., parish development committee because food security is the main concern.

18. INTERVIEW OF UGANDA PROTESTANT MEDICAL BUREAU (UPMB)

- **Interviewer:** Dr. Peter Okaalet, Norman L. Olsen and Samuel Irungu, Dan Wamanya, and Charles Serwanja
- Element of IRCU: Partner
- **Date/Time/Location:** May 6, 2013, 9:05am, UPMB Offices, Mengo, Balintuma Road
- **Person(s) interviewed:** Dr. Tonny Tumwesigye, Executive Director of the UPMB

a) What are the actual and potential strengths of IRCU? How effectively has IRCU mobilized those strengths?

- IRCU brings awareness of HIV / AIDS prevention strategic program to the church.
- IRCU is linking with other faith leaders and considers all faiths when providing logistics.
- IRCU is linking the HIV / AIDS prevention strategic program with working with the church leaders.
- IRCU has continuously linked up the district systems with the church religious structures.

b) How effectively has IRCU mobilized those strengths?

- IRCU funds the training in HIV / AIDS prevention training to all religious leaders from different religions.
- Many training programs have taken place at the parish level, health centre III & II levels (in charges), with political leaders and sub-county and parishes. IRCU also trained VHT and a CQI team in HIV / AIDS prevention.
- The CQI (Continuous Quality Improvement) Team monitors post training performance through improved adherence, the tracking of the TB numbers, and improved treatment of patients.
- Church leaders are involved in the mobilization. The invitations go out through the Bishop and the diocese. The Bishop opened the training for the church leadership & politicians.
- Initially prevention was HCT where ABC strategy is used through post-test clubs to go out in the community, radio talk show, and particular emphasis is put on discordant couples. C was difficult to use and emphasis
- SMC has been introduced and is being conducted and implemented

c) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

- There is overlapping of IRCU and UPMB. Resources are not enough (277 facilities); thus, IRCU needs to streamline and harmonize implementation to avoid duplication.

d) **Recommendations and Way Forward?**

(i) UPMB has not had a critical direct working relationship with IRCU.

(ii) IRCU found a cost recovery mechanism at the facilities and therefore UPMB should discuss with IRCU and IRCU should involve the UPMB and look at the gaps of UPMB filled by IRCU.

(iii) IRCU has another army of the Muslims and Orthodox; the UPMB is very happy to support and coordinate with these linkages.

19. INTERVIEW OF IRCU BOARD

- **Interviewer:** Dr. Peter Okaalet, Norman L Olsen, Samuel Irungu, and Dan Wamanya
- Element of IRCU: Governing Arm
- **Date/Time/Location:** May 6, 2013, 10:00am, IRCU office at Namirembe Hill
- Person(s) interviewed:
  - **Msgr. Charles Kasibante**, Board Chairperson (Representing the Roman Catholic Church)
  - **Sheikh Mohammed Ali Waiswa**, Member (Representing the Uganda Muslim Supreme Council)
  - **Mr. Vasco Kura**, Member (Representing Church of Uganda)
  - **Mr. Frank Kiggundu**, Treasurer (Representing the Seventh-day Adventist Uganda Union)
  - **Eng. Sheikh Kavuma Siraje Zaid**, Ex-officio Member (Secretary General of the Uganda Muslim Supreme Council)
  - **Pr. Daniel Matte**, Ex-officio Member (Executive Secretary of the Seventh -day Adventist Uganda Union)
  - **Msgr. Dr. John B. Kauta,** Ex-officio Member (Secretary General, Uganda Episcopal Conference)
  - **Rev. Canon. George Bagamuhunda**, Ex-officio Member (Provincial Secretary, Church of Uganda)
  - **Mr.Theodore Kato**, Ex-officio Member (Secretary General, Uganda Orthodox Church)
  - **Joshua Kitakule**, Board Secretary (IRCU Secretary General)
  - **Charles Serwanja,** HIV / AIDS & Public Health Specialists
  - **Jackie Katana B**, Project Manager HIV / AIDS prevention project
  - **Lydia Cathy Tamale**, Human Resource Manager
  - **Paul Ssenyonjo**, Senior Internal Auditor
  - **Godfrey Olwol**, Executive Assist to Sec General

a) **What are the actual and potential strengths of IRCU?**

- IRCU brought together major faith and religious leaders from different faiths to work together in the HIV / AIDS prevention strategy and communicate to communities. People listen to them because people believe in religious leaders and trust them as they see them as people who came to serve.
- IRCU unites religious leaders who agree to work together as brothers and sisters and are happy to work together in the HIV / AIDS prevention strategy.
- IRCU is for humanity since HIV does not discriminate among religions.
- IRCU has a cross section and can reach so many people; thus, IRCU becomes a platform through which different religious leaders communicate to the community.

b) **How effectively has IRCU mobilized those strengths?**

- The IRCU board supervises the Secretariat and monitors the HIV / AIDS prevention strategy.
- The IRCU board has committees that go down to the grassroots at the different levels to coordinate activities. In these committees the board projects the future for regional and district level committees.
- The information sharing network by IRCU moves quickly around all the religious leaders.
- Churches / mosques have good advocacy; i.e., SMC where they emphasis 60% surety.

c) **Recommendations and Ways Forward**

(i) IRCU should be strengthened and given more money in order to be more efficient in its work and get better benefits.

(ii) IRCU expand and increase its coverage by 25%.

(iii) The dialogue between the government and partners should be strengthened with an emphasis on who performs what tasks best. There is also need for IRCU to dialogue with all religious leaders and find a way to address the uniqueness of IRCU.

(iv) IRCU should have a permanent home and stop renting.

(v) There is need for IRCU to compare situations in order to know how best it is performing and doing in terms of HIV / AIDS prevention strategy.

(vi) IRCU needs to agree on what structures are appropriate for what tasks. There is need to put emphasis on the fact that IRCU is an effective service provider.

(vii) Partnership should be encouraged to be able to fill in the gaps and increase coverage.

(viii) The donor and council of Presidents should hold dialogues.

(ix) IRCU needs re-awakening of the giant.

(x) There is need to strengthen flow of information from IRCU Secretariat to the board of IRCU and Council of Presidents thus better communication mechanisms.

(xi) USAID should have dialogue with the board of IRCU and agree on what to do. USAID needs to work with IRCU in areas where IRCU has Comparative Advantage and the Board of IRCU should come up with the list of Comparative Advantage. IRCU should engage USAID and discuss target to be attained.

(xii) FBOs should be empowered, structures strengthened and facilitation given to enable ownership and sustainability.

(xiii) IRCU should have regional offices to enhance implementation.

(xiv) IRCU's implementation management needs to be strengthened.

(xv) The previous Board of IRCU and the Council of Presidents were not sufficiently aware of the work of IRCU

(xvi) The big health facilities are not part of the IRCU benefiting facilities and these health facilities include Lubaga Hospital, Nsambya Hospital, Kibuli Hospital and St Anthony Hospital. IRCU is not everywhere.

20. INTERVIEW OF EXECUTIVE DIRECTOR OF PACANET(PAN AFRICAN CHRISTIAN AIDS NETWORK)

- **Interviewers:** Dr. Peter Okaalet, Norman L Olsen, Samuel Irungu, and Charles Serwanja
- Element of IRCU: Partner
- **Date/Time/Location:** May 6, 2013, 1:30pm, Quality Cuts Nsambya
- **Person(s) interviewed:** Rev. Edward Balaremwa, Executive Director of PACANet

a) What are the actual and potential strengths of IRCU?

- IRCU involves both Christians and Muslims.
- IRCU brings together all the faith groups in the HIV / AIDS prevention strategy.
- IRCU is unique because of its Comparative Advantage where advocacy is put in the religious leaders.

b) How effectively has IRCU mobilized those strengths?

- Could not get any responses to this question because the person(s) directly involved with IRCU was in the field.

c) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

- Could not get any responses to this question because the person(s) directly involved with IRCU was in the field.

21. INTERVIEW OF ACTING DIRECTOR OF UMMB (UGANDA MUSLIMS MEDICAL BUREAU)

- **Interviewer:** Dr. Peter Okaalet, Norman L Olsen , Samuel Irungu, and Charles Serwanja
- **Date/Time/Location:** May 6, 2013, 2:24pm, Old Kampala Mosque
- **Person(s) interviewed:** Dr.Karama Saud – Ag Executive Secretary of the UMMB
- Element of IRCU: Partner

a) What are the actual and potential strengths of IRCU?

- IRCU unites different faiths, like the Muslims, Catholics, Anglicans, Orthodox and Seventh Day Adventists Church to work together for the good of everybody.
- IRCU is on big scale where the top leaders of the different religions are working together.
- The way IRCU operates is unique in the way it caters for all activities such as HIV / AIDS prevention, family issues, and political issues.

b) **How effectively has IRCU mobilized those strengths?**

- Senior Leadership passes on information to the lower managers who do the work.
- Muslims have structures such as the Muslim Supreme Council and below it there are the sub-counties and mosques that reach out to the communities and the communities listen to the Imam.
- IRCU has used the Muslim organizations such as NGOs and community based organizations to do a lot of work in OVC, i.e. Iganga OVC program has 1568 orphans.
- IRCU is using religious leaders to mobilize communities.
- The UMMB is educating the communities through the religious leaders about SMC and carrying out HCT in communities.
- The Muslim community has managed to handle the condom issue through discussions with the Mufti and agreed to use the condom in the marriage context in case of family planning, discordant couples, and those of unknown status. Still some Muslims have some questions.
- UMMB caters for the youth through the religious education offered to them in the mosques. This includes follow up. The UMMB conducts trainings and makes follow ups of these trainings.
- There is a big success in HIV / AIDS prevention strategy because the Imams visit homes. Home visits are highly effective in encouraging behavior compliance.
- IRCU is successful because of the working together of religious leaders in the communities such as in Wakiso, where all religious leaders worked together and were welcomed by communities.
- There are institutions (Bwaise, Mukono, and Jinja) which teach Muslim religious education to the Imam up to A-Level exams.

c) **How has IRCU contributed to the overall HIV/AIDS program in Uganda? Recommendations for improvement?**

- Regional offices throughout Uganda that concentrate of HIV/AIDS prevention would strengthen IRCU.
- IRCU should involve more partners and increase from 19 to more partners in order to improve on the way they do their programs like SMC, HIV / AIDS prevention.
- There should be more HIV / AIDS prevention programs on behavioral change and HCT should reach down to the villages.
- There is need to involves leaders like the Imam to put more focus and emphasis on the HIV / AIDS prevention strategy and pass on the message to the congregation and community.
- IRCU should deal with the UMMB directly thus the need to be more direct with IRCU and the UMMB.

- The National HIV prevalence level can reduce from 7 to 5 if everyone does something.

22. FOCUS GROUP DISCUSSION WITH UGANDA CATHOLIC MEDICAL BUREAU (UCMB)

- **Interviewer:** Dr. Peter Okaalet, Norman L. Olsen, Samuel Irungu, and Charles Serwanja
- Element of IRCU: Partner
- **Date/Time/Location:** May, 7th, 2013, 10:10am, UCMB Offices, Nsambya
- Person(s) interviewed:
  - Dr. Samuel Orach, Executive Secretary of the UCMB
  - Dr. Gamba Isinga, Linkage between UCMB and IRCU
  - Dr. Peter Paul Opatat, In charge of the Non-Clinical Services

a) What are the actual and potential strengths of IRCU?

- IRCU is a platform where different churches collaborate on issues of common interest like HIV / AIDS prevention strategy, peace, politics.
- IRCU is a tool like the UPMB and UCMB that joined and formed the Joint Medical Stores (JMS).The major faiths of Uganda formed IRCU to serve common interests of all religions.
- IRCU obtains funds to help religious leaders fight against HIV / AIDS. IRCU was formed as a tool to mobilize funds for HIV / AIDS prevention Strategy.
- IRCU exists to strengthen the religious structures addressing HIV/AIDS. It brings together different religions and tries to support different religious leaders.
- IRCU was able to make it possible to unite different religious leaders to work together. Different religious leaders come together to create response in the HIV / AIDS prevention, peace and reconciliation.
- Religious bodies have taken the lead in contributing to the HIV / AIDS prevention strategy. Religious leaders have come together and sit and speak with one mind.

b) How effectively has IRCU mobilized those strengths?

- The UCMB has 281 health facilities and IRCU supports only four (4) facilities. UCMB has training institutions for nurses that train human resources who go down to the villages to reach the people in the grass roots.
- ABC strategy is implemented in the facilities where A is for Abstinence, B is Be Faithful and C is Character change. Condoms are not distributed in the facilities but if needed by the communities, people are referred. (Note this is a practical example of not de-campaigning.)
- SMC is still a big debate.

c) How has IRCU contributed to the overall HIV/AIDS program in Uganda? Recommendations, Challenges and Ways forward

- The strength of IRCU is not yet being fully exploited. IRCU has what could be a good governance structure, although there is room to improve it. Thus, IRCU is not the secretariat of the different religious bodies but simply a secretariat of partnership. Therefore, IRCU should have the capacity to stand aside and help the institutions see what it does not see.
- IRCU needs better governance that can allow for internal checkups.
- IRCU has gained some confidence that can be cultivated, i.e. donor confidence.
- The Council of Presidents should act as trustees and trust the board to work with IRCU management. The COP should also ensure that IRCU has good technical working relationship with its partners.
- The communication flow is often unclear. Slow continuous work on improving the communication flow is necessary and should be a priority of the IRCU Secretary General.
- There is need for secular elements in western nations to face the fact that Uganda is a country of believers. We are Christians and Muslims.
- There is need to revisit on how we are delivering the message to the people and the message should not be harmful to the communities.
- Need to guide parents on the best ways of parenting with emphasis on behavioral change and encouragement of AB in conjunction with growth of C.
- Need to improve documentation, which is a big challenge.

- There is need for dialogue between IRCU and its partners.

23. INTERVIEW OF INSTITUTE OF INFECTIOUS DISEASES (IDD)

- **Interviewers:** Dr. Peter Okaalet , Samuel Irungu, and Norman L. Olsen
- Element of IRCU: Partner
- **Date/Time/Location:** 23rd April 2013, 12:00pm, IDI Learning Hub Office, Kitante Road
- Person(s) interviewed:
  - Sam Anguria, Project Coordinator
  - Dr. Richard Mwesigwa, Project Manager
  - Dr. Umaru Ssekabira, Deputy Head of Training
  - Judith Kyokushaba, Lab Specialist
  - Sumaya Nakibuuka, Grants Officer
  - Milly Namalwa, Training Operations Manager

a) What are the actual and potential strengths of IRCU?

- Strengthening the facilities of FBOs; quicker turn around.
- IRCU works with people who believe in God. This enhances their motivation and commitment to what they do.
- IRCU partners are located in remote parts of the country – the hard to reach places.
- IRCU's has skill in bringing together the major religious groups. They also have the operational pragmatism to partner with a group like IDI to bring practical results (in this case improved laboratory performance) to go with the religious idealism. (Religious idealism combined with practical management skill – it's there and needs to be built upon.)

b) How effectively has IRCU mobilized those strengths?

- The Four Objectives of IDI are:
  - Strengthen the facilities of IRCU
  - Build the capacities of 17 IRCU supported laboratories
  - Build the capacities of the 19 health facilities
  - Build the capacities of the G. I. Systems
- Based on a 2010 agreement IDI supervises the IRCU labs: 19 hospitals, and 17 labs using an external Quality Assurance program. (Many groups are not involved with this.)
- FBO facilities have superior work attitude, demonstrated by better daily coverage and response to emergency care. There is a lower level of absenteeism. Facilities are managed in a more orderly professional manner and they follow approved care/treatment standards more closely. There are fewer stock outs – although this is also a problem. They have a positive outlook to patient care. They have a higher motivation to work and use their training more effectively in performing their jobs.
- Personnel turnover is a major issue. Personnel receive training and then reasonably quickly leave for GOU facilities. They tend to leave their work ethic behind while gaining greater salaries, benefits, and potential training. They also can simultaneously work outside the facility.
- Districts need to recognize FBO capacity. FBOs lack effective coordination with GOU facilities. FBOs have loose networks that should be tightened to achieve higher-level performance. Local politics can have negative impact.
- Support by religious leaders is positive; in particular Bishops issue press releases that follow the latest guidance.

c) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

- We asked if IDI had an extra $1.0 million to invest in either FB or government facilities, which would they choose. The IDI staff agreed the FB facilities provided superior care, better management, higher motivation, and superior staffs. Most would choose the faith based; however, one person noted the very limited number of FB facilities and thus she would be inclined to choose the government. All noted that $1.0 million would not have a system wide impact.

d) Looking to the future, the IDI staff proposed:

- Inclusion of FBO representatives in leadership and management committees at all levels: national, district and community levels.

- Strengthening the IRCU and government coordination at the district level.

24. INTERVIEW OF KANSANA-LUWEERO DISTRICT INTERFAITH COMMITTEE

- **Interviewers:** Dr. Peter Okaalet , Samuel Irungu, and Norman L. Olsen
- **Element of IRCU:** Luweero District Interfaith Committee
- **Position-** Representatives of the Catholics, Church of Uganda, Pentecostal Church, SDA, Orthodox and Muslim.
- **Date/Time/Location**: April 24, 2013. 12:30pm, at Catholic Church, Kasaana, Luwero
- Person(s) interviewed:
  - Fr Gerald Wamala, Chairperson
  - Pst Kairaga Gerald, Member, SDA
  - Sheik Umar Mukus, Muslim
  - Rev Fr D. Sserugenda, Representative, Orthodox
  - Rev. Karwani Samson, Full Gospel Church of Uganda

a) What are the actual and potential strengths of the IRCU?

- Five strong Faith Communities brought together
- National outlook with board based coverage
- Structures and facilities used for service provision
- Changed attitudes of Religious Leaders
- People listen to Pastors, Imams, and other Religious Leaders

"IRCU brought us together, started a dialogue during which we found common ground. IRCU also provides training and support that has increased our capacity. Thanks to USAID, which, through IRCU, demonstrated its trust in the leaders of the religious committee."

All share the vision of greater unity over the next five years, and reducing the current district prevalence rate of 10.4% down to 5%. (This seems a reasonable goal).

b) How effectively has IRCU mobilized those strengths?

- Built capacity of Religious Leaders
- Promoted ABC approach
- Facilitated networking and referral of clients
- Gained the support of the Chief Administrative Officer and Resident District Commissioner
- Hold quarterly committee meetings, which follow a democratic process.
- Catholic OVC – 2000. Combine peace and reconciliation with ABC approach. Created a peaceful co-existence process that reaches the grass roots levels. Further empowered with civic education supported by IRCU.
- Encourage testing.
- Developed strategic plan with IRCU.
- Regularly meet with District officials. Structures need to continue.
- Uganda Joint Christian Council a predecessor.
- Muslims and orthodox very pleased to be included.
- Greater emphasis on HIV+ living.
- All faiths do information training.
- Groups have different levels of HIV understanding. Want more empowerment of women and girls.
- Refer congregants to clinics to clinics and follow referrals from beginning to end.

c) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

Without the active intervention of IRCU, it is unlikely that these faiths would have gotten together. Now they actively dialogue in a previously conflict torn district. They also plan and seem to be beginning actual implementation.

Summary

This is an excellent example of grass roots interfaith cooperation. It appears the Catholic Father is the driving force but the others are cooperating.

25. INTERVIEW OF ORTHODOX HIV/AIDS PREVENTION PROGRAM, MITYANA DISTRICT

- **Interviewers:** Peter Okaalet, Samuel Irungu, Norman L. Olsen, and Charles Serwanja
- **Element of IRCU:** Member of the IRCU
- **Date/Time/Location:** April 30, 2013, 12:15pm, Orthodox Church Compound, Mityana
- Person(s) interviewed:
  - Renal Mugerwa, M&E Officer
  - Petros Sande Lugya, Field Officer
  - John Kagwa
  - Paulina Nakayima
  - Dissan Mulumba
  - F. Nanyonjo
  - Dorothy Namande
  - Norah Nabakunja
  - Edith Nabukeera
  - Florence Muganzi
  - Rev. Fr. Emmanuel Mukisa
  - Rev. Moses Kato
  - Paul Bukenya Kato

a) Description of the Participants

We met under the trees outside the church. The participants had walked for 30 – 60 minutes to get to the meeting. They were all active in the counseling process. The tragedy we saw directly illustrates the difficulties facing both IRCU and the people it seeks to help**.**

An approximately 30-year-old mother of three is HIV+; so too is her new two year old baby. Her husband died of AIDS. Both she and her baby appear to be in poor health with a negative prognosis. According to the HIV/AIDS counselors, the woman was advised during her pregnancy how to avoid transmission of the HIV virus to her child. She did not follow this advice, perhaps because the nearest hospital having the required medicines is hard to reach, expensive, and according to this group of counselors, often out of medicine. After the birth of the child, the women were advised not to breast feed because of the possibility of virus transmission. Again she did not follow this advice, but again her options might not have allowed it because of the expense of formula.

What did the counselors want? They want transport and sitting-fee money. The desire was understandable in that they have very little income; however, IRCU cannot meet that type of demand.

b) What are the actual and potential strengths of the IRCU? How effectively has IRCU mobilized those strengths?

- The uniqueness of IRCU is it combines the major churches and does not discriminate. It does not stop at the secretariat level but gets down to ground level.
- Emphasizes absence talks, and bio medical – HTC services. Sensitization – need to move beyond sensitization to long term compliance. Entry point: emphasize couples and youth fellowships.

c) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

- In this case, IRCU support provides a very small isolated rural church with some support in terms of training that in turn generates hope.

Summary

Looking for change over the next five to ten years! This location needs help in getting the major tea plantations to contribute to a reinforced HIV/AIDS prevention and treatment campaign.

ANNEX 2.3 FOCUS GROUP DISCUSSIONS WITH SERVICE CLIENTS

1. FOCUS GROUP DISCUSSION WITH CLIENTS OF ISHAKA ADVENTIST HOSPITAL

- **Interviewers:** Dr. Peter Okaalet, Norman L. Olsen, and Catherine Muwanga
- **Date and time:** May 2, 2013 at 10:48am
- **FGD Participants:**
  - Geoffrey Makona, Magezi S Mawanda, Benon Mujuzi, Bosco Muchuguzi, Milton Muzurusi, Claire Tumushabe, Nsiime, Yoweri Mubagizi, JonasFokwegi, Eleth Naija (Translator),.

a) Contributions:

Magezi S Mawanda

Started in 2004 with CD4 of 10, Magezi was very weak and sick but with the HIV / AIDS care and treatment services given to him by the hospital, he has greatly improved. He is married and his wife is HIV negative thus, a discordant couple. He greatly appreciates the services offered at the hospital and he has received HCT, CD4 and CBC testing, free CTX and ARVs and basic care kits to prevent malaria. Offers support help to the OVC in the community and discordant couples.

NaumeTumusiime

Husband died in 1991 and has three (3) children and they are all HIV negative. She was counseled and tested HIV positive and she started HIV/AIDS care and treatment at the hospital and appreciates the services offered at the hospital.

Benon Mujuzi

Started when he was very weak but with the Care and Treatment at the hospital, he has greatly improved. He has had cough for two (2) weeks, tested negative for TB. He appreciates the care and treatment services at the hospital.

Nsiime

She started visiting Ishaka when she was very weak but has greatly improved because of the good care and treatment services received from Hospital. Has three (3) children, two older (first born is 10 years and second born is 8 years) and one is a baby of 18 months. Gave birth through PMTCT program and never breast fed and was not influenced by community.

Gideon K Mayanja

Started in 2004 at 20 years on CTX when he was very malnourished and had CD4 of 16 and now has a CD4 count of over 600. Father died in 1990 and mother died in 2002. He likes the facility and appreciates the Care and Treatment services it offers. He is self-employed, married and gave birth to a baby girl through PMTCT. The Child is 2 years and HIV negative. Not using condoms but was advised to use condoms by the Clinical Officer. Recommended that the youth in the community need constant follow up and counseling.

Geoffrey Makona

Appreciates the good friendly services offered at the hospital and has greatly improved because he had lost a lot of weight and hope and has tested TB negative.

Claire Tumushabe
Started with TASO in 2004, joined Ishaka Hospital in 2012 with low CD4, and was put on second line drugs. Gave birth through PMTCT program and husband died in 2004 and has four children and they are all HIV negative. She is CCA and talks to her children about HIV / AIDS issues. She requests the facility to provide support in terms of school fees for the children and food to the HIV positive clients. Provide all OI drugs in the facility to avoid stock out of OI drugs.

Milton Muzurusi
Has been in care and treatment for 9 years and started with very little or no hope but has greatly improved with CD4 550.Appreciates the Care and Treatment services offered at the hospital. He is married and wife is positive and also receiving care and treatment at the hospital and all their children are HIV negative.

Yoweri Mugagizi
Has been in Care and Treatment for 8 years and has 5 children all HIV negative and in school. Requests for psychosocial support in terms of school fees for the children

Jonas Fokwegi
Started Care and Treatment in 2004 and had CD4 test done in 2006 as 9 cells and has greatly improved. He is married and his wife is HIV positive and receiving Care and Treatment at Ishaka Hospital. They have 3 children who are all HIV negative and they are grateful to IRCU for the joint support.

All the Clients appreciated the good friendly services and the easy accessibility of the facility. They appreciated the presence of People Having AIDS (PHA) networks and the Post-test clubs where people meet to encourage and discuss various issues.

b) Recommendations

(i) Request for psychosocial support to the community in terms of school fees.
(ii) Provision of all O.I. drugs at the facility to avoid O.I. drug stock outs.

2. FOCUS GROUP DISCUSSION WITH CLIENTS OF ST. FRANCIS HEALTHCARE SERVICES, NJERU-JINJA

- **Interviewers:** Dr. Peter Okaalet, Samuel Irungu, Norman L. Olsen, and Charles Serwanja
- **Element of IRCU**: Partner
- **Date/Time/Location:** April 26, 2013 at 3:00p.m., St Francis Njeru Health Centre
- **FDG Participants:**

NAME	POSITION
1. Phionah Konjo	Client
2. Francis Charles Kiiza	Client
3. Maurine Nantondo	Client
4. Ali Nyende	Client
5. John Kisembo	Client
6. Emmanuel Ojur	Client
7. Frank Adrabo	Client
8. Annet Nankusu	Client
9. Jacinta Twesigye	Client
10. Gerald Tezikya	Client
11. Getrude Lyaka	Client
12. Violet Nabukenya	Client
13. Yahaya Nsubuga	Client
14. Teddy Namirimu	Client
15. Brendah Mulisa	Client
16. Jonathan Ntale	Client
17. Constance Kisaka	Client
18. Angela Otoa	Clinician
19. Paul.Mwanje	M&E
20. Moses Sharangabo	Data Clerk
21. Olive Mbabazi	Counselor
22. Penninah Asiimwe	Volunteer

a) Description of the Facility

- St. Francis is an impressive facility. It is clean, well-organized, with an enthusiastic and articulate staff. The interview started with the core staff of nine. It rapidly expanded to approximately 25, most of whom were eager and able to explain their role in the overall work.
- St. Francis is also located at a hot spot for night life which is a favorite of long haul truck drivers. Still the community HIV prevalence rate is between 6.5 and 7.4 percent.
- Stockage is a relatively modest problem, with much credit going to IRCU's role in making the system work. Retention is a much greater problem with the significantly higher level of government salaries and benefits being blamed. Those that stay draw strength from God. They also value the holistic approach employed by St. James
- The training provided IRCU is highly valued. It includes M&E training. The St. James staff credits it with significantly upgrading their capacity.

b) What are the actual and potential strengths of the IRCU?

- Uniting the faith Communities in Uganda (5+)
- Faith-based approach to delivery of services
- Wholistic approach to health of individuals

- Building capacities of staff – towards effective customer care
- Down to earth approach – Guiding and walking with the customers
- Has chosen to work with the RL who are trusted by the community
- Clients are valued - Quality of care high

c) How effectively has IRCU mobilized those strengths?

- In response to the question of what is unique about IRCU, the group cited the hands-on approach, the follow up visits the appropriate work protocols. When challenged by the statement that other groups can provide this as well, the group basically said "IRCU does it better."
- A patient satisfaction survey is planned for the next month.
- The lab was particularly impressive, not only for its orderly clean appearance but for the fact it is working with IDI to achieve a higher level certification. Moving from III to II.
- There are some no cost drugs. Patients do pay a Ush 2000 users fee. St. Francis has a 15/100 default rate on ARV, while the national average is 55/100. In a possible lesson learned – best practice - the priest prays with clients on clinic days.
- St. Francis works with the ESSO welfare staff. For three years, St. Francis has combined the welfare improvement program with testing. The impression of some of the St. Francis staff is that some commercial sex workers start in the business as an alternative livelihood.
- A concern of the St. Francis staff is the decreased emphasis on prevention. They noted the decline in outreach, and specially mentioned the lack of drama teams. Drama teams were a previous staple of the HIV/AIDS prevention message and, according to the St. Francis staff, were highly effective. (A live drama team at the community level could be a partial antidote to the message of free sexuality presented on TV.)

d) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

- By respecting the norms of the Faith Communities
- By praying for the Clients
- IRCU assistance has been indispensable for St. Francis, which within its catchment area is providing excellent services. It works with all faiths including Muslims and Pentecostals.

e) How has IRCU contributed to the overall HIV/AIDS program in Uganda?

- Provided Care and Treatment
- Supply of Laboratory Reagents and needed materials
- Complimentary services
- Provided affordable medicines for Opportunistic Infections (OIs)
- Strengthened the linkages with RL – on VCT, Community Based Health Care
- Adherence to ARVs is 85% (defaulting lowest at St. Francis Health Care Services facility)
- Messages on Prevention were high initially but slackened over time. This has led to increased prevalence of HIV in Uganda (now standing at 7.3%).

f) Recommendations and Way Forward?

- Undertake M&E Client Satisfaction Survey – due in a month
- To enhance Prevention, increase the number of counselors and Drama teams going out to communities

- Respond to MARPs (CSW) aggressively – provide alternative livelihoods to those who are 'ready'. Enhance partnership with ESKOM and Nile Breweries, Uganda.
- Work on influencing attitudes – In-School and Out-of-School youths
- Reduce negative messages
- Purpose to hold Annual Forums for RL
- Be flexible in budgeting – so as to retain Human Resources!

Summary

St. Francis is a well-managed facility staff by enthusiastic competent personnel. It could be a model for small community based facilities. Integrating priests into the treatment program at the point of service could be a lesson learned with potential to become a best practice.

3. FOCUS GROUP DISCUSSION WITH CLEINTS OF MITYANA SEVENTH DAY ADVENTIST CHURCH

- **Interviewers:** Dr. Peter Okaalet, Samuel Irungu, Norman L. Olsen, and Charles Serwanja
- Element of IRCU: Member of IRCU
- **Date/Time/Location:** April 30, 2013, at 3:00pm, Mityana
- Participants:
    1. Pr. Joseph Mbabaali, District Leader
    2. Paul Kigozi, Chairperson LC-1
    3. Julius Makubyya, Counselor
    4. Keith Kyasa Mulumba, Counselor
    5. Aip Mumbere John Lombo
    6. Cissy Mulado
    7. Paul Kyeyune
    8. Isaac Mulindwa
    9. Pr. John Happy
    10. Robert Mugabe
    11. Olivia Nnalongo Sekamatte
    12. Sarah Kirabira
    13. Jotham Kyeyune
    14. Tamali Ssimbwa
    15. Kititula Wilson

a) What are the actual and potential strengths of the IRCU?

- IRCU considers this SDA location as one of its top performers. The interview tended to confirm this view. SDA/Mityana has a very favorable view of IRCU, crediting IRCU with empowering religious leaders to become actively and effectively involved in the prevention and treatment program. This takes advantage of the trust the local people have in the religious leaders. The church based approach fits the local culture in which the church is a focal point of community activity not only on Saturday and Sunday but also throughout the week.

b) **How effectively has IRCU mobilized those strengths?**

- SDA/Mityana has an effective outreach program. Present at the meeting were the Chief of Police, Hospital Coordinator for HIV/AIDS prevention, Radio program director, and GOU representative. The rest were SDA officials involved with the HIV/AIDS program. They described the program as Fellowship, Service, and Security.
- SDA refers patients to the hospital for services SDA does not provide. The prevalence rate in Mityana is 6.7 %. Described as high by the SDA/Mityana team. Pointed out this is lower than the national average, the SDA/Mityana team explained that because they are on a major transport route they think of their community as high risk. The dance clubs and tea houses attract both commercial sex workers and truck drivers.
- Interestingly, in August 2012 in a test of over 200 persons, only one tested positive. The SDA religious leaders candidly stated they are confident there are a number of HIV positive persons in their congregation.
- The SDA/Mityana follows an open admission policy. Key messages are repeated every Sabbath. There are also special services for HIV/AIDs. An ABC program specifically targets school children. Youth, Family Life, and Pathfinder programs also actively promote prevention. The representative of the local high school stated the program is popular with students. Prime radio holds two programs per week on HIV/AIDS. In one call-in show, the woman stated she was extremely happy that her husband was tested because it showed his love for her. (Hopefully

this can have a demonstration effect similar to husbands accompanying their wives to the hospital for testing.)

- Pre marriage and post marriage counseling through the Family Life program. The two pastors had differing views concerning the marriage of discordant couples. One would not marry such couples; the other would seek outside counsel. Practically the issue has not yet presented.
- All of this is reported to IRCU monthly, both electronically and through hard copy. (Check in combination with latest DQA). The budget is 8$Ush over five years. Inflation is a problem. Occasionally SDA/Mityana has failed to meet its targets because of budget constraints.

c) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

- SDA/Mityana would like a modem for its computer. Condom quality is also an issue. In terms of future programs, SDA/Mityana would increase emphasis on prevention by emphasizing testing. There was some support for obligatory testing. Supplying of bicycles is a positive step.

Summary

The SDA/Mityana program seems like a potential model program involving a comprehensive approach embracing the local religious culture and welcoming all ethnic groups. The network with local facilities and structures is positive even though the hospital may have significant performance deficiencies.

4. FOCUS GROUP DISCUSSION WITH CLIENTS OF FAMILY CONCEPT CENTRE, IGANGA

- **Interviewers:** Dr. Peter Okaalet, Samuel Irungu, Norman L Olsen, and Charles Serwanja
- **Element of IRCU:** Partner, youth-focused
- **Date and time:** 25th April 2013
- Persons Interviewed:

	Name	Position
1.	Asio Agnes	Tailoring
2.	Deborah Waiswa	Farmer
3.	Afuwah Mutesi	Teacher
4.	Hassan Kakande	Imam
5.	Juweria Kagoya	Business Lady
6.	Esther Nyanzi	Farmer
7.	Rehema Nakagolo	Farmer
8.	Enid Kyaligonza	Saloon & Hair dresser
9.	Kagoya Winnie	Tailoring
10.	Loy Kauma	Tailoring
11.	Afuwah Nakagolo	Saloon & Hair dresser
12.	Nasaba Namuwaya	Farmer
13.	Sophia Kameri	Restaurant attendant
14.	Rehema Nangobi	Farmer
15.	Fauzah Mutesi	Farmer
16.	Robinah Nabirye	Business Lady
17.	Sarah Babirye	Center Manager
18.	Simon Balondemu	Social Worker
19.	Beatrice	Counselor

a) **Background and Function of the Centre, as presented by the Center Manager**

- The Center was established in 2006 with the help of IRCU. It serves youth, both In-School Youths, and Out of School Youth. To date, the Center has trained 520 Youths. About 330 of them received 'Kits' containing the basic tools necessary to start their careers.
- Services provided at the Family Centre Clinic include:
  - (i) Training – on OVC, IGAs, Strategic Plan Development, Vocational Skills, Life Planning, BCC…
  - (ii) Other businesses: Running Groceries, Selling Foodstuffs and Bananas, Brick laying,
  - (iii) Working with the Children – Health care and medication, addressing Stigma
  - (iv) Partnership with The Islamic Medical Centre – via Referral of patients.

b) Focus Group Discussion with the Women Caregivers

Please see list of names of the Women Caregivers above who attended the meeting.

The Women Caregivers were very appreciative of IRCU and its role.

Issues for IRCU to address:

- Burden of paying School Fees for their children and supporting the OVC is heavy on them.
- The women proposed that IRCU assist the FCC to establish a Clinic for treating OVC Referring the clients to other centers is expensive.
- Churches and Mosques to support RL more, so that the RL can support them and OVC, more.

c) ISLAMIC MEDICAL CLINIC - (part of the overall establishment)

N.B.: We met with Charles Mabandha, a Data Clerk at The Medical Clinic.

- The Medical Clinic has been receiving regular medical supplies.
- IRCU partners with the Joint Medical Stores (JMS) to support them.
- They see at up to 60 Clients per day; about 800 Clients per month.
- SMC: About 25-50 Male circumcisions per month.
- Laboratory Services: The Clinic partners with Buluba Hospital – who test their samples for them.

5. FOCUS GROUP DISCUSSION WITH KIMASA CAREGIVERS GROUP, JINJA OVCs PROGRAM

- Interviewers: Norman L Olsen and Samuel Irungu
- **Element of IRCU:** OVC site outside of Jinja
- **Date/Time/Location:** April 26, 2013, 10:30am, Jinja
- Persons Interviewed:

	NAME	VILLAGE
1.	Haruna Wamange (Vice Chairperson)	Kitovu
2.	Halidi Masuba	Kitovu
3.	Elizabeth Naigulu	Makenke
4.	Betty Achayo	Makenke
5.	Layet Selepina	Makenke
6.	Zaituni Igita	Makenke
7.	David Opio	Makenke
8.	Sauda Mahadi	Makenke
9.	Eva Nabirye	Makenke
10.	Florence Nakagolo	Makenke
11.	Margret Auma	Makenke
12.	Ashe Apai	Makenke
13.	Nasaba Kyazike	Makenke

a) Description of the Focus Group

- There are twelve women in the group. Most are OVC graduates. Many of the OVC are refugees from northern Uganda who have taken on the responsibility of caring for the orphans as well as their own children. The advantage is that both groups of children receive some help – either directly or indirectly. Approximately 120 of the children are OVC. The former occupants of the homesteads abandoned much of the land during various conflicts. The refugee families are squatting on the land and farming it. Title to the land is in many cases unclear.

b) What are the actual and potential strengths of the IRCU? How effectively has IRCU mobilized those strengths?

- IRCU support to the church provides support to approximately 120 OVC. A typical OVC family unit is a widowed or abandoned woman, with from 6 to 9 biological children and from one to three orphans. IRCU provides school fees, exercise books, uniforms, other materials and shoes. (Note: at a previous OVC facility, school fees were not provided.) Generally, the children are not performing well in school.
- A service to children work ethic, and the material benefits for their children motivate the caregivers. They do provide hope. Five of the women have started businesses, primarily fruit/vegetable sales. All stated because of the IRCU business training, they have increased their income. They have also opened saving accounts with local banks. The IRCU startup kits were very helpful to the women.

c) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

- In a difficult local situation, the Diocese has done very well in providing a means for refugees to graduate from that status and, while still desperately poor, the former refugees are basically self-supporting.

Summary

The OVC and their support families face very difficult situations but they seem to be coping well with the challenges. They are very grateful for the support. Under the circumstances, their success as businesswomen in the informal sector is a highly positive achievement

6. FOCUS GROUP DISCUSSION WITH CLIENTS OF IGANGA MUSLIM DISTRICT HIV PREVENTION PROJECT

- **Interviewers:** Dr. Peter Okaalet , Samuel Irungu, and Norman L. Olsen
- **Element of IRCU:** Caregivers to OVC
- **Date/Time/Location:** 25th April, 2013, 10:30am, Iganga
- Person(s) interviewed:
  - A group of 12 women and 4 OVC graduates. All female.

a) **Description of this Focus Group**

- A group of 12 women and 4 OVC graduates. All female. While this is a Muslim facility the dress of the majority of women suggested they are Christian. The women were mothers generally taking care of from four to six of their own children and two to three OVC. They are able to feed all of the children but without exception are struggling to make school fees. In turn the children are struggling in school, needing to repeat years because of poor grades.
- The stated motivation of the women in becoming caregivers was the desire to help children in need. They appreciate the opportunity, and greatly appreciate the support of USAID and IRCU.
- The main concern of the women in choosing a health facility is cost. All facilities cost, and all are viewed of similar quality. None of the women are able to afford a referral hospital. The availability of medicine and medical staff is the critical factor.
- The Iganga OVC program seemed well run. We toured the facility especially looking at the job training programs (tailoring, baking, and hairdressing). The children in the program, almost all girls, put on an enthusiastic and entertaining dance program. The head mistress said over 500 children had been through the program. Regrettably, she does not keep gender statistics. Nor is she able to comprehensively follow up on the job placement.
- Especially noteworthy were the four OVC graduate successes. They had all found jobs, three in tailoring, one in hairdressing. While none admitted to making much money (we avoided probing how much) all seemed to be self-supporting and happy with themselves.

Summary

The OVC program is working for this community. The children get training and a startup kit. At least some obtain employment and income. Our suspicion is the percentage getting employment is modest, probably around 25%. But, for orphans who in many cases also seem to be refugees from the north, this represents hope, a vital and rare commodity.

b) How effectively has IRCU mobilized those strengths?

- Organized Religious Leaders under one umbrella
- Introduced programs that they did not have before, such as on Gender Based Violence, Peace and Reconciliation, HIV/AIDS
- Respect for the faith groups – Not proselytizing
- Partnering with the GOU through the MOH, to reach out to Faith communities utilizing their structures
- IRCU is the "Good Samaritan" to the FBOs that were 'left by the roadside'…!

c) How has the IRCU contributed to the overall HIV/AIDS program in Uganda?

- Channeled funding from USAID to the Implementing Partners. Their budget is approximately 99 Million for five years
- Supported them to develop proposals, Work plans, and to enhance Standards
- Supervision and evaluation of the FBOs and IPs

- Provided equipment to IPs: Bicycles, computers, and Mosquito Nets
- Capacity building of staff at the Health Centre, thereby bringing them to the same footing as compared to the Christian FBOs
- Besides the Iganga Medical Center, they have opened and were assisted to equip two other centers – Kiwanyi and Budhani.
- Safe Male Circumcision now preferred… Done by Trained Circumcisers. The healing is faster, and it is free. The pain is much less. It is accompanied by counseling.
- Integrated Services – Reproductive Health and Family Planning

Sheik Omar himself has benefited from IRCU through Training in Project Management.

- He has attended Annual Conferences organized by IRCU
- Has assisted in counseling others, and pointed them to biomedical approaches.
- He now can link Scriptures (*Suras*) to HIV messaging
- Counteracting cultural myths surrounding HIV and AIDS
- He has trained 60 Muslim Youths and 50 Religious leaders on HIV/AIDS
- A member of Iganga District Health Committee
- A strong advocate for IRCU and promoter of the Role of FBOs in Healthcare.

d) Recommendations and Way Forward?

- They need more support to reach out to many in Iganga. The town is located on the Mombasa-Kigali Highway. Number of new infections continues to rise!
- Biomedical approaches being received well. But challenge is on human resource limitations to roll out the programs
- Need to do better with respect to the Biomedical strategy
- Assist them with Resources Mobilization
- Need to strengthen Inter-faith Committees at national, district and grassroots levels
- Is it possible to open Regional Health facilities run by IRCU?

ANNEX 3. COMPARISON OF IRCU PERFORFOMANCE AGAINST TARGETS

ON HCT AND MMC FOR THE 19 SITES – JANUARY TO MARCH 2013

	Name of Site	HCT Target	Actual	HCT % Actual	MMC Target	Actual	MMC % Actual	Comments and Challenges cited
1.	AIDS Orphans Education Trust	10,793	861	8%	25	25	100%	Transport, Stockouts, Weather, Funds for HCT delayed
2.	St. Francis Hospital Buluba	No target	2,159	-	144	37	25%	Space a challenge, Competition and outreaches not approved
3.	Holy Cross Hospital	1750	473	27%	12	86	716%	HCT: Claim to have reached 1,333
4.	Iganga Islamic Medical Center	5,706	2,358	41%	66	52	79%	Ran out of testing kits
5.	Islamic Medical Association of Uganda	1,700	823	48%	60	117	195%	Numbers segregated by occupation
6.	Ishaka SDA Hospital	No target	721		120	95	79%	Great work despite limited space
7.	Diocese of Kampala CoU	600	1,002	167%	23	30	76%	HCT equipment destroyed by fire not replaced
8.	Kisiizi Hospital CoU	No target	2,172	-	225	210	93%	Community

								mobilizers not motivated hence low mobilizatio n

	Name of Site	HCT Target	Actual	HCT % Actual	MMC Target	Actual	MMC % Actual	Comments and Challenges cited
9.	Kiwoko CoU Hospital	No target	1,124	-	188	277	147%	Delay in funds disbursements; Rainy season
10.	Kuluva CoU Hospital	No Target	2,050	-	1123	75	6%	Inadequate number of testing kits, target (unstated) never met
11.	Kumi Hospital	3,984	1,610	44.7%	180	13	7%	Funds received late and competition; Hard to reach areas
12.	Kyetume Community Based Health Care prog	No target	1,872	-	10	142	1420 %	HCT number reached increased by 18% from previous quarter
13.	Lyantonde Muslim H.C.	900	1,266	143%	50	72	144%	Overshot the targets
14.	Meeting Point Kampala	6248	3,522	56%	10	51	510%	Ran out of testing kits and shortage of staff
15.	Meeting Point Kitgum	600	814	135%	200	293	146%	Fuel for transport a challenge
16.	Mengo Hospital	11761	3,691	31%	846		26%	Funds not available for outreaches and scale up
17.	Holy Family Hospital Nyapea	1000	439	44%	15	24	160%	Few Lab assistants; Stockouts

18.	St. Francis H.C Njeru	5,084	1,333	26%				HCT: Stockout of test kits /reagents; lack of logistics to facilitate MMC
19	St Luke's Health Center Namaliga	2,754	3,003	109%	27	33	122%	No challenges sighted

The above table presents a summary of analysis of two randomly selected activities namely: HCT services for first timers and MMC. It is noted that the hospitals' performance against set targets was generally lower compared with the rest. Several challenges to explain this situation have been cited. They include delays in remittances of funds, shortage of testing kits and inadequate staffing. Competition by other health providers was also mentioned.

In addition to these observations, we note a number of reporting issues, thus:

1. On HCT, the activity is: Adult HIV Counseling and Testing (HCT). All reported more to include couples and children
2. Differences on reporting: At IMAU, for example, they refer to couples as individuals. This was not the case with all the others.
3. While many of the 19 sites indicate targets, others had none. The hospitals seem not to have recorded the targets!
4. One site reported cumulative data to include 2^{nd}. 3^{rd}. and 4^{th}. Testers although the activity reporting was on first timers.

Therefore, there is need to address these reporting issues. The IRCU partners will require further capacity building through mentoring and coaching. This will add value to the quality of the reports and make them more accurate.