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**“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

(ABRIDGED VERSION)

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List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
CAO	Chief Administrative Officer
CBR	Community Based Rehabilitation
CDO	Community development Officer
CRPD	Convention on the Rights of People with Disabilities
CSO	Civil Society Organisation
DC	Deaf Children
DCDO	District Community development Officer
DEO	District education Officer
DPO	Disabled People's Organisation
FGD	Focus Group Discussion
HICs	Hearing Impaired Children
HIV	Human Immune Virus
LQAS	Lot Quality Assurance sampling methodology
MDGs	Millennium Development Goals
MGLSD	Ministry of Gender, Labour and Social Development
MoES	Ministry of Education and Sports
MoH	Ministry of Health
NCD	National Council for Disability
NDP	National Development Plan
NGO	Non-governmental organisation
NUDIPU	National Union of Disabled Persons of Uganda
PTA	Parents & Teachers Association
PWD	Person(s) with disabilities
SDGs	Sustainable Development Goals
SNE	Special needs education
UBOS	Uganda Bureau of Statistics
UNAD	Uganda National Association of the Deaf

Executive Summary

This is a summary version report of final evaluation 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. A participatory approach that involved both quantitative and qualitative methods was used to generate the information required for evaluation.

Key Evaluation Findings

The findings of this evaluation focused on assessing project relevance, effectiveness, efficiency, impact, sustainability and learning from the project implementation processes and results. The overall performance on output achievement has been outstanding scoring more than 100% on most targets.

✓ Relevance

The project was found 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 responding to 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 and result in poverty, this project was appropriate and relevant to the needs of young children with hearing problems and their families.

✓ 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, There was also timely and quality technical and financial support to the project; both DFID and Signal UK 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.

✓ Efficiency

The evaluation found out that a number of strategies to achieve value for money were employed which include; use of volunteers, partnering with Local Government technical teams and competitive bidding among others. These resulted in cost cutting and harnessing the synergy of multi stakeholder approach to project implementation.

Conclusion

The project has greatly achieved the intended objectives. The deaf young people are now well 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.

Recommendations

- i) Given the poverty levels among Children with disabilities' families, strengthening economic empowerment component of a programme 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 bearers 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 monitored and shared. The nature of data to be collected and frequency of data collection should be clear.

1.0 INTRODUCTION

1.1 Background

Uganda currently ranked 163 out of 188 among countries with poor health indicators (2016 UN Human Development) and is a signatory to both Education for All and the Convention on the Rights of Persons with Disabilities. 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 voiceless. As a result, they are not employed, have no access to information and limited access to social and economic services (UNAD, 2012). 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 trend, Signal UK, designed interventions following a holistic approach to tackling the various barriers affecting deaf and hearing impaired children and young people face in accessing education. The interventions designed were structured to cover 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.

1.2 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 Evaluation goal and objectives

The overall objective of evaluation was to assess project relevance, effectiveness, efficiency, impact, sustainability and learning of the project; and the extent to which Signal achieved its project goal and objectives. In light of this, the evaluation exercise did assess implementation since its inception, focusing on what can be learned from Signal’s approach and which future direction(s) programming on deafness and rights might pursue.

1.3.1 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 Districts.

1.4 Methodology

A participatory approach that involved both quantitative and qualitative methods was used to generate the evaluation 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. The evaluation exercise sought information from 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 sampling (LQAS) technique was used to determine the sample size of individual children with hearing impairments.

Other respondents and methods include - 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. Focus group discussions were also conducted among the deaf children/HICs in school and those out of school as well as peer leaders.

2.0 EVALUATION FINDINGS

2.1 Project relevance

Project relevance was contextually looked at as in 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 a response to DFID Global Poverty Action 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”*.

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. It is also partly because there is limited adoptability of infrastructure to provide friendly services to children with hearing problems. 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 consider them as human beings with rights to education as any other children, love them and have bothered to take them to school.

"We had abandoned our deaf children as useless but thanks to signhealth 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." AruaFGD for parents/guardians of deaf/hearing impaired children/young people

2.2 Project Effectiveness

2.2.1 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.
- ✓ 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 HIV specific awareness and communication training to health workers by deaf trainers and partners.

These activities among others were implemented and the related outputs and results delivered.

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. The Focal Point Teachers and health workers did a lot in educating both parents and other teachers at school level and health workers at health centre levels respectively.

- ii) Skill and competence of implementing agency- Signhealth Uganda has few but skilled staff with seasoned experience in social development and programming for hearing impairment in particular. The implementing team drew from past experience of implementing similar projects to achieving the success.
- iii) Cooperation of local governments that provided office space (Masaka) and technical staff providing input for example in community training and mobilising communities for participating in the project.
- iv) Timely and quality technical and financial support to the project. Both DFID and Signal UK 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.

2.2.2 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 Signhealth 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 Signhealth 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 programme. **PWD Councilor, AroiSubcounty, Arua district**

Regularity of participating deaf children and young people school attendance.

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 revealed by Key informant interviews held with teachers and head teachers of respective schools like Kapere Parents and Lutenga Primary schools in Masaka; according to their class daily registers.

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

Reasons given for improved school attendance regularity by HICs included improved knowledge and awareness of teachers in handling the children due to training, parents positive attitude 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); now they make us sit in front seats of class such that we can hear better what they are 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 Signhealth project 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.

“Signhealth 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 lessons. Also the pupils accommodate each other, reduced stigma, and has created friendly learning environment for HICs”. **Head teacher, Ekarakafe P/S, Vurrasub county, Arua district.**

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

As part of the interventions, Signhealth identified and trained health workers on how to recognize and communicate with the deaf /HICs and help them to access medical services including treatment and referral. Information gathered from the sampled health centres indicated that health workers were sensitized and trained on how to identify and help deaf/HICs and enlightened them on where they can refer 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, records of all HICs/deaf people who visit the health centres are now kept, 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 Signhealth 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” and has greatly improved health wise. 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. In each Health centre, there is Health Focal point person who has been trained to act as a point of contact and reference for people with hearing impairment before seeking the specialized treatment.

Thus, a number of health centers visited both in Arua and Masaka commended Signhealth interventions that have bridged the gap between people with hearing impairment (deaf) and health workers. The fact that several health centres 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 with less difficulty than before.

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.

Furthermore, Information from interviews conducted among HICs also indicates that the main sources of information about HIV and AIDS were school/teachers (28.4%), family member (17.7%), community health workers (12.5%) and Television 7.3%).

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 other 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. Further 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 hung in their class. This therefore explains why the awareness levels reduce at lower primary school.

Furthermore, it was also found out that the most common 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.

Targeted young deaf men and women and deaf boys and girls who report they have adopted positive behaviors to support HIV prevention and reduce transmission.

One of the targeted outcomes in HIV response was 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.

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, 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. Only 18% think there is need for further improvement is supporting their family members communicate with them.

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 were considered knowledgeable, those who could mention either one or two were considered as fairly knowledgeable 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 Masaka fairly know their health and education rights. Females 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 female 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. The HICs children participated in advocacy through drama themselves.

2.3 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 mobilization 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 lime light some of 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 with star performances!

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 HICs 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 supported 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).

2.4 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 include:

✓ 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 and parents 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.

✓ 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.

3.0 Implementation 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 (UNICEF 2014). A project with components of disability and health-knowledge seeking behaviour and hearing difficulty corrective actions where possible would include strengthened economic empowerment. This would help reap all the synergies that come with integration. For example, some of the children who were initially assessed and referred for rehabilitation didn't not get the services because of poverty related reasons.

✓ Limited Data on disability 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 cannot 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 is both in general ailment Ministry of Health (MoH) and HIV and AIDS reporting forms 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 manner that provides for feedback from trainees after training and interacting with DCs, it would yield results.

4.0 Lessons learnt, Conclusion & Recommendations

4.1 Lessons learnt

4.1.1 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.

- 4.1.2 Sign language training (well structured) inclusion in such project is crucial for effective delivery of project results.
- 4.1.3 Information, education and communication (IEC) materials need to varied to include enough visual both print and television (like cartoons) to improve communication to HICs.
- 4.1.4 Bringing different sectors and actors 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.
- 4.1.5 There is a need to trigger economic empowerment since these people are mobilized and motivated.

4.2 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.

4.3 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 organizational website, final evaluation report shared with implementing partners at district level (within budget constraints) and final report posted on the website of implementing partners.

Facilitated by:



Focus Development Associates Ltd

Contact Details:

Bombo Road-Kavule Plot 934, Suit F1N,

Phone: +256-783535570 +256 772-492155

Email: johnson.kamu@gmail.com, magarasiragi2013@gmail.com