“IMPROVED KNOWLEDGE AND AWARENESS OF HEALTH, HIV, EDUCATION RIGHTS AND CHOICE FOR DEAF PEOPLE IN UGANDA” - GREATER MASAKA AND ARUA DISTRICTS

END-OF-PROJECT EVALUATION REPORT (DRAFT 1)

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Table of Contents

List of tables and figures .................................................................................................................. 6
Executive Summary .......................................................................................................................... 7
1.0 INTRODUCTION ......................................................................................................................... 10
1.1 Background .................................................................................................................................. 10
1.1.1 About Sign health Uganda ........................................................................................................ 10
1.1.2 Signal, UK .................................................................................................................................... 10
1.2 Project Background ...................................................................................................................... 10
1.3 End of project evaluation ............................................................................................................. 11
1.3.1 Final evaluation goal and objectives ....................................................................................... 11
1.3.2 The key evaluation questions ................................................................................................... 11
1.3.3 Evaluation Scope ...................................................................................................................... 12
2.0 METHODOLOGY ......................................................................................................................... 13
2.1 SAMPLING AND DETERMINATION OF RESPONDENTS ............................................................. 13
2.2 Data collection methods used ..................................................................................................... 14
2.2.1 Individual deaf/Hearing Impaired children/young people interviews ...................................... 14
2.2.2 Key informants ....................................................................................................................... 14
2.2.3 Focus Group discussions ......................................................................................................... 15
   FGD with deaf children out of school in Dadamu sub-county, Arua district. .................................. 15
2.3 Planning and implementation of the final project evaluation exercise ........................................ 15
2.3.1 Evaluation tools preparation .................................................................................................... 15
2.3.2 Evaluation team and field work preparation .......................................................................... 16
2.4. Respondents’ mobilization ........................................................................................................ 16
2.4.1 Mobilization of respondents .................................................................................................... 16
2.5 Data Processing and Analysis ..................................................................................................... 16
3.0 EVALUATION FINDINGS ......................................................................................................... 17
3.1 Project relevance........................................................................................................................................ 17
3.2 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS ......................................................... 18
  3.2.1 Main Source of Household Income ................................................................................................. 18
  3.2.2 Education level of Household head .................................................................................................. 19
  3.2.3 Sex of HICs sampled ....................................................................................................................... 20
  3.2.4 Representation of age group and sex among sampled children ..................................................... 21
  3.2.5 Extent of hearing difficulty among sampled children ...................................................................... 21
3.3 PROJECT EFFECTIVENESS .................................................................................................................. 22
  3.3.1 Performance on outputs .................................................................................................................. 22
  3.3.2 Performance on Outcomes ............................................................................................................... 26
    ✓ Enrollment of deaf children and HICs in school .................................................................................... 26
    ✓ Regularity of participating deaf children and young people attending primary school ................. 27
    ✓ HIV Knowledge access by HICs/Deaf young people .......................................................................... 30
    ✓ Awareness on HIV prevention among HICs ....................................................................................... 31
    ✓ Awareness of HIV transmission modes by sex .................................................................................. 32
    ✓ Deaf children and young people who report improved communication within their family .......... 34
    ✓ Deaf children and young people who correctly identify their education and health rights .......... 35
    ✓ Other actors in the disability sector helping children with disabilities ............................................. 36
3.4 Value for money (vfm) considerations .................................................................................................... 36
3.5 Assessment of project impact ................................................................................................................ 38
  Case Stories ............................................................................................................................................... 39
    Case 1: Kizito up in the limelight .......................................................................................................... 39
    Case 2: Parents as magical change agents ............................................................................................ 40
    Case 3: Signal Project saved my life ....................................................................................................... 41
3.5 Sustainability ........................................................................................................................................... 42
4.0 Implementation gaps and Challenges ..................................................................................................... 43
5.0 Lesions learnt ................................................................. 43
6. Concussions ................................................................. 44
Conclusion ........................................................................ 44
Recommendations ................................................................ 44
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>CAO</td>
<td>Chief Administrative Officer</td>
</tr>
<tr>
<td>CBR</td>
<td>Community Based Rehabilitation</td>
</tr>
<tr>
<td>CDO</td>
<td>Community development Officer</td>
</tr>
<tr>
<td>CRPD</td>
<td>Convention on the Rights of People with Disabilities</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>DC</td>
<td>Deaf Children</td>
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<tr>
<td>DCDO</td>
<td>District Community development Officer</td>
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<tr>
<td>DEO</td>
<td>District education Officer</td>
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<tr>
<td>DPO</td>
<td>Disabled People’s Organisation</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>HICs</td>
<td>Hearing Impaired Children</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune Virus</td>
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<td>LQAS</td>
<td>Lot Quality Assurance sampling methodology</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MGLSD</td>
<td>Ministry of Gender, Labour and Social Development</td>
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<td>MoES</td>
<td>Ministry of Education and Sports</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>NCD</td>
<td>National Council for Disability</td>
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<tr>
<td>NDP</td>
<td>National Development Plan</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
</tr>
<tr>
<td>NUDIPU</td>
<td>National Union of Disabled Persons of Uganda</td>
</tr>
<tr>
<td>PTA</td>
<td>Parents &amp; Teachers Association</td>
</tr>
<tr>
<td>PWD</td>
<td>Person(s) with disabilities</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>SNE</td>
<td>Special needs education</td>
</tr>
<tr>
<td>UBOS</td>
<td>Uganda Bureau of Statistics</td>
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<tr>
<td>UNAD</td>
<td>Uganda National Association of the Deaf</td>
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</tbody>
</table>
List of tables and figures
Executive Summary

1.0 Introduction
This is a final evaluation report of the “Improved knowledge and awareness of health, HIV, education rights and choices for deaf people in Uganda” project implemented in 2015-2018 in Greater Masaka (Central Uganda) and Arua (Northern Uganda). The project focused on peer support training to empower deaf children and young people with improved communication, self-worth, access to rights-based information (education and HIV/AIDS) and engagement with advocacy networks. The project worked directly with the children, young people, their families, community leaders, teachers and local and national stakeholders. The primary objective was to evaluate project relevance, effectiveness, efficiency, impact, sustainability and learning of the project. ie the extent to which Signal achieved its project goal and objectives. In light of this, the evaluation assessed implementation since its inception, focusing on what can be learned from Signal’s approach and which direction(s) future programming on deafness and rights might pursue.

2.0 Evaluation methodology
A participatory approach that involved both quantitative and qualitative methods was used to generate the information required for evaluation. In addition evaluation study methodology utilized both primary and secondary sources of data. The data collection methods used include; i) Individual deaf children/HICs and young people structured interviews. Lot Quality Assurance (LQAS) methodology was used to determine the sample size of respondents. ii) Key informant Interviews mainly for head teachers, focal teachers, parents of deaf children/HICs, health workers, district officials (CDO and DEO), local leaders, leaders of DPOs among others were interviewed. iii) Focus group discussions were also used among the deaf children/HICs in school and those out of school as well as peer leaders. All these methods sufficiently provided the required information for the final evaluation.

3.0 Key Evaluation Findings
The findings of this evaluation clearly document project relevance, effectiveness, efficiency, impact, sustainability and learning of the project as follows; The overall performance on output achievement has been outstanding scoring more than 100% on most targets.

Relevance
The project is relevant since it sought to achieve success by fostering health and education rights (Sustainable development Goal 4) and be part of the global development agenda. This project was also response DFID Global Poverty Action Fund (GPAF) meeting three of the priority areas of focus of disability, education and literacy and HIV and AIDS. The fact that deafness and hearing impairment among children was found to be an inhibiting factor to the progress, this project was appropriate and relevant to the needs of young children with hearing problems.
Effectiveness
The overall performance on output achievement was outstanding scoring more than 100% on most targets. This is attributed to a number of factors according to implementing teams; most outstanding being: Cooperation of stakeholders – Skill and competence of implementing agency- Signhealth Uganda. Cooperation of local governments that provided office space (Masaka) and technical staff providing input and mobilising communities for participating in the project. Timely and quality technical and financial support to the project. Both DFID and Signal provided the required support to the local implementing partner that facilitated achievement of planned outputs. In addition project outcomes were well achieved since the attitudes among teachers, health workers and parents have positively changed and they now support deaf children and HICs. Among the other key outcomes is the increase in awareness of HIV transmission and prevention among different age groups and improved communication.

Efficiency
The evaluation found out that a number of strategies to achieve value for money were employed which include; use of volunteers, partnering with LG technical teams and competitive bidding among others.

4.0 Conclusion
The project has greatly achieved the intended objectives. The deaf young people are now very equipped to protect themselves against HIV and are already linked with other service providers. The misconception among parents, health workers and teachers about disability, like relating disability to witchcraft, that hitherto was barrier to HICs accessing services has been greatly removed. The project was well structured that it involved a spectrum of participants (stakeholders) in education, health; administration and community that help the project achieve outstanding results.

There are however, still gaps in knowledge levels among parents, service providers and policy in understanding disability that require continued efforts by existing structures to eliminate.

5.0 Recommendations

i) Given the poverty levels among Children with disabilities’ families, economic empowerment component of a programme like this one would be paramount for consideration in future projects.

ii) Considering a general data and information gap existing on disability future projects should consider generating clear disaggregated data on disability in project targeted districts to ease the monitoring and evaluation framework.
iii) Advocacy as a component or thematic area in such project should be well structured to generate advocacy issues and actions expected from duty barriers to eliminate some of the policy gaps that if corrected would yield long lasting improvements in service delivery for children and young people with hearing challenges.

iv) The monitoring and evaluation framework should always endeavour to provide for how project progress and reporting shall be shared. This should be annual reports, midterm reviews and final evaluation. Annual reports need to be synthesized and posted on organisational website, final evaluation report shared with implementing partners at district level (within budget constraints) and final report posted on the website of implementing partners.
1.0 INTRODUCTION

1.1 Background

According to 2005 estimates by the World Health Organization, 278 million people worldwide have moderate to profound hearing loss in both ears. In Uganda, more than 1,080,000 people are Deaf (UBOS 2014). 90% of deaf people in East and Central Uganda have never been to school. They live in absolute poverty, powerless, isolated and voice less. As a result, they are not employed, have no access to information and limited access to social and economic services (UNAD, 2012).

Uganda is currently ranked joint 163 out of 188 in the 2016 UN Human Development and is a signatory to both Education for All and the Convention on the Rights of Persons with Disabilities. Whilst huge strides were made towards reaching the MDGs in education, the pace of progress was not sufficient to enable all Ugandan children to enrol and complete a full primary education. For children with special education needs the situation is worse. It is estimated that around 65% of deaf children fail to access primary education, and hearing children are statistically still four times more likely to attend school than deaf children.

To reverse the above, signal UK, designed interventions following holistic approach to tackling the various barriers affecting deaf and hearing impaired children and young people face in accessing education, linking: the identification of deaf and hearing impaired children; community awareness training; training and support for deaf and hearing impaired children and their families; and a range of skills based teacher training on inclusive education and deaf awareness training to service providers. These interventions were implemented in partnership with Signhealth Uganda.

1.1.1 About Sign health Uganda

Signhealth Uganda is a locally registered NGO set up in 2009 to promote equitable access to social services and opportunities for deaf people and their families in Uganda through advocacy and partnership for cost effective and sustainable services. They have offices in Kampala, Masaka and Arua and are the implementing partner for all Signal’s work in Uganda.

1.1.2 Signal, UK

Signal (formerly the Woodford Foundation) is a UK charity working to empower people with hearing loss in the UK and overseas. Our vision is a world where people who have a sensory impairment are full and active members of their families, communities and societies, and where they are free to make choices about their own lives. Overseas we work in Malawi, Uganda, Tanzania and Zambia and in the UK in Shropshire.

1.2 Project Background

Signal, UK in partnership with Signhealth Uganda implemented a 36-month, UK AID-funded project, “Improved knowledge and awareness of health, HIV, education rights and choices...
“for deaf people in Uganda”. The project focused on peer support training to empower deaf children and young people with improved communication, self-worth, access to rights-based information (education and HIV/AIDS) and engagement with advocacy networks. The project worked directly with the children, young people, their families, community leaders, teachers and local and national stakeholders.

1.3 End of project evaluation

Following the implementation of the project that ended 31st August 2107, Signal, UK and Signhealth Uganda independently verified record of achievement and assess the extent to which the project achieved good value for money. The final evaluation focused on Masaka, Central Uganda and Arua, Northern Uganda. The key target groups were 3750 deaf young men, women, girls and boys, deaf and hearing impaired children and young people both in and outside the formal education system; their parents and guardians; mainstream teachers and head teachers and other education staff; community representatives (community leaders) and health workers in Arua and greater Masaka districts.

1.3.1 Final evaluation goal and objectives

As presented in the Terms of Reference (ToRs) for this final evaluation, the primary objective was to evaluate project relevance, effectiveness, efficiency, impact, sustainability and learning of the project. I.e the extent to which Signal achieved its project goal and objectives, the results of the project, assess the effectiveness of the project. In light of this, the evaluation assesses implementation since its inception, focusing on what can be learned from Signal’s approach and which direction(s) future programming on deafness and rights might pursue.

1.3.2 The key evaluation questions

Accordingly, the final evaluation sought to answer the following questions;

✓ Relevance
  • To what extent did the grantee support achievement towards the international, partner and national dev’t goals?
  • In which way were key beneficiaries involved in the design of the project?
  • How well did the project respond to the needs of the target beneficiaries, including how these needs evolved over time?

✓ Effectiveness
  • To what extent have the targets set (outputs and outcomes) in the project log frame met?
  • To what extent is the results that are reported a fair and accurate record of achievement?
  • What has happened because of DfID funding that wouldn’t have otherwise happened; and
  • To what extent has the project used learning to improve delivery?
  • What are the key drivers and barriers affecting the delivery of results for the project?
• What is the level of satisfaction from the perspective of families and communities and the degree with which the outputs/outcomes have met community interests and priorities?
• What notable changes (including attitudes and behaviors), if any, have occurred in the lives of girls, their families and communities during the project period?
  ✓ Efficiency
• To what extent has the project delivered results that are value for money- applying value for money principles of economy and efficiency in relation to delivery of its outcome?
• To what extent did the grantee deliver results on time and on budget against agreed plans?
• To what extent did the project understand cost drivers and manage these in relation to performance requirements?
  ✓ Impact
• What changes and benefits have the project brought to targeted beneficiaries?
• To what extent and how has the project built the capacity of civil society?
• How many people are receiving support from the project that otherwise would not have received support?
• To what extent and how has the project affected people in ways that were not originally intended?
• Has the voice of the deaf children/young person been heard
  ✓ Sustainability
• What structures, capacity of beneficiaries, knowledge and skills has the project put in place that can support continuation of project benefits?
• Are there existing constraints that cause beneficiaries not to fully transform inspite of the existing strategies
  ✓ Learning
• What evidence is available to suggest internal learning, and adaptation and continuous improvement?
• What are the most valued good practices?
• How is M & E information that is generated input into improving project processes?
• What key advice would you give for future programming on capacity development and knowledge sharing on deaf rights and health and education rights awareness in Uganda.

1.3.3 Evaluation Scope
The final evaluation took place in both urban and rural Masaka, Central Uganda and Arua, Northern District. The key target groups were deaf and hearing impaired children and young people both in and outside the formal education system; their parents and guardians; mainstream/focal teachers and head teachers; community representatives, district officials in these districts. Other key stakeholders include other disability organisations and local government officers within Masaka and Arua District’s.
2.0 METHODOLOGY

A participatory approach that involved both quantitative and qualitative methods was used to generate the baseline data and information. Triangulation of methods was adopted which involved comparing information from different sources, such as documentation and interviews, or interviews on the same subject with different respondents/stakeholders; this was used to corroborate and check the reliability of findings. That said, the evaluation study methodology utilized both primary and secondary sources of data.

2.1 SAMPLING AND DETERMINATION OF RESPONDENTS

A mix of sampling techniques was used in coming up with the required number of respondents for this evaluation. The consultant used purposeful sampling for example of sub-counties of study since they are already predetermined. Random sampling also is used for example in getting participants in FGDs and deaf children and young people. The consultant used Lot quality Assurance sampling in determining number respondents.

2.2.1 Deaf/ hearing impaired children and young people sample size determination

To generate the required statistical sample size of deaf/hearing impaired children/young people in the evaluation area (Masaka and Arua Districts), the consultant hereby proposes to use Lot Quality Assurance sampling (LQAS) methodology. LQAS sampling methodology uses a small sample of 19 respondents per supervision area that provides an acceptable level of error for making management decisions. It has been proven that samples larger than 19 do not practically have better statistical precision than 19 therefore they do not result in better information, and instead they cost more. This method is the most appropriate for studies that target population samples of similar characteristics like pregnant mothers, children under 5 years, children with disabilities; data collected from a sample of 19 will be representative for 1000 population.

Using LQAS sampling methodology therefore each sub-county was mapped as a sampling area. This means data collection will take place in 11 sub counties and spread in all the parishes of that sub-county. In each sub-county 19 deaf child(n) and young people as well as hearing impaired children and young people. This therefore implies that a total of 209 (19x11) households will be interviewed across the 11 sub counties. Where a sampling area has less than 19 of the targeted respondents, all the eligible respondents found are interviewed.

To further minimize the non-response error the consultant added 1 respondent to the sample size of 19 implies that 220 household respondents were interviewed in the two districts.

Note 1: Where possible, a ratio of 1:1 boys to girls was taken in selection of respondents because of gender considerations.
Table 1: Sub-counties where data collection took place and sample size

<table>
<thead>
<tr>
<th>Sub-county</th>
<th>District</th>
<th>No of sampled deaf/HI children using LQAS and additional 1 respondent catering for non-response error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lukaya</td>
<td>Kalungu</td>
<td>20</td>
</tr>
<tr>
<td>Butenga</td>
<td>Bukomansimbi</td>
<td>20</td>
</tr>
<tr>
<td>Mukungwe</td>
<td>Masaka</td>
<td>20</td>
</tr>
<tr>
<td>Kimanya/Kyabakuza</td>
<td>Masaka</td>
<td>20</td>
</tr>
<tr>
<td>Lwanda</td>
<td>Rakai</td>
<td>20</td>
</tr>
<tr>
<td>Lwengo</td>
<td>Lwengo</td>
<td>20</td>
</tr>
<tr>
<td>Aroi, Arua</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Dadamu, Arua</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Vurra, Arua</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Pajulu, Arua</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Adumi, Arua</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>220</td>
</tr>
</tbody>
</table>

2.2 Data collection methods used

2.2.1 Individual deaf/Hearing Impaired children/young people interviews

Individual structured interviews that involved responding to questionnaire was conducted. This questionnaire was administered to deaf/Hearing Impaired children/young people on issues of disability, health awareness, HIV/AIDs, education rights and other cross cutting issues.

In selecting individual respondents, care was taken to ensure a balanced ratio of boys to girls in selection of respondents because of gender considerations. Also the interviews included deaf/hearing impaired young people.

2.2.2 Key informants

To ascertain information regarding the extent to which the project achieved its objectives, key informant interviews were conducted. Based on the information requirements and scope of study covering individual deaf/hearing impaired children and young people, Community, school, health centres and policy levels; selection of respondents was guided by purposive sampling at each of the selected public primary schools. From each Sub County, one public / government aided schools were visited and data relating to deaf/hearing impaired children was collected and documented. A focal teacher in charge of special needs education and Head teacher were interviewed from each school. A total of 18 schools were visited and
children interviewed in both Arua and Masaka districts. These schools were selected in consultation with the field officers from Arua and Masaka districts. At the health centers, the in charge or the focal health worker for this project was interviewed. Thus, a total of 8 health workers (4 in Arua and 4 in Masaka) were interviewed. At sub county level, councilor for Peoples with Disabilities and head of community based services/DCDO and DEO at the district level were interviewed.

2.2.3 Focus Group discussions

Community (parents/guardians of deaf Children and young people /hearing impaired children) focus group discussions were conducted from each sub county with each group constituting 8-12 members. Focus group discussions for children were conducted among the sampled four (4) sub-counties (2 in Arua and 2 in Masaka). In addition, 4 FGDs for deaf young people were also conducted in communities (2 in Arua and 2 in Masaka) as well as 4 FGDs for deaf/hearing impaired children in school.

FGD with deaf children out of school in Dadamu sub-county, Arua district.

2.3 Planning and implementation of the final project evaluation exercise

Planning and implementation of the final evaluation had several activities including preparation of inception report, evaluation team preparation and respondents mobilization for field data collection.

2.3.1 Evaluation tools preparation

To collect all the relevant information using the different methods as stated in the, a number of tools were formulated for the purpose. The tools formulated were mainly used to collect primary data. These included:
i) Individual Questionnaire of deaf/hearing impaired Child/young person.
ii) Key Informant Guide District officials (DCDO and DEO)
iii) Key Informant Guide for Counselors for People with disabilities
iv) Key Informant Guide for NGOs/DPOs in the area
v) Head teacher’s Interview guide
vi) Focal teacher Interview guide
vii) Deaf/Hearing impaired Children in school FGD guide
viii) Deaf/hearing impaired young people (out of school) - FGD guide
ix) FGD guide for Parents of deaf/hearing impaired Children and young people

2.3.2 Evaluation team and field work preparation
A team of 8 people comprising of two consultants supervising the team and 6 Data collection assistants was assembled for the evaluation exercise. Two of the six assistants were experts in sign language interpretation. The team had two days of training in data collection & interviewing techniques, interpersonal relations, creating rapport, child protection policy and disability issues.
In addition, the evaluation was divided into two teams. One team was assigned to go to Masaka and another team went to Arua. Data collection was done simultaneously.

2.4. Respondents’ mobilization

2.4.1 Mobilization of respondents
Mobilization of the respondents was assisted by the field team who alerted and mobilized the targeted respondents. Therefore getting all the needed respondents was forthcoming.

2.5 Data Processing and Analysis
Data entry was done using SPSS computer software and data analysis was done using both SPSS and Excel. Frequency, percentage and cross tabulation statistics were used to develop the aspects related to health awareness, education rights in Arua and Masaka districts. As part of quality control, it started with training the Research assistants to ensure skills in interviewing and questionnaire filling were not in doubt. Each day after the field work, supervisors would go through the filled questionnaires to ensure that all questions have been responded to and filled and consistence of responses. At data entry stage, filled questionnaires were numbered sequentially to avoid a questionnaire being entered twice. A few cross tabulations were run to check consistence and logic to avoid conflicting relationships in data and where found it would be corrected there and then.
3.0 EVALUATION FINDINGS
This chapter provides the analysis of the levels of achievements of the program outputs and outcomes using the standard evaluation criteria of relevance, efficiency, effectiveness and sustainability. The analysis discussion is guided by the questions presented in the terms of reference for each of the criterion. It covered a few respondents’ demographics that are deemed to have direct bearing on exposure and attitudinal influence on people in their environments. These are sex of respondent, education level of household head, occupation of household head and availability of parents which have bearing on vulnerability.

3.1 Project relevance
Project relevance was contextually looked on how it contributes to the 2015 Millennium development Goals (2,3 &5 MDGs), Sustainable development goals, and alignment to DFID strategy, how well it targeted beneficiaries, stakeholder involvement and disability policy environment.

The project sought to achieve success by fostering health and education rights (Millennium development Goal 4) and be part of the global development agenda. This project was also response DFID Global Poverty Acton Fund (GPAF) meeting three of the priority areas of focus of disability, education and literacy and HIV and AIDS. It is part of the DFID 10th component strategy of “Focusing on the poorest and most marginalised people, the majority of whom work in the informal sector. We will place the economic empowerment of girls and women at the heart of our approach and help marginalised groups, including people with disabilities, to access productive employment”.

The Uganda Disability Policy (2006) recognizes that PWDs are vulnerable by virtue of their impairment and negative societal attitudes arising from fear, ignorance, superstitions, neglect and lack of awareness. As a result, PWDs have inadequate access to services, information, resources as well as limited participation in the socio-economic development process. “They receive less education, skills training and medical attention, which reduces their employment opportunities and may even result in secondary disabilities and sometimes early death. The major concerns of PWDs, are poverty, education and skills, employment, conflicts and emergencies, social security, health, HIV/AIDs and accessibility. Gender and age in disability exacerbates their situation in accessing services as a priority” (Policy (Page 7) on disability 2006). This project appropriately responds to this need.

At the community level, many parents or guardians do not take education of deaf children as a priority. Many still think these children cannot be useful in school and therefore keep them at home. However following signal’s interventions, it was observed that the attitudes of parents towards their deaf children regarding school attendance have changed. Most parents who attended awareness meetings and training are now reporting a positive attitude towards their deaf children. They now love them and have bothered to take them to school.

“We had abandoned our deaf children as useless but thanks to sign health sensitization we have now enrolled our deaf children in school and we also take them to hospitals and health...
centers for medical attention. We also keep them under mosquito net such that they are not disturbed by malaria anymore.” Arua FGD for parents/guardians of deaf/hearing impaired children/young people

This is in line with UPE policy of educating all children with special attention given to vulnerable children including those with disabilities.

It should be noted that the continued involvement and consultations with HICS/DC, parent leaders and other stakeholders in project planning and implementation process ensured that the project addressed the needs of the target groups. Information from Key informant interviews indicates that most of the stakeholders including the district community development officer were involved right away from the inception and implementation of the interventions. This means that these interventions were indeed responsive to people’s needs both at community, school and policy level.

“Whenever Sign health had programs for sensitization and training, I have always been participated in the training myself and all CDOs at sub county level and sometimes I do mobilize the target groups myself” Key Informant interview; DCDO, Arua district.

3.2 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

3.2.1 Main Source of Household Income
Accordingly, the main source of household income was found to be from peasant farming (21% and 17% of the respondents) for both Masaka and Arua respectively. Peasant farming is small scale growing of crops and rearing of animals to meet basic domestic needs. The main source of income for the household has implications on income levels and family capacity to provide adequately to household members and reducing vulnerability. Petty trading (15.5%) was also found dominant in Masaka while income from artisan works (13%) followed in Arua. Petty trading is small scale sale of merchandise of various nature, in most cases with no single consistent product. Artisans are people with skills in craftsmanship acquired largely from informal training like carpentry and metal fabrication and machine repairs. Income from formal employment which provides the most reliable source of household income was found only among 12.9% of respondents from Arua and 9.9% from Masaka.
3.2.2 Education level of Household head

Education level of household head was considred important because of its influence in changing attitudes and faciliatin access to infromation. The assumption would be that the higher education level of the household head, the more positive the attitude to disability for example and the more people in the household can access information like on HIV and AIDS.

It was found out that most of the children interviewed, parents had completed some primary school 13.4% for Arua and 7.3% for Masaka. 7.3% in both Masaka and Arua had completed ordinary level of education and 4.7% tertialy/nivreisty in Arua with 7.3% same level of education in Masaka. The education levels among parents of HICs is good enough to provide a a good basis for project information delivery especially in training and chaging attitudes.

The source of income as well as income levels have agragreat implication on the capacity of parents and guradians in providing for the deaf children. The fact that the majority of hosueholds both in Masaka and Arua are peasant farmers partly explains the low income levels and inability to properly cater for the needs of disabled children including the deaf and HICs.
3.2.3 Sex of HICs sampled

Quantitative information was gathered from two districts and among both boys and girls with 22% equal representation in Arua and 35% girls and 21% boys in Masaka respectively.

Table 2: Percentage of girls: boys sampled for the evaluation study

<table>
<thead>
<tr>
<th>Sex of Children with hearing impairment by District</th>
<th>DISTRICT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ARUA</td>
<td>MASAKA</td>
</tr>
<tr>
<td>Female</td>
<td>50</td>
<td>81</td>
</tr>
<tr>
<td>Male</td>
<td>52</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>102</td>
<td>130</td>
</tr>
</tbody>
</table>
3.2.4 Representation of age group and sex among sampled children
The project design targeted children and young people, male and female as primary beneficiaries. From the data collected and analyzed young people constituted 24.6% and children 75.4% respondents respectively. The biggest number of children fell within the age ranges of 10-12 and 13-15 majority being girls. Targeting young people falls within the Sustainable development goal (SDG) 1; of ending poverty targeting vulnerable groups; and goals 4 and 5 of ensuring all inclusive education and gender equity respectively.

Fig..: Age and sex of HICs

3.2.5 Extent of hearing difficulty among sampled children
Evaluation exercise also looked at extent of hearing difficulty among children and young people. This is important to compare how much the extent of hearing difficulty has implications on learning, communication and attitude issues. 37% and 40.9% of the respondents from Arua and Masaka respectively, were of partial hearing impairment while 6.% and 15.1% were total deaf respectively from Arua and Masaka.
3.3 PROJECT EFFECTIVENESS
Project effectiveness attempts to answer the “what” of project implementation. This subsection therefore looks at what has been achieved in relation to what had been planned and even beyond the plan. This part looks at achievements in outputs, outcomes and observable changes; how the project has impacted on people it was intended to support. It further looks at reasons that account for what has been achieved.

3.3.1 Performance on outputs
The project was designed to deliver several outputs through implementation of several activities. Some of the major activities included:

- Recruitment and training of deaf men and women from both areas (aged over 18) to be involved in the delivery of family and communication training sessions.
- Community sensitization, networking and promotional activities to identify beneficiary DC and families.
- Recruitment and training of deaf men and women (aged 18 up) to be involved in the delivery of teacher communication and awareness training.
- Half day HIV and gender workshops delivered to girls and young women at schools and community centres (to follow on from rights session).
✓ Recruitment and training of deaf men and women (aged 18 up) to be involved in the delivery of deaf awareness and communication training to health workers (in HIV prevention.

✓ Delivery of 1 day HIV specific awareness and communication training to health workers by deaf trainers and partners.

These activities among others were implemented and the out results are presented as bellow:
### Table 3: Project Output Performance Assessment

<table>
<thead>
<tr>
<th>Out Put indicator</th>
<th>Planned - Masaka</th>
<th>Achieved - Masaka</th>
<th>Arua Planned</th>
<th>Arua Achieved</th>
<th>% Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>1.1 Number of a) deaf men and women (over 18 years of age) and b) parents of deaf</td>
<td>a) 5</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>children recruited and trained as voluntary educators for the project.</td>
<td>b)6</td>
<td>13</td>
<td>6</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>1.2 Number of deaf children &amp; young people (disaggregated by age and gender)</td>
<td>a)91</td>
<td>b)Not</td>
<td>a)121</td>
<td>b)120</td>
<td>168</td>
</tr>
<tr>
<td>who have taken part in family awareness and communication training.</td>
<td>b)Not</td>
<td>b)Not set</td>
<td>120</td>
<td>128</td>
<td>b)Not set</td>
</tr>
<tr>
<td>1.3 Number of family members (disaggregated by role and gender) who have</td>
<td>416</td>
<td>343</td>
<td>362</td>
<td>380</td>
<td>661</td>
</tr>
<tr>
<td>taken part in communication and awareness workshops.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Number of male and female (a) teachers and (b) education workers trained</td>
<td>a) 83</td>
<td>87</td>
<td>89</td>
<td>129</td>
<td>97</td>
</tr>
<tr>
<td>in target areas (disaggregated by location)</td>
<td>b)7</td>
<td>10</td>
<td>27</td>
<td>45</td>
<td>10</td>
</tr>
<tr>
<td>3.1 Estimated number of deaf children and young people engaged in age and</td>
<td>238</td>
<td>246</td>
<td>374</td>
<td>647</td>
<td>430</td>
</tr>
<tr>
<td>gender appropriate HIV awareness programme (disaggregated by location &amp;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>gender).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Number of health workers in target</td>
<td>58</td>
<td>62</td>
<td>89</td>
<td>193</td>
<td>78</td>
</tr>
<tr>
<td>areas trained in communication, deaf awareness, gender specific HIV prevention relating to deafness (disaggregated by location &amp; gender).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4.3 Number of health facilities that provide deaf friendly HIV health information</td>
<td>12</td>
<td>15</td>
<td>16</td>
<td>21</td>
<td>Masaka : 20% Arua: 38%</td>
</tr>
<tr>
<td>5.1 Number of deaf boys and girls who have attended peer led rights training (disaggregated by gender &amp; location).</td>
<td>104</td>
<td>106</td>
<td>288</td>
<td>262</td>
<td>189</td>
</tr>
<tr>
<td>5.3 Estimated number and percentage of target deaf children and young people who engage with local advocacy</td>
<td>15 %</td>
<td>193</td>
<td>15%</td>
<td>303</td>
<td>Masaka: 35% Arua: achieved 30 %</td>
</tr>
<tr>
<td>5.4 Number of relevant District, community leaders and CSOs trained by representatives of advocacy groups or NGOs to deliver on deaf awareness, deaf rights, information and service delivery and choice (disaggregated by gender and location)</td>
<td>38</td>
<td>26</td>
<td>79</td>
<td>84</td>
<td>59</td>
</tr>
</tbody>
</table>
The overall performance on output achievement has been outstanding scoring more than 100% on most targets. This is attributed to a number of factors according to implementing teams; most outstanding being:

i) Cooperation of stakeholders – Parents very receptive and willingly volunteering to train and sensitise others, the school and health authorities that allowed to have specific teachers and health workers be trained and coordinate project activities within the selected schools and health centres.

ii) Skill and competence of implementing agency- Signhealth Uganda has few but skilled staff with seasoned experience in social development and hearing impairment in particular. The implementing team drew from past experience of implementing similar projects.

iii) Cooperation of local governments that provided office space (Masaka) and technical staff providing input and mobilising communities for participating in the project.

iv) Timely and quality technical and financial support to the project. Both DFID and Signal provided the required support to the local implementing partner that facilitated achievement of planned outputs.

v) Correct and appropriate problem identification. The deaf and HICs problem in the two districts and Uganda in general is a real issue affecting both children and adults. However there has been very minimum intervention especially for deaf children/HICs thus the intervention was timely, very necessary and responsive to the real needs of the target group. Therefore mobilisation, support and ownership of the project were forthcoming and the implementation of project activities was very smooth.

3.3.2 Performance on Outcomes

✓ Enrollment of deaf children and HICs in school.
Several schools visited in Arua and Masaka district indicated that there was increase in enrollment and retention of deaf children and HICs in school. This is partly attributed to the change in attitude by both parents and teachers following Sign health interventions. It was reported that since the inception of the project, parents have been keen in bringing the HICs and deaf children to school and giving them the support they need to stay in school. Whereas this evaluation did not comprehensively track the enrollment of HICs, some selected schools reported a positive change in enrollment. For example Ekarakafe primary school, Vurra sub-county, Arua district, had only 21 HICs/deaf children enrolled in school before the project but after sensitizing the parents the school currently has 75 HICs/deaf enrolled in school.

“Before the sign health came, the deaf children/HICs were at home, but when they came, many children were sensitized as well as parents and teachers which have improved the retention of children with hearing impairment-we surely appreciate the program by sign health. PWD Councilor, Aroi Subcounty, Arua district
Regularity of participating deaf children and young people attending primary school

Data from the children interviewed indicate impressive school attendance of HICs. 94% of the children were attending 100% of the days required and 6% attending 80% Arua and Masaka combined. This was supported by Key informant interviews held with teachers and head teachers of respective schools like Kapere Parents and Lutenga Primary schools in Masaka.

“Overall, these children (HICs) in the last two years do not have any difference from other children in terms of regularity of attendance. Our Term 2 (2017) records for example indicate that these children attended 60/64 days a term.” Head teacher Kapere P/S.

There were no major cases of school drop outs by HICs; where it has occurred was due to reasons that do affect other children generally like inability to provide by the parents. Head teacher Sembabule C.U Primary School,

“We may have like 3 hearing impaired children dropping out in a period of two years due to parents’ inability to provide but this can also happen to other children. At least it’s not because these children have hearing impairment but poverty.” Focal teacher, Okazara P/S, Arua.

Table 4: Regularity of school attendance by HICs by district

<table>
<thead>
<tr>
<th>Sex of the Deaf</th>
<th>DISTRICT</th>
<th>ARUA</th>
<th>MASAKA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Frequency of school attendance</td>
<td>% of attendance</td>
<td>% of attendance</td>
</tr>
<tr>
<td>Always (100%)</td>
<td>15</td>
<td>19</td>
<td>72</td>
</tr>
<tr>
<td>Can miss one day in a week (80%)</td>
<td>24</td>
<td>30</td>
<td>3</td>
</tr>
<tr>
<td>Attends half of the time (50%)</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Sub Total</td>
<td>41</td>
<td>51</td>
<td>75</td>
</tr>
<tr>
<td>Male</td>
<td>Frequency of school attendance</td>
<td>% of attendance</td>
<td>% of attendance</td>
</tr>
<tr>
<td>Always (100%)</td>
<td>16</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Can miss one day in a week (80%)</td>
<td>22</td>
<td>27</td>
<td>4</td>
</tr>
<tr>
<td>Attends half of the time (50%)</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Sub Total</td>
<td>40</td>
<td>49</td>
<td>44</td>
</tr>
<tr>
<td>Grand total</td>
<td>81</td>
<td>100</td>
<td>119</td>
</tr>
</tbody>
</table>

Reasons given for improved school attendance regularity by HICs included improved knowledge and awareness of teachers in handling the children due to training, parents costiveness that lead to improved care and facilitation like preparing them early enough for school and friendliness of fellow children. The Focus group discussion held with HICs in Lutenga P/S children revealed that (in own words):

“Teachers no longer abuse us. They used to refer to us as “kasulu” (a local dialect meaning deaf but also meaning stupid), they make us sit in front seats of class when teaching. Some children who are not HICs have also learnt communicating with us, some sign language.” Children FGD Lutenga P/S Masaka.

Primary school teachers’ role in effective project delivery

It is important to note that the project aimed at improved understanding, support and skills of mainstream primary school teachers to support and effectively teach HIC in an inclusive manner without impinging on other learners. In view of this noble objective, teachers were reported to be largely supportive to HICs/deaf children as well as other children with disabilities than before. In a bid to ease handling of HICs in every project school, a focal contact teacher was instituted by the head teacher to work directly with Sign health staff in identifying and mobilizing HICs/deaf children. Indeed the focal contact teachers were pivotal in identifying the HICs and take charge of all the activities. As already noted, this has encouraged many of them to be retained in school since they have been at the forefront of helping the HICs/deaf children to realize their potentials..

“Sign health has done a great job here, the sensitization and training has made our teachers to adjust the way they handle these HICs and they now help them to cope in class either by making HICs to sit in front or giving them special attention during and after the lesson. Also the pupils accommodate each other, reduced stigma, and has created friendly learning environment for HICs”. Head teacher, Ekarakafe P/S, Vurra subcounty, Arua district.

Role of health workers in health/HIV awareness, and treatment

As part of the interventions, Sign health identified and trained health workers on how to recognize the deaf /HICs and helps them to access medical services including treatment and referral. Information gathered from the sampled health centers indicated that health workers were sensitized and trained on how identify and help deaf/HICs and enlightened them on where they can refer a deaf children with a problem beyond their control. In addition, all the health workers targeted were trained in sign language so that they learn how to
communicate to the deaf people in attending to their medical and other problems. Therefore most of the health workers are now able to handle deaf children/HICs well and able communicate and understand their problems. In addition, we now record all HICs/deaf people who visit the health centres, treat them and make follow up to see their progress. Health workers are now more informed and aware about deafness and particular communication needs and are working to provide deaf friendly services with basic sign language and use of pictorial IEC materials. This in turn has increased support for DC&YP to access all health services.

“Before Sign health intervention, health workers were isolating deaf people. They could not communicate well when they come for health services and now the communication is somehow smooth. We were also able to follow up an exposed deaf child to HIV from their home and put him on ARVs”. Health Information Assistant Pajulu Health Center III, Arua district.

To achieve the above, the project engaged a number of health centers in Arua and Masaka districts. The health centers where interventions were done are summarized in the table below:

<table>
<thead>
<tr>
<th>District</th>
<th>NAME OF HEALTH CENTRE</th>
<th>Sub county</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masaka</td>
<td>TASO Masaka</td>
<td>Kimanya/ Kyabakuza.</td>
</tr>
<tr>
<td></td>
<td>Uganda Cares</td>
<td>Kimanya/ Kyabakuza.</td>
</tr>
<tr>
<td></td>
<td>Kalisizo Hospital</td>
<td>Kalisizo town council</td>
</tr>
<tr>
<td></td>
<td>Kitovu Hosp</td>
<td>Nyendo /Ssenyange</td>
</tr>
<tr>
<td></td>
<td>Masaka Ref. Hosp</td>
<td>Kimanya/ Kyabakuza.</td>
</tr>
<tr>
<td></td>
<td>KIwangala health centre III</td>
<td>Kiwanagala</td>
</tr>
<tr>
<td></td>
<td>Kyazanga Health centre III</td>
<td>Kyazanga</td>
</tr>
<tr>
<td></td>
<td>Kinoni Health centre III</td>
<td>Kiseka</td>
</tr>
<tr>
<td></td>
<td>Butenga Health Centre IV</td>
<td>Butenga</td>
</tr>
<tr>
<td></td>
<td>Masaka municipal health centre</td>
<td>Katwe/Buteogo</td>
</tr>
<tr>
<td></td>
<td>Bigasa health centre</td>
<td>Bigasa</td>
</tr>
<tr>
<td></td>
<td>Kyamulibwa Health Centre</td>
<td>Kyamulibwa</td>
</tr>
<tr>
<td></td>
<td>Bukakata Health centre III</td>
<td>Bukakata</td>
</tr>
<tr>
<td></td>
<td>Lambu Health Centre II</td>
<td>Bukakata</td>
</tr>
<tr>
<td></td>
<td>Mirambi HC III</td>
<td>Kibinge</td>
</tr>
<tr>
<td></td>
<td>Bukulula Health centre IV</td>
<td>Bukulula</td>
</tr>
<tr>
<td></td>
<td>Kasali health centre III</td>
<td>Kasali</td>
</tr>
<tr>
<td>Arua</td>
<td>Aroi Health centre III</td>
<td>Aroi</td>
</tr>
<tr>
<td></td>
<td>Vurra Health Centre III</td>
<td>Vurra</td>
</tr>
<tr>
<td></td>
<td>Lazebu Health centre II</td>
<td>Logiri</td>
</tr>
<tr>
<td></td>
<td>Logiri Health Centre III</td>
<td>Logiri</td>
</tr>
<tr>
<td></td>
<td>Offaka Health Centre III</td>
<td>Offaka</td>
</tr>
<tr>
<td></td>
<td>Ajia Health Centre III</td>
<td>Ajia</td>
</tr>
</tbody>
</table>
Thus, a number of health centers visited both in Arua and Masaka commended Sign health interventions and were actually requested for project renewal due to overwhelming need that exists in these areas. The fact that several health centers from both Arua and Masaka were part of the project, there is hope that deaf people/HICs are able to access health services from the above health centers without difficulty.

**HIV Knowledge access by HICs/Deaf young people**

As part of assessing HIV Knowledge access, HICs were asked whether they have ever heard of HIV and AIDS. 80% in Arua and 97% in Masaka of the HICs interviewed had heard about HIV and AIDS.

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>ARUA</th>
<th>MASAKA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever heard about HIV</td>
<td>Yes</td>
<td>82</td>
<td>126</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>102</td>
<td>130</td>
<td>232</td>
</tr>
</tbody>
</table>

Furthermore, Information from interviews conducted among HICs also indicates that the main sources of information school/teachers (28.4%), family member (17.7%), community health workers (12.5%) and Television, 7.3%).
The fact that teachers are reported to be the main source of information about HIV, partly reflects the effectiveness of the project. As part of the planning and implementation, teachers were the main targets sensitized and trained in HIV awareness, with a hope of them transferring the same message to the learners.

✓ **Awareness on HIV prevention among HICs**
Evaluation was also concerned with assessing knowledge levels among HICs on understanding ways of HIV prevention. One was considered knowledgeable if he/she was able to identify at least three ways one can prevent self from HIV infection. Accordingly from Arua only 22% of the children interviewed were knowledgeable, 50% some- how knowledgeable and 28 not knowledgeable. Comparatively, in Masaka 35% were knowledgeable, 52% some- how knowledgeable and 13% not knowledgeable on HIV prevention. It is important to note that the deaf young people who were adopted as peer leaders demonstrated sufficient knowledge about HIV prevention and health issues in general as compared to children.
✔ Awareness of HIV transmission modes by sex

The same criteria of being able to identify at least three ways by which HIV is transmitted was used to assess the knowledge levels on transmission. It was found out that 28% and 21% of female and boys were knowledgeable 13% and 15% of female and male somehow knowledgeable; and 10% and 8% not knowledgeable. Analysis indicates that knowledge levels are very low for younger children compared to older children. This is perhaps due to the fact that young children cannot easily comprehend some reproductive another health messages compared to older children. Besides the IEC materials distributed by sign health were all in English language which cannot easily be comprehended by children in lower primary school especially in Arua district. For example all children in primary four at Ambalu primary school –Ullepi sub-county could not read any word on the sign health posters that were hanged in their class. This therefore explains why the awareness levels reduce at lower primary school.

Fig: Showing knowledge levels on modes of HIV transmission.

Furthermore, it was also found out that the sources of HIV and AIDS services were Health centers and schools. These services include HIV awareness, testing & counseling, referral and treatment. Other public based services include Community health workers, public health campaigns and Radio and television messages.

“The project has done its level best in creating awareness about HIV/AIDS to all DC/HICs, ways of transmission and prevention. These children are fully aware of the modes of transmission. also child rights has been well understood by both teachers and children and since the start of the project, the attitude of teachers have changed towards punishment, no corporal punishment, no giving hard labor to children. they are encouraged to keep in school”. Focal teacher, Ambalu p/s, Arua district.
Target young deaf men and women and deaf boys and girls who report they have adopted positive behaviours to support HIV prevention and reduce transmission.

One of the general targeted outcomes in HIV response is to change behavior and influence practices that reduce the risk of HIV infection. Evaluation wanted to know whether by understanding HIV messages, has resulted in HICs and young people adopting behaviour that lead to reduction of risk of HIV transmission.

Table: Showing adopted behaviour and practices to reduce risk of HIV transmission

<table>
<thead>
<tr>
<th>Behaviors and practices adopted</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable (under age)</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Don’t share sharp objects</td>
<td>94</td>
<td>39</td>
</tr>
<tr>
<td>Practice protected sex</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>HIV testing</td>
<td>24</td>
<td>10</td>
</tr>
<tr>
<td>Circumcision (for boys)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Done nothing</td>
<td>45</td>
<td>19</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>37</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>240</td>
<td>100</td>
</tr>
</tbody>
</table>

(N=232, multiple responses)

The majority of the HICs and young people indicated that they stopped sharing sharp objects (39%) like razor blades, a number have gone for HIV testing (10%) and practicing protected sex (9%). The high levels of children reporting to be doing nothing is perhaps due to young
age and many of them are not sexually active and are not even conscious about what they needed to do to prevent themselves from HIV. This is partly because; HIV transmission is largely related to indulgence in sexual activity.

✓ Deaf children and young people who report improved communication within their family

One of the problems identified at project design level, was communication challenges between HICs with family members, with health workers and teachers.

“The attitudes of some health workers to people with disabilities and hearing difficulties in particular were bad. They would be attended to last whenever they visited the health center seeking health services. Now at least there is a health worker in every department who can greet in sign language. This makes deaf people feel welcome.” KII, Health worker at Buyunga HC IV.

“Ever since the project taught parents in communicating and supporting HICs, we have observed a lot of positives among children. Children would prefer being at school than home because of communication challenges and an environment perceived hostile at home” Special needs teacher in in Kalungu, Masaka.

Results from interviews conducted among HICs and their experience of whether communication with family have improved since the training revealed that 82% (52% very improved, 31% improved) find the communication improved and friendly. 18% think there is need for further improvement is supporting their family members communicate with them

Table 5: Status of comfort of HICs communicating with people at home

<table>
<thead>
<tr>
<th>Children who find communicating with people at home improved and easy</th>
<th>Age of child</th>
<th>Tota l</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7-9</td>
<td>10-12</td>
</tr>
<tr>
<td>Nos</td>
<td>% Nos</td>
<td>% Nos</td>
</tr>
<tr>
<td>Improved; very friendly, easy</td>
<td>4 2</td>
<td>44 19</td>
</tr>
<tr>
<td>Improved, Friendly</td>
<td>4 2</td>
<td>28 12</td>
</tr>
<tr>
<td>Improved, somehow friendly</td>
<td>2 1</td>
<td>6 3</td>
</tr>
<tr>
<td>Not improved; unfriendly, difficult</td>
<td>1 0</td>
<td>4 7</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>87</td>
</tr>
</tbody>
</table>

232
Deaf children and young people who correctly identify their education and health rights

Evaluation assessment explored the level of knowledge among HICs and young people with hearing difficulty on understanding their health and education rights. Children who could mention at least three of their rights was considered knowledgeable, those who could mention either one or two was considered as fairly knows and third category that dint know at all. There are those (aged 4-6 years) that were excluded because of being considered too young to understand rights issues.

Accordingly, 30% and 23% of female HICs in Masaka and Arua respectively know their rights compared to their male counterparts of 15% and 20%. 26% of the boys in Arua and 16% in Arua Masaka fairly know their health and education rights. Female stand at 23% for Masaka and 18% Arua who fairly know their rights. Only 5% of male respondents didn’t know completely their rights compared to 7% of their female counterparts. Overall analysis show no major disparity between knowledge levels among male and female HICs.

In terms of participating in rights advocacy work, 51% of the children interviewed in Masaka had participated in advocacy activities compared 50.4% of male children. Some of the advocacy activities they have participated in include drama on World AIDS day, disability day and school open days.
Other actors in the disability sector helping children with disabilities

There are other actors in the disability sector helping children with disabilities including HICs in both Masaka and Arua. The CSOs/NGOs include: Uganda Society for Disabled Children on disabled child related issues, Masaka Deaf association on deafness, parents leaders and representatives of women groups such as MIFUMI, organisations working with orphans and vulnerable children and local community based supporting organisations working across all disabilities including FOHO among others. According to the District Community Development Officer Masaka, main active ones in addition to Signhealth the implementing partner for Signal UK are Foundation of Hope, River of Life Church, Buganda Kingdom and OKOA refuge. Working with Masaka School for children with special needs where most of the children are deaf, Signhealth with Buganda Kingdom organized a fundraising that raised money which is supporting 15 HICs who otherwise would have dropped out of school. With related mobilisation and awareness, government now supports school units of children with hearing difficulties with additional funds for this purpose.

The mobilisation and formation of groups of youth of deaf people and their parents have provided an opportunity for them to be funded by government through enterprise development funding windows. A number of NGOs existing however are not in advocacy but service provision. For example OKOA build a business center for people with disabilities to secure stalls and exhibit their products and Uganda society for disabled children (USDC) in children rehabilitation.

3.4 Value for money (vfm) considerations

Delivery of results on time & budgets against plans, understanding cost drivers – adequacy of project number of staff, use of existing structures, volunteer groups, competitive bidding in procurement of project inputs were the major actions taken by project management to ensure value for money is achieved during the implementation of this project.

Accordingly procurement of projet materials like printing of sign language charts, stationary was subjected to competitive bidding through acquiring a range of price and sample quotations to ensure good quality materials are got at fair prices. Related recruitment of project went through a competitive interview process and Sourcing and employing resource persons with modest fees, e.g. trainers/facilitators, and focal persons in partner agencies.

Another strategy for achieving value for money and cost cutting was employed by the project working with and through volunteer parent leaders and volunteer young deaf people to deliver outreach work and share knowledge and skills. A lot of work performed by these volunteer groups like parent peer-education, management of referrals of HICs to health centers would have costed a fortune to the project if it was to be done through the formal institutional structure. This approach was also used to enhance sustainability.
Strengthening partnerships for example initiating good working relationships with media houses for cheaper media services, Masaka District Local government provided free office space for Signhealth (implementing Partner for Signal) which provides continuity and real (non cash) saving for investing in direct project deliverables. Sourcing for community contribution, such as free or reduced price venues, as was also the case with Arua Hospital.

Signhealth Uganda (SU) works closely with other agencies to deliver quality training to deaf youth and other stakeholders at a nominal fee, where possible. SU staff, volunteers, and peer educators/leaders have shared facilitation roles within trainings and community awareness sessions. This enables SU to build skills in facilitation within the organisation and the project, reducing the cost that comes with dependence on external facilitators and improving the sustainability of the project impact.

Project implementation also developed referral linkages with other agencies, such as referring deaf young people to health institutions for hearing assessment and for condoms. This has helped in offering a combined approach and created synergies in service delivery, where organisations offer support in areas where they have a comparative advantage over others, reducing the duplication of services and costs.
3.5 Assessment of project impact

The project set out to achieve improved health, education and greater life choices for young deaf people and children in the targeted locations of Masaka and Arua. Project implementation has been concluded and evaluation found out the following changes brought about the project.

In terms of increasing access to health and education services, there has been enhanced identification of families of Deaf Youth (DY) and Deaf Children (DC) and increased mobilisation efforts through peer support groups and volunteers, especially in remote and hard to reach villages. This has helped identify children with hearing difficulties brought to the limelight some whom would never have been seen to access education. One example is a boy from Arua who was identified from Dadamu Sub county Arua district whose parents had no plan of taking him to school because of hearing difficulty. He now participates in National students’ athletics championship!

Furthermore, Aroi Sub county (Arua) has offered free land towards the first deaf secondary school following advocacy by peer leaders and parents. There has also been improved understanding, support and skills of mainstream primary school teachers to support and effectively teach HIC in an inclusive manner without impinging on other learners. This was achieved through teachers’ orientation on disability, basic training on sign language and inclusive education.

There has been increase in number of duty bearers and CSOs actively responding to DC&YP’s advocacy, addressing identified needs in adapting existing service provision opportunities. For example, Masaka local government helped youths and parents to register their associations, a pre-requisite for accessing community grants. Two groups have so far accessed those government grants. Buganda kingdom also took lead through its radio station to fundraise for more vulnerable deaf children who were on the verge of dropping out of school. Fifteen children have been support with school necessities out of this fundraising.

At HIV and AIDS front the simplified training kits and information materials on issues relating to HIV/AIDS, rights, health and deaf awareness which were developed by project staff stimulated visual learning of the target group. There is greater awareness and understanding for DC&YP around HIV/AIDS prevention and risks and their respective gender roles. There is more acceptances to Health center staff of people with hearing difficulties and this gives confidence to DC & DY to improve their health seeing behaviour.

There has been increase in linkages and referrals to other services as the project continued to become known and supported. This included referrals for deaf children identified by other stakeholders (5 in Masaka by TASO and 15 others referred to the Masaka Special needs education school for children with different and multiple disabilities.
Case Stories on: Improved health, education and greater life choices for young deaf people and children in the targeted locations

Case 1: Kizito up in the limelight

Matua Kizito story.

Matua Kizito is in Primary seven (P.7) with hearing impairment who is so courageous to learn at all levels if supported. He is very talented in sports and was the champion for long race and 800m, 1500m at the district and participated at national level. Sign health helped us to identify him and keep him in school. He is now going to complete P.7 we hope he will be supported to join secondary education. From a family of 9 children I am seventh born. My parents are poor and I find difficulties to get school fees and other requirements. When my parents fail to pay for me, I go to look for the money by digging and sell fruits like mangoes so that I get money for fees. Ambalu primary school –Ullepi sub-county, Arua
Case 2: Parents as magical change agents

When Sign health mobilized, sensitized parents of deaf children/HICs, they were able to come together, know each other, and hence were motivated to start an association that will keep them together, perhaps work together and do advocacy for their deaf children as a group. The parents therefore registered the association with the sub-county and started working together. “Because of sign health, we were mobilized and we have been organized as a CBO and registered to have a common voice for our children. The objective of our association is to support our deaf children to attend schools and support them to other related services”. Parent, of deaf child, Aroi subcounty.

This group benefited from the skills training including liquid soap making and consequently they have started soap making on commercial scale and selling to community members. This has started to enhance their incomes and is conscious that this income should be used to support their deaf children access school and provide for other necessities. Following the groups organisation, togetherness and hard work, Aroi sub-county community development office considered them and extended them a small grant of shs. 2 million to enhance their income generating activities. I addition, the CBO membership also benefited from government programme of Operation Wealth Creation (OWC) and were given seedlings and other planting materials.

“We have been empowered by sign health, we therefore conduct home visits by parents in their homes and counsel the parents and talk about health of education issues. We talk about how to keep deaf children safe, feeding care and health issues affecting these children Parents of deaf children are now better informed on how to maintain their children than before”.

Parents of deaf child, FGD, Aroi subcounty.

This project has therefore triggered a lot of action and the parents of the deaf people/HICs have become agents of change and are raising voices of their deaf children than ever before.

Photo: Parents of deaf children/HICs displaying a sample liquid soap they produce, pack and sell as part of the income generating project.
Case 3: Signal Project saved my life

Nakamya Rose is a deaf young person (20 years) who lives in Mabuye Village Bukulula sub county Kalungu District in Greater Masaka. She is among the many deaf young people that were identified as project beneficiaries, she was identified by Nakagwa Neo, a T.O.T and parent leader in the area.

Unlike other deaf youth in the project, Rose was contracted HIV after initially living an irresponsible life as she was totally unaware of the existence of HIV/AIDS and how it was transmitted. As Neo explains, being the only deaf girl in the village, at the early age of 14 yrs, many men started to engage Rose in sexual activities just taking an advantage of her deafness.

After many illnesses and complications occurring to Rose, her mother decided to take her to the hospital for medical checkup and treatment.

Unfortunately, Rose was tested positive and her immune system had gone low. Despite of being positive, she had vehemently refused to take ARV drugs, many attempts were made by Rose’s mother and health workers to see that she takes drugs but all were in vain. She could sometimes tell them “Why me take drugs every day when me no sick!!!!”

The project organized an HIV/AIDS training and awareness at Bukulula Health Centre IV and Rose was invited to attend the same. After the training all the deaf youth were taken through HIV guidance and counselling and from that training, Rose realized the need to take her ARVs regularly. She eventually recovered and she is among the first person to pick her drugs from the health facility every week, now Rose is living a happily positive life.
3.5 Sustainability

Thorough interaction with project stakeholders and Signhealth Uganda as main implementation partner reveals strategies that were put in place that can support a number of project activities be sustained even after the closure of the project. These include the structures set up to mobilize and engage communities and target beneficiaries, capacity building of beneficiaries, knowledge and skills acquired during awareness and training among others can support continuation of the project benefits. The structures put in place included:

**Deaf Peer leaders**

These were identified, brought together and trained in various aspects mainly their rights, HIV/AIDS prevention, and general social work surrounding disability and deafness. These peer leaders were in turn challenged to identify DC&YP out of school in remote rural areas, supporting their inclusion in family and community life and helped in sensitizing and training other children in sign language. These peer leaders are now seen as positive role models and agents of change of the deaf youths who demonstrate more confidence and knowledge relating to holistic being, deafness and health/HIV awareness and responsible behavior. The positive behavior change, teamwork seen among the peer leaders, demonstrated knowledge about their rights as well as exposure to duty bearers such as health workers, teachers and administrators has put peer leaders in a prime position of self-advocacy for their rights, benefiting from government programmes like access medical services. For example, two groups of deaf youths (peer leaders) in Masaka were earmarked to benefit from Government funding under the Youth Livelihood Fund and CDOs in three sub counties in Arua committed to put them on the next funding round. In addition, the annual project reports indicated that successful exposure exchange visits between deaf peer leaders from the two locations inspired individuals and families to try income generating activities. In Arua three families are exploring soap making and at least two girls are now engaged in hairdressing following their exposure to positive deaf role models working in these fields in Masaka.

**Parent volunteers**

Another important category of community structure was the parents of deaf/HICs who were mobilized and brought together with the help of peer leaders. The parents in turn became very important for the project success. They actively participated in all the awareness meetings and continue to, and overall the parents registered positive change of attitude and believes that such positive attitudinal change towards their deaf children and HICs will continue even after the project.

**Knowledge and skills gained**

One of the key deliverables of this project has been the knowledge and skills in advocating for deaf children, skills in communication, inclusive education and engagement with duty
bearers. The knowledge and skill will continue being used to support HICs even after the project.

4.0 Implementation gaps and Challenges

Project integration
Poverty is a major characteristic that cuts across most of households with children with disabilities especially hearing difficulties, according to Situational Analysis on the Rights of Children with Disabilities in Uganda (2014). A project with components of disability and health-knowledge seeking behaviour, economic empowerment and hearing difficulty corrective actions where possible; would have reaped all the synergies that come with integration; for example some of the children that were initially assessed and referred for corrective treatment didn’t get the service because of poverty related reasons.

Limited Data to facilitate planning
There is general limited reliable data on disability available to development stakeholders to adequately facilitate planning on disability in the country. What is available is largely estimates and at national level. One therefore can not with precision establish the level of magnitude for example of the problem of hearing impairment in Masaka and how the difficulties that come with it have been reduced. This was also testimony to a Male disability Councilor of Masaka district and had been echoed by the District education officer of Amolator district in Uganda in a different study by Leonard Cheshire disability (LCD) UK.

Health information systems reporting
The Uganda health reporting system doesn’t provide for disability information capture. This both in general ailment Ministry of Health (MoH) reporting forms and HIV and AIDS. As such it remains difficult to know the situation of health and HIV prevalence among people with disabilities and hearing impairment in particular. This remains a policy advocacy issue.

Training of service providers not enough
Training of service providers like school teachers and health center staffs in sign language and disability issues was done but in haste according some of the beneficiaries. If phased, for example, across the project period and be done in matter that provides for feedback from trainees after training and interacting with DCs, it would yield results.

5.0 Lesions learnt
The implementation of this project helped provided an opportunity to learn how to improve future programmes through carrying on what has been appreciated as working and dropping or changing what has not worked.

The significant active role of project beneficiaries as agents of intervention is crucial and should always be considered in similar future project designs. For example peer leaders
beyond educating fellow community members, could help their peers in understanding project purpose and operational issues that did not have to wait for project staff.

Sign language training (well structured) inclusion in such project is crucial for effective delivery of project results.

Information, education and communication (IEC) materials need to varied to include enough visual both print and television (like cartoons) to improve communication to HICs.

Bringing different sectors together like education, health and administration in project implementation is quite important to reap the synergy benefits of knowledge, cost and learning for effective and efficient project delivery.

There is a need to trigger economic empowerment since these people are mobilized and motivated.

6. Concussions

Conclusion
The project has greatly achieved the intended objectives. The deaf young people are now very equipped to protect themselves against HIV and are already linked with other service providers. The misconception among parents, health workers and teachers about disability, like relating disability to witchcraft, that hitherto was barrier to HICs accessing services has been greatly removed. The project was well structured that it involved a spectrum of participants (stakeholders) in education, health; administration and community that help the project achieve outstanding results.

There are however, still gaps in knowledge levels among parents, service providers and policy in understanding disability that require continued efforts by existing structures to eliminate.

Recommendations

v) Given the poverty levels among Children with disabilities’ families, economic empowerment component of a programme like this one would be paramount for consideration in future projects.

vi) Considering a general data and information gap existing on disability future projects should consider generating clear disaggregated data on disability in project targeted districts to ease the monitoring and evaluation framework.

vii) Advocacy as a component or thematic area in such project should be well structured to generate advocacy issues and actions expected from duty barriers to eliminate some of the policy gaps that if corrected would yield long lasting improvements in service delivery for children and young people with hearing challenges.
viii) The monitoring and evaluation framework should always endeavour to provide for how project progress and reporting shall be shared. This should be annual reports, mid term reviews and final evaluation. Annual reports need to be synthesized and posted on organisational website, final evaluation report shared with implementing partners at district level (within budget constraints) and final report posted on the website of implementing partners.
Annexes

i) Children and young people individual questionnaire
ii) List of Key informants consulted
iii) The evaluators’ work schedule