# TITLE II HIV/AIDS INITIATIVE

# MID TERM EVALUATION OF THE TITLE II HIV/AIDS INITIATIVE IN 11 SAMPLED DISTRICTS

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**List of Abbreviations and Acronyms**

| | |
|---|---|
| ACDI/VOCA | Agricultural Cooperative Development International/Volunteers Overseas Cooperative Assistance. |
| AED | Academy for Education Development |
| AFR | Africare |
| AIDS | Acquired Immune Deficiency Syndrome |
| CBO | Community Based Organization |
| CEDO | Community Enterprise Development Organisation |
| CRS | Catholic Relief Services |
| CSB | Corn Soy Blend |
| DDS | Dietary Diversity Score |
| FANTA | Food and Nutrition Technical Assistance |
| FAO | Food and Agricultural Organization |
| HIV | Human Immuno-deficiency virus |
| IEC | Information Education and Communication |
| IGA | Income Generating Activities |
| IP(s) | Implementing Partner(s) |
| KMP | Kitovu Mobile Program |
| OVC | Orphans and Vulnerable Children |
| PLWHA | People/Person living with HIV/AIDS |
| PVO | Private Voluntary Organization |
| Sd | Standard deviation |
| TASO | The AIDS Support Organization |
| TSC | The Ssemwanga Centre |
| UBOS | Uganda Bureau of Statistics |
| UDHS | Uganda Demographic and Health Survey |
| UPE | Universal Primary Education |
| USAID | United States Agency for International Development |
| Ushs. | Uganda shillings |
| VCT | Voluntary Counseling and Testing |
| WAZ | Weight for Age Z-score |
| WV | World Vision |

## EXECUTIVE SUMMARY

The Title II HIV/AIDS Initiative has been operational since January 2002. ACDI/VOCA has been providing for and monitoring the distribution of corn soy blend and vegetable oil to people living with HIV/AIDS (PLWHA) through implementing partners (TASO, World Vision, Catholic Relief Services and Africare). The overall objective of the program is to alleviate food insecurity and mitigate some of the impacts of the pandemic on the lives of PLWHA. This mid term study is aimed at evaluating the progress of the initiative by comparing the current situation with the baseline using specified indicators.

A randomized 30-household cluster survey design was used to capture information from 11 of the 14 districts previously visited at baseline. A total of 421 households (14 clusters) were interviewed using a pre-tested questionnaire and children under 5 years of age had their weights and heights taken. In addition, focus group discussions and key informant interviews were conducted with the PLWHA and IP staff respectively for qualitative information.

Of the 421 households visited 67% were of adult beneficiaries while 33% were of orphan beneficiaries. This is different from the situation at baseline where 84% were adults and 16% were orphans and may explain some trends in the quantitative results. About 67% of the beneficiaries were female and 33% were male and the mean household size was 6.6.

Household food consumption was assessed using dietary diversity score (DDS) and meal frequency. Both these indicators showed a significant increase since baseline (DDS; 4.7 to 5.8 and meal frequency; 2.9 to 4.1). Beneficiaries reported eating more cereals (94%), legumes (90%) and vegetable oil (71%) because of the CSB and vegetable oil they receive. In addition, 90% of the beneficiaries reported using CSB at least twice a day.

The percentage of children categorized as stunted decreased from 36% at baseline to 32% and those categorized as underweight decreased from 18.6 % at baseline to 15.9% at midterm. In addition, the mean z-scores for specific age groups showed significant increases since baseline.

The health status of the primary beneficiaries also shows an improvement. The incidence of disease dropped from 82% at baseline to 56% while the percentage of beneficiaries reporting 2 or more episodes of illness decreased from 38% to 30%. While the changes in beneficiary population may

explain some of these changes the beneficiaries believe that their improved health is mainly due to CSB consumption.

Although the beneficiaries reported that they had been taught about hygiene and sanitation (64%), the situation in their households had not changed significantly. The % of beneficiaries with appropriate hand washing techniques and proper storage of drinking water is still low (15% and 35% respectively). There is a need to employ strategies that will reach the beneficiaries at the household level. The level of nutrition knowledge had improved since baseline. About 52% reported 3 correct reasons why food is eaten compared to the 38% at baseline. Focus group discussions reported this being due to the nutrition education talks they attended during food distributions.

Household expenditure on non food services has increased from Ushs 43,641 at baseline to Ushs 65,686 at midterm. This implies improved welfare since beneficiaries are able to spend more money on non-food items. Their increased productivity is also implied by the lower percentage (31%) reported inability to work due to illness compared to what was reported at baseline (56%).

The mean number of children enrolled in school has remained at 3, this is also the mean number of children between 5 and 15 years in beneficiary households. This shows school enrollment has not changed since baseline possibly because it was high even at baseline due to Universal Primary Education, a government initiative supported by a number of donors. However, the percentage of households reporting children missing school in the previous 2 months decreased from 52% to 40%.

The mean number of times non food services were attended in the previous 2 months has decreased from 2.3 to 1.96 ($p<0.05$) possibly because of the reduced vulnerability. However, some IPs do not offer the same non-food services over a period of time so low attendance reported may be due to the fact that the service was not offered during the previous 2 months.

In conclusion, the situation in the beneficiary households has improved especially as regards food security, nutrition and health. Basing on the proxy indicators of productivity "inability to work due to illness" and income "household expenditure" beneficiaries seem to be more productive now than at baseline. Focus group discussions confirmed that the improved health was mainly due to CSB consumption.

## Table A Indicator table

| Indicators | Baseline (FY02) | Midterm (FY04) |
|---|---|---|
| **Household Characteristics** | | |
| Mean number of children enrolled in school per household | 3 | 3 |
| Mean number of school days missed in previous two months per child per household | 11 | 11 |
| **Household food Security** | | |
| Mean number of meals consumed per day | 2.9 | 4.0 |
| Mean number of different food groups consumed in the last 24 hours | 4.7 | 5.8 |
| **Knowledge of nutritional strategy** | | |
| % of beneficiaries who know the benefits of consuming recommended foods | 37 | 52 |
| % of beneficiaries who know 2 recommended nutritional practices | 32 | 45 |
| **Ration Utilization** | | |
| % of beneficiaries who know at least 2 maize soya recipes | 25 | 88 |
| **Health condition** | | |
| % of beneficiaries ill at least twice in the last 2 months | 38 | 30 |
| Mean number of times beneficiaries have not been able to work in the previous 2 months | 2 | 1.6 |
| **Attendance of non food services** | | |
| Mean number of times non-food services are attended in the previous 2 months | 2.3 | 1.96 |
| % of beneficiaries getting assistance from CBOs | 15 | 25 |
| **Household Expenditure** | | |
| Mean monthly household expenditure on non-food items (Ushs.) | 43,641 | 65,686 |
| **Hygiene** | | |
| % Beneficiaries with proper hand washing techniques | 23 | 15 |
| %Beneficiaries with proper storage and usage of drinking water | 34 | 35 |
| **Nutritional status** | | |
| % of children with low weight for age (Underweight) | 18.4 | 15.9 |
| % of children with low height for age (Stunting) | 36 | 32 |

## 1.0 Introduction

### 1.1 The Title II HIV/AIDS Initiative

The Title II HIV/AIDS initiative is a USAID funded food aid intervention whose primary objective is to alleviate the food insecurity among people living with HIV/AIDS (PLWHA). It has been operational since January 2002 and beneficiary households receive a monthly dry ration of corn soy blend and vegetable oil. In addition, a nutrition and hygiene education component was introduced at the beginning of 2004 and it is intended to improve the handling and utilization of food and thus the impact of the program. The beneficiaries have nutrition/hygiene education sessions at food distribution points as they wait to receive the food. In addition, information/education materials with illustrations of what they have been taught are given to them to use for continued reference at home.

To monitor the food aid intervention, the implementing partners collect information on the health status of the beneficiaries, the ration utilization and the food distribution process on a quarterly basis. ACDI/VOCA synthesizes this information and uses it to improve the food distribution and nutrition education activities. In addition, annual studies are conducted to give an in depth assessment of the program.

This study aims at evaluating impact by comparing the current food security, nutrition, socioeconomic and hygiene situation in the beneficiary households to that at baseline. In addition, it will endeavor to find out any hindrances to the programs objectives so that they can be addressed in the remaining part of the phase.

### 1.2 Study objectives

The main objective is to quantify the beneficiary state of affairs using specific indicators used at baseline. The specific objectives include:

1. Assess the household food consumption of the beneficiary households using dietary diversity and meal frequency as the main indicators;

2. Determine the nutritional status of children below five years of age, expressed as percentage of children below –2 z scores for weight for age (underweight) and height for age (stunting);
3. Determine the level of awareness of proper nutrition for PLWHA looking specifically at knowledge of appropriate nutritional practices;
4. Assess the level of hygiene and sanitation in the households of PLWHA by looking at their hand washing behavior, access to safe water and adequate sanitation;
5. Obtain information on level of utilization of corn soy blend and vegetable oil;
6. Obtain information on school enrollment and retention of children of PLWHA;
7. Obtain information on household expenditure in the households of PLWHA and
8. Obtain information on level of attendance on non food services by PLWHA.

# 2.0 Methodology

## 2.1 Study design

A pretest-post test evaluation design was used where the mid term (posttest) survey results are compared to the baseline (pretest) results in order to determine the difference between the two periods. No control group was used because we envisaged difficulties in interviewing PLWHA who are not food beneficiaries and biases resulting from the need to be enrolled on the program.

## 2.2 Sample size determination

Sample size of 420 was used i.e. 14 clusters of 30 households each.

This was determined using the equation below.

where:

$n = D[(Z_1+Z_2)^{2} * (sd_1^{2}+sd_2^{2}) / (X_2-X_1)^{2}]$

n = the required minimum sample size per survey round,

D = design effect (=2 for cluster surveys)

$Z_1$ = z-score corresponding to the degree of confidence with which it is desired to be able to conclude that an observed change of size ($X_2$-$X_1$) would not have occurred by chance (=2.326).

$Z_2$ = z- score corresponding to the degree of confidence with which it is desired to be certain of detecting a change of size ($X_2$-$X_{1)}$ if one actually occurred (=2.320).

$sd_1$ and $sd_2$ = expected standard deviations for the indicators for the respective survey rounds (=1.74 and 1.82)

$X_1$= estimated level of the indicator at baseline (= 5.3)

$X_2$ = estimated level of the indicator at a future date (=5.9).

## 2.3 Sampling procedure

The two-stage cluster sampling procedure was used to choose 14 clusters from the 21 visited at baseline. The clusters were based of food distribution points (FDPs) in the program area.

The same clusters were chosen so as to reduce variability resulting from background characteristics and make the task of determining real change easier[1].

At the first stage clusters were chosen using the random systematic sampling technique and at the second stage, households were chosen using a purposive sampling technique. This was to ensure that beneficiaries chosen were not those previously interviewed in the study held last year thus avoid biases and also to try and include as many children as possible from each area.

Clusters were chosen from the following areas; Kamwokya, Entebbe, Kituntu, Ssi, Kasangombe, Bukulula, Kiwangala, Mbarara Kyagaju, Nyenga, Nakaloke and Ntungamo. A total of 11 districts spreading from the east to west of Uganda were visited and 421 beneficiary households were interviewed. The division by IP is shown in Table 1.

Table 1 Areas visited by Implementing Partner

| **Implementing Partner** | **Areas visited (FDP)** | **Number of clusters** |
|---|---|---|
| TASO | Entebbe, Mbarara, Kyagaju, Nyenga, Nakaloke and Busia | 6 |
| CRS | Kamwokya, Gaba, Bukulula and Kiwangala | 4 |
| WV | Kituntu, Ssi, Kasangombe | 3 |
| AFRICARE | Rushoka | 1 |

## 2.4 Data collection methods and instruments

A pre-tested structured questionnaire was used to collect quantitative data during household interviews and a checklist for focus group discussions and key informant interviews. The latter two were aimed at collecting qualitative information on the contextual factors that explain the quantitative results obtained from the household interviews. In addition, children under five years old in the beneficiary households were weighed and their heights taken using standardized scales and stadiometers to enable assessment of their nutritional status. The enumerators were trained and standardized to reduce measurement errors. In addition, observations were made of hygiene practices and sanitation facilities in the beneficiary households. The data collection exercise lasted a period of 3 weeks.

[1] Magnani R 1997 *Sampling Guide* Food and Nutrition technical Assistance, Academy for educational Development, Washington DC.

## 2.5 Data coding and entry

Data coding and entry was done manually and questionnaires were scrutinized for irregularities before and after data entry was done.

## 2.6 Data analysis and presentation

SPSS and Epi Info packages were used to analyze data for means, frequencies and z-scores. Cross tabulations, stratification and correlations were used to compare the results by gender, geographical setting, IP and other background characteristics. All data was analyzed at the 95% confidence level. Statistical information has been presented using tables, graphs and charts.

# 3.0 Results and Discussion

## 3.1 Household Food Consumption

Household food consumption was assessed using two impact indicators; dietary diversity score (DDS) and meal frequency. In addition, a food frequency questionnaire (FFQ) was used to clarify the DDS and give a long-term assessment of the beneficiaries' diet.

### 3.1.1 Dietary Diversity score;

Dietary diversity is defined as the number of food groups consumed by an individual or household in a given period of time. In this study the food group classification was done according to the FAO food groups; Cereals, roots/tubers, pulses/legumes, milk/milk products, meat, fish/sea food, eggs, poultry, oil/fats sugar/honey, fruits and vegetables and a 24 hour recall period was used to get information on the beneficiaries' food intake.

The analysis shows that DDS has gradually increased since baseline. The mean DDS program-wide was found to be 5.8 this is above the target set for this FY04 (5.5). The change by district is shown in Figure 1 below.

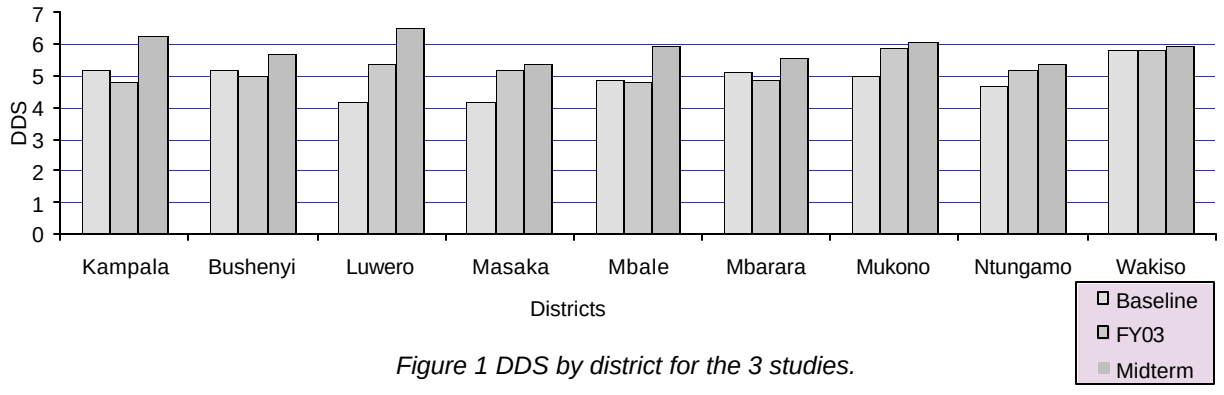


*Figure 1 DDS by district for the 3 studies.*

A high DDS (=6) indicates a varied diet and has been associated with improved anthropometric status, birth weight, reduced risk of mortality and adequate caloric and protein intake[2]. Five out of the nine districts had a mean DDS of 6 and above. The common food groups mentioned were

[2]Hoddinott J and Yohannes Y *Dietary diversity as a Household Food Security Indicator* Washington DC Food and Nutrition Technical Assistance Project, Academy of Educational Development, 2002.

cereals (93%) and legumes (80%), followed by vegetables (79%), fruits (72%) and oil/fats (71%). Honey/sugar (55%) and tubers (52%) were next. Fewer beneficiaries. (percentages below 35%) reported the rest of the food groups. This shows a change in the feeding patterns since baseline where 73-90% were consuming tubers, 60% were consuming fruits and vegetables and about 25% were consuming oil/fats. The FFQ gave similar percentages with 94% reporting consuming cereals more than once weekly, 90% reporting legumes and 75% reporting tubers for the same period. Results for the FFQ are presented in Table 2.

*Table 2 Frequency of food group consumption*

| **Food Group** | **% reporting consumption of food groups more than once weekly** |
|---|---|
| Tubers | 76 |
| Cereals | 94 |
| Legumes | 90 |
| Meat | 11 |
| Fish | 40 |
| Milk | 38 |
| Eggs | 19 |
| Poultry | 6 |
| Vegetables | 73 |
| Fruits | 65 |
| Sugar | 68 |

The changes in the feeding patterns were attributed to the food distribution and the nutrition education. Focus group discussions reported the high percentages of cereals, legumes and oils are mainly due to CSB and vegetable oil received every month. An increase in vegetable consumption was reported to be due to availability of oil in the beneficiary households. However, it was not as high as cereals or legumes because of the dry season.

3.1.2 Meal frequency – No of meals per day;

Meal frequency is a proxy for adequacy of caloric intake and can also be used in capturing transitory food insecurity[3]. The mean number of meals across the districts ranged between 2 and 6 with the majority (≥80%) reporting meal numbers between 3 and 5. The mean for the whole program is 4.1. This is significantly different form what was reported at baseline - 2.9 *($p<0.05$)*. All of the areas visited had experienced a prolonged drought season and 71% of the beneficiaries reported limitations to increasing meal frequency. Lack of money (51%), lack of other food (14%),

[3] Food and Nutrition Technical Assistance (FANTA) project and Food Aid Management (FAM) *Food Access Indicator Review* Washington DC 2003

sickness (11%) and drought (10%) were the most common limitations reported. Meal frequency is also affected by cultural practices and livelihoods so even with increased food availability it may still be limited by these factors.

### 3.2 Ration Utilization.

Ration utilization was assessed by looking at the frequency of CSB consumption and the number of different recipes known to the beneficiaries. The analysis showed that CSB consumption has continued to remain high with a vast majority (>90%) reporting use of CSB twice or more times a day. The largest percentage (48%) reported using CSB three times. This concurs with the data collected quarterly where the majority report using CSB two to three times a day. Table 3 below shows frequency of CSB use per day for FY03 and FY04 (midterm).

*Table 3 Frequency of CSB consumption*

| **Frequency of daily consumption of CSB** | **FY03 %** ***(n= 429)*** | **Midterm %** ***(n=415)*** |
|---|---|---|
| Once | 4 | 7 |
| Twice | 27 | 29 |
| Thrice | 48 | 48 |
| More than thrice | 21 | 16 |

#### 3.2.1 Percentage of beneficiaries who know at least 2 recipes using CSB

About 88% of the beneficiaries reported knowing at least two recipes. Table 4 shows the different CSB recipes reported by the beneficiaries during the annual study of FY03 and at midterm. The most common recipes for both are CSB porridge and *posho*.

*Table 4 CSB recipes reported by beneficiaries*

| **Recipes** | **FY03 %** | **Midterm %** |
|---|---|---|
| Porridge | 97 | 99 |
| Posho | 76 | 69 |
| Sauce | 37 | 45 |
| Bread | 4 | 32 |
| Pancakes | 35 | 30 |
| Chapati | 0 | 15 |
| Doughnuts | 7 | 11 |
| Bagiya | 0 | 1 |
| Samosa | 1 | 1 |

Some families, especially those with children reported using it to make snacks for their children like pancakes and doughnuts with the oil provided, while others prefer it in the food either as part of the sauce or *posho*. Focus group discussions reported that the demonstrations at food distribution points (FDPs) led to the increase in recipes used for CSB preparation.

### 3.2.2 Storage of CSB

About 63% of the beneficiaries stored CSB on a raised stand. The stands included stools, benches, jericans and stones. About 21 % stored it on the floor while 5.6% stored it in a plastic container. The latter was common in urban areas. Plastic containers were used to keep away ants and rodents. FGDs reported nutrition training at FDPs as the main source of information on CSB storage.

## 3.3 Nutritional Knowledge

About 77% of the beneficiaries reported knowledge of the food that is recommended for them to eat. Beneficiaries reporting 3 correct reasons for consuming particular food groups were 52%, 15percentage points higher than those reporting them at baseline. The responses were highest for cereals where 81% reported at least one correct response, and legumes where 62 % reported at least one correct reason. About 45 % reported at least 2 correct eating habits for PLWHA. This is also higher than the 32 % at baseline.

## 3.4 Nutritional status

Nutritional status has been defined in a number of ways; FAO defines it as net outcome of an individual's usage of food while Gibson (1999) defines it as the outcome of interactions between individuals' genetic potential and environmental factors, which include food, health, income, lifestyle, and education. Since the beneficiaries have had access to food, the nutritional status is expected to improve assuming that other environmental factors such as care and health status remain constant. Nutritional status was assessed using anthropometric measures of children below five years old and using them to calculate z scores. The percentages of children underweight/low weight for age (with z-scores < –2) and stunted/low height for age (z-scores < –2) were determined and compared to the previous years including baseline.

### 3.4.1 Percentage of children with low weight for age (underweight)

Weight for age z-scores were analyzed for 126 children using Epi Info software package and the results have been compared to baseline and FY03 in Table 5.

*Table 5 Prevalence of Underweight among children below 59 months by age group*

| **Age group (months)** | **Percent of children below –2 z-scores** | | |
|---|---|---|---|
| | Baseline (FY02) *(n=289)* | FY03 *(n=190)* | MidtermFY04 *(n= 126)* |
| >12 | 0.6 | 1.0 | 3.1 |
| 12 - 23.9 | 3.3 | 5.3 | 5.6 |
| **24 – 35.9** | **5.5** | **3.1** | **0.8** |
| **36 – 47.9** | **7.3** | **4.2** | **4.0** |
| 48 – 59.9 | 1.5 | 3.2 | 2.4 |
| **Mean** | **18.4** | **16.8** | **15.9** |

The prevalence of underweight among children below five years of age is gradually decreasing and this is more evident among children between 24 and 48 months. Focus group discussions reported that it was a common practice among beneficiary households to give children CSB porridge as a midmorning and evening snack in addition to their regular meals and this they believed was one of the main contributing factors to the improvement in nutritional status. The change in feeding patterns is mainly attributed to the nutrition training received at food distribution points.

### 3.4.1 Percentage of children with low height for age (stunted)

The prevalence of stunting (low weight for age) among children below 5 years of age decreased from 36% at baseline to 32%, Table 6 shows the details in the different age groups. The most significant change is in the age group of children between 12 and 36 months.

*Table 6 Prevalence of Stunting among children below 59 months by age group*

| **Age group (months)** | **Percentage of children below –2 z scores** | |
|---|---|---|
| | Baseline *(n=289)* | Midterm *(n=104)* |
| < 12 months | 1.0 | 1.0 |
| **12 – 35.9** | **13.9** | **8.6** |
| 36 – 47.9 | 13.2 | 13.4 |
| 48 - 59.9 | 8.0 | 9.0 |
| **Mean** | **36** | **32** |

NB Stunting is not expected to change over a period of a year and it was therefore not assessed during FY03

### 3.4.2 Mean z scores

The mean z scores for weight for age (WAZ) and height for age (HAZ) increased from baseline to midterm. This also portrays an improvement in the nutritional status of the children on the program. Table 7 shows the increases in z scores since baseline.

*Table 7 Change in mean z scores among specific age groups*

| | **WAZ 6 - 35 months** | **HAZ 24 - 59 months** | ***p value*** |
|---|---|---|---|
| **Baseline** | -1.66 | -1.33 | *p>0.05* |
| **Midterm** | -0.81 | -0.73 | *p>0.05* |

## 3.5 Health status

Improved health status is one of the outcomes that have been reported on beneficiaries given CSB or fortified soybean. This study looked at incidence and duration of illness as the main indicators for assessing health status of the beneficiaries.

### 3.5.1 Percentage of beneficiaries ill at least twice in the previous 2 months

Beneficiaries reporting two or more episodes of illness in the previous 2 months decreased from 38% at baseline to 30%. While those reporting at least one episode of illness decreased from 82% to 56% in the sampled population. Focus group s reported fever as the commonest symptom suffered. Table 8 below shows the change since baseline.

*Table 8 Incidence of illness over the 2 year period*

| **Beneficiaries** | **Baseline** *(n=630)* | **FY03** *(n=429)* | **Midterm** *(n=421***)** |
|---|---|---|---|
| % Reporting = 1episodes of illness | 82 | 68 | 56 |
| % Reporting = 2 episodes of illness | 38 | 41 | 30 |

### 3.5.2 Mean number of times beneficiaries are unable to work due to illness.

The percentage of beneficiaries reporting inability to work due to illness in the previous 2 months decreased from 56% at baseline to 31% at midterm. The mean number of times decreased from 2 to 1.6 (*p<0.05*)

The longest periods during which the beneficiaries were unable to work was compared with what was reported at baseline and for FY03. Table 9 shows the details.

*Table 9 Distribution of clients by period unable to work in the previous 2 months*

| **Period** (days) | **Baseline** | | **FY03** | | **Midterm** | |
|---|---|---|---|---|---|---|
| | ***No.*** | ***%*** | ***No.*** | ***%*** | ***No.*** | ***%*** |
| 1 – 7 | 151 | *24* | 74 | *17* | 63 | *15* |
| 8 – 14 | 69 | *11* | 31 | *7* | 23 | *5* |
| 15 – 30 | 78 | *12* | 15 | *4* | 21 | *5* |
| 31 - 60 | 58 | *9* | 32 | *7* | 19 | *4* |

For almost all the periods the percentages have decreased, this implies the beneficiaries are coping much better now than at baseline. Focus group discussions concurred with this, they reported feeling stronger and many of them were returning to work. Some distribution officers reported using this as a basis of phasing out some beneficiaries from the program.

### 3.5.3 Health seeking behavior

The places where beneficiaries sought treatment are shown in Figure 2. Over 50% went to the IP center while most of the others went to health centers.

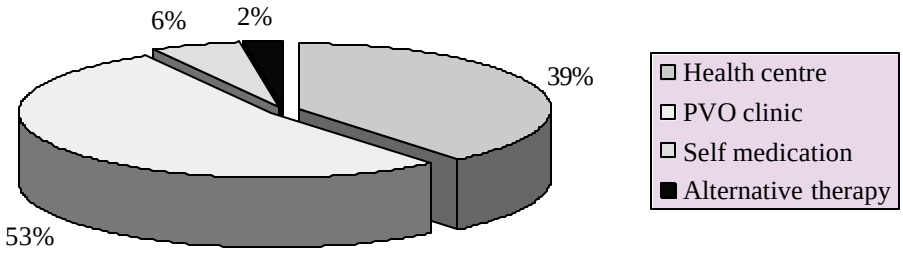


*Figure 2 Places where beneficiaries sought treatment*

## 3.6 Water and Sanitation

Improved water quality has been associated with up to 20% reduction in diarrheoal diseases[4]. This can only be achieved by using a protected water source and keeping water in containers that are

[4] International Nutrition Foundation for Developing Countries 1997 *Hygiene Evaluation Procedures – Approaches and measures for assessing water and sanitation related hygiene practices INFDC 1997*

clean and covered to avoid re-contamination. Research shows that hygiene related practices such as safe disposal of feaces and hand washing after contact with fecal material can reduce rates of intestinal infections by 35%[5]. This is important for people living with HIV/AIDS since diarrhoea is one of the diseases that tremendously affect their health. Information on water source and storage and hand washing techniques and facilities was collected and the results are presented below.

### 3.6.1 Percentage of beneficiaries with proper storage of water

About 67% of the beneficiaries collected water from a protected source (protected spring, borehole tank and tap) while 33% collected it from an unprotected source. Table 10 below shows the sources of water since baseline. The slight difference may be only because of changing samples. In addition, the water source may change in periods of prolonged drought when some rivers/streams dry up or when facilities like boreholes breakdown.

*Table 10 Sources of water reported by beneficiaries*

| Water source | Baseline % | FY03 % | Midterm % |
|---|---|---|---|
| Protected spring | 31 | 29 | 23 |
| Borehole | 17 | 20 | 21 |
| Tap/Tank | 18 | 22 | 23 |
| Unprotected source | 34 | 28 | 33 |

Observations of the storage containers revealed that about 79% had separate containers for drinking water, slightly higher than the 77% last year. Table 11 summarizes the characteristics of the container.

*Table 11 Storage container characteristics*

| Storage Container | Baseline (%) | FY03 (%) | FY04 (Midterm) (%) |
|---|---|---|---|
| Clean | 62 | 60 | 67 |
| Covered | 74 | 60 | 66 |
| On a raised surface | 33 | 37 | 39 |

Various descriptions were given for the water in the separate container; about 77% described it as water "not used for other purposes", 65% described it as "boiled", 5% described it as "kept aside"

[5] International Nutrition Foundation for Developing countries 1997 *Hygiene Evaluation Procedures - Approaches and methods for assessing water and sanitation related hygiene practices INFDC 1997*

and another 5% as "clean and safe". These descriptions give an indication of the treatment the water is given.

### 3.6.1 Percent of beneficiaries with proper hand washing practices

About 90% of the beneficiaries washed both hands rubbing them at least 3 times; however only 62% used soap and 24% dried them hygienically. The percentage of beneficiaries practicing all the four recommended practices was only 15%. Drying hygienically is the challenge in the rural setting since it is not easy to have towels hanging outside toilets. In addition, beneficiaries mentioned that sometimes they do not have soap and thus do without it. Observations in the homesteads showed that although 93% had toilets/pit latrines only 18.6 % had a hand washing facilities outside their toilets.

Beneficiaries mentioned a number of reasons why they thought it was important to wash hands. These included killing germs (46%), removing dirt (36%), removing germs and odours (16%) and cleaning hands (9%). Health workers (41%) and community workers (21%) were the main source of the information. Details on the sources of information are shown in chart below.

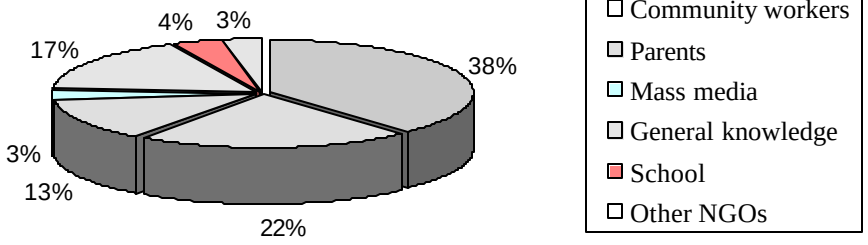


*Figure 3 Source of hygiene information*

### 3.6.2 Hygiene education

About 63% of the beneficiaries reported that they had been taught about hygiene and sanitation with topics ranging from personal, food and kitchen hygiene to waste disposal and construction of racks. Observations in their homes revealed that 54% had drying racks, 46% had kitchen racks and 24% had compost pits. The kitchen racks were mainly made of wood and reeds. Racks were generally more common in the rural areas than urban ones. Focus groups reported that this because of the little space available in the urban areas where many of the beneficiaries stay in 1 or 2 roomed

houses. Community workers reported that the hygiene situation was beginning to improve in the beneficiary homesteads.

### 3.7 Household Expenditure

This is used as a proxy of household income and welfare. Data on expenditure on food and non-food items was collected using recall methods of 7 days, 3 months and yearly periods. The values were multiplied by factors to get monthly expenditure. The mean expenditures were analyzed for the whole program and were compared with those at baseline.

#### 3.7.1 Mean household expenditure on non-food items

Mean household expenditure on non-food items was found to be U Shs 65,686 per month. This is significantly different from the mean at baseline U Shs 43,641 but not significantly different from the mean for FY03 (U Shs 68,438). The greatest expenditure is on education while the least is on water. About 25% of the beneficiaries reported receiving assistance from children and other relatives. Household expenditure on non food items for those who did not receive assistance was found to be significantly lower (U Shs 55,566).

#### 3.7.2 Mean household expenditure on food items

Data on expenditure on food items shows an increase from U Shs 29,856 at baseline to U Shs 37,052 per month at midterm. It was reported lowest in Ntungamo (UShs 12,053) and highest in Entebbe (U Shs 98,931). This can be explained by the fact that residents of Entebbe are living in an urban setting where they cannot grow their own food but have to buy all that they eat. In addition, most of them are employed and can afford to buy food while those in Ntungamo grow most of their food and just buy a little extra food on market days once a week. Focus group discussions revealed that beneficiaries were getting more productive and able to earn more especially those living in urban settings.

### 3.8 School enrollment and retention

School enrollment and attendance were expected to improve with the food distribution and the annual study (FY03) reported an increase. However, because of the universal primary education

the numbers were already high. Analysis of this data shows that the mean number of children in school is 3.61 while the mean number of children between 5 and 15 years in the beneficiary household is 3.4. This implies that most of the children are enrolled in school. In addition, only 39% reported missing school and this is lower than what was reported at baseline (52%).

### 3.9 Attendance of Non food services

The beneficiaries accessed a number of different non food services. These can be categorized into four including; clinical services, counseling services, nursing care and social support services. The attendance varied because of a number of reasons like how often they were offered and what else the beneficiary could access at the same time. For example, food aid services are accessed at the same time as when they receive food while counseling services are accessed when they seek clinical services. The attendance rates ranged from 1.3 to 2.2 in the previous 2 months. Attendance at baseline has been compared to midterm. Table 12 below shows the details.

*Table 12 Mean number of times non food services were attended*

| Non food aid services | Baseline | Midterm |
|---|---|---|
| Clinical | 2.50 *(n=683)* | 2.20 *(n=223)* |
| Counselling | 2.50 *(n=572)* | 2.00 *(n=242)* |
| Nursing care | 2.30 *(n=639)* | 1.80 *(n=479)* |
| Social support | 2.56 *(n=328)* | 1.95 *(n=248)* |
| **Mean** | **2.45** | **1.96** |

The attendance of non food services has decreased possibly because the beneficiaries are improving and so they do not have to seek the services as often as before. As the beneficiaries are getting more and more productive they are involved in small income generating activities and will only seek support services when they are in need. Other reasons reported for not accessing some of the services were lack of funds and the long distance they would have to travel to the centers.

About 13% of the beneficiaries reported receiving assistance from community based organizations (CBOs). Nature of assistance included school fees (6 %), medicines (5%), household items (1%) and domestic animals (1%).

## 4.0 Conclusions

1) The food security situation has improved in the beneficiary households as shown by the improved DDS and meal frequency. Focus group discussions reported that this was mainly because of the CSB and vegetable oil. Some efforts to improve production of food among beneficiary households were reported in Bukulula with the help of a CBO-CEDO. However, it was not possible to ascertain how much the beneficiaries had gained because the crops had been destroyed by the prolonged dry season.
2) The nutritional and health status have improved as demonstrated by the nutritional indices for stunting and wasting and the incidence of disease. Focus group discussions reported that beneficiaries are beginning to produce their own food and a lower percentage reported inability to work due to illness.
3) Although hygiene education has been conducted in some areas percentage of beneficiaries adopting new hygiene practices are still low as shown by the percentages practicing recommended hand washing practices and appropriate storage of drinking water.
4) Attendance of non food services has decreased implying reduced vulnerability among the beneficiaries. Beneficiaries are getting productive and are involved in other activities other than the specific non-food aid services offered by the IPs.
5) Utilization of CSB has increased since FY03 and more respondents reported knowledge of different CSB recipes.

## 5.0 Recommendations

1. Strategies that will reach beneficiaries at household level need to be explored so that hygiene practices at household level are improved. This may involve working more with community workers who will reach the beneficiaries at household level. Community workers reported that this could improved by increased facilitation to enable more home visits and follow up.
2. More CBOs that can work with the beneficiaries to help them improve on their productivity should be encouraged as the beneficiaries are getting stronger and some of them are being phased out of the program. IPs may consider exploring the possibility with existing CBOs in their areas of operations.

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**ACDI/VOCA PL-480 LIFE INITIATIVE.**

**MID TERM SURVEY QUESTIONNAIRE.**

Date of interview. _____

Time: Start _____End _____

Enumerator's code _____ Supervisor's code_____

## Section 1. Household identification

This section is to be completed by the enumerator

101 Name of the district _____
102 Name of the sub county _____
103 Name of the village _____
104 Name of the IP_____
105 Cluster #_____106 Household #_____
107 ID # _____

108 – 111. ***INSTRUCTIONS: This information is available either on the card or from the primary beneficiary or caregiver and should be filled in by the interviewer.***

| # | Questions | Code |
|---|---|---|
| 108. | Identification No. of the primary beneficiary _____ | |

| | |
|---|---|
| 109. Status of Beneficiary *(Tick one answer)* | 1: HIV+ |
| | 2: Orphan |
| | 3. Both |

| | | |
|---|---|---|
| 110. | Gender *(Tick one answer)* | 1: Male |
| | | 2: Female |

| | | |
|---|---|---|
| 111. | Date of birth of primary beneficiary ____/_____/_____<br>*(estimate if necessary)* Day/month/ year | Age *(in years)* = |

**Use past events to ascertain this date**

## Section 2. Household characteristics

***INSRUCTIONS: The respondent is the primary beneficiary or caregiver***

| # | Questions | Code |
|---|---|---|
| 201(a) | Household head<br><br>What is the relationship of the household head to _____?<br>(name of beneficiary)<br>(*Tick one answer*) | 1: Beneficiary him/herself |
| | | 2. Spouse |
| | | 3. Parent |
| | | 4: Elder sibling >15 |
| | | 5: Elder sibling < 15 |
| | | 6: Other relative adult |
| | | 7: Non relative |

| | | |
|---|---|---|
| 202 – 207. (b) | Family structure *(write the number in each category in the right column)*<br>How many members does this household have? | *(write number)* |
| 202. | How many boys <5 are there in the household? | |
| 203. | How many girls <5 are there in the household? | |
| 204. | How many boys between 5 - 15 are there in the household? | |
| 205. | How many girls between 5 - 15 are there in the household? | |
| 206. | How many male >15 are there in the household? | |
| 207. | How many female >15 are there in the household? | |

| | | |
|---|---|---|
| 208. | How many children are in school? *(write number)* | # : |
| 209 | **If the number is less than the total of 204 and 205 ask**<br>Why aren't the other children in school? *(write reason)* | |

| | | | |
|---|---|---|---|
| 210 | Did any children miss any school last month?<br>(*Tick one answer*) | 1 Yes | 2 No<br>**-> Go to section 3** |

| | | | |
|---|---|---|---|
| 211 – 214. | If yes which children missed school last month and how many days did each of them miss?<br>*(write the number of days missed by each child in the right column)* | | # days: |
| | | 211. Child 1 | |
| | | 212. Child 2 | |
| | | 213. Child 3 | |
| | | 214. Child 4 | |

## Section 3. Dietary diversity

***INSTRUCTIONS: The respondent is the primary beneficiary or caregiver.***
301 - 306. Yesterday, did you or anyone in your household consume…?

| Eating occasion<br>*(tick yes or no)* | Yes | No | Limitations |
|---|---|---|---|
| | | | 308 (a) Is there anything that limits the number of meals you have in a day?<br>1. Yes 2. No |
| 301. A morning meal? | | | |
| 302. Any food between morning and Lunch? | | | |
| 303. Lunch? | | | |
| 304. Any food between Lunch and Supper | | | 308(b) If yes what are these things? |
| 305. Supper | | | |
| 306 Any food after supper? | | | |
| 307 Total number of meals (Confirm and write figure) | | | |

309 – 319Yesterday did you or anyone in your household consume any of the following foods?

| Food Group | Yesterday, did you or anyone in your household consume any of the following foods? | Food Group | Yesterday, did you or anyone in your household consume any of the following foods? |
|---|---|---|---|
| **CEREAL:** Maize ,Millet, Sorghum Rice, wheat,, **CSB** | 309. 1. Yes 2. No | **FISH: Ngege, Mukene, Mputa,…** | 315. 1. Yes 2. No |
| **ROOTS / TUBERS:** **Cassava, Yams, Irish** Potato, sweet potato, | 310. 1. Yes 2. No | **OIL /FAT:** Ghee, Eshabwe, Simsim, Sunflower **USA veg oil** | 316 1. Yes 2. No |
| **LEGUMES:** Peas, G.nuts, Soya, Beans Pigeon Peas **CSB** | 311. 1. Yes 2. No | **SUGAR / HONEY / MOLASSES:** | 317 1. Yes 2. No |
| **MILK / MILK PRODUCTS**: Yoghurt, Whey, (Amacunda) | 312 1. Yes 2. No | **FRUITS:** Matooke, Water melon, Banana, mango, papaya, pineapple, guava, jackfruit, orange, | 318. 1. Yes 2. No |
| **EGGS:** | 313 1. Yes 2. No | **VEGETABLES:** Ovacado, Carrots, Cabbage,Onion, Greens, eggplant, pumpkin, tomato, squash | 319. 1. Yes 2. No |
| **MEAT** Beef, mutton, pork rabbit ,Goat Meat Offals | 314 1. Yes 2. No | **POULTRY:** Chicken, duck, pigeon Turkey, Guinea fowl | 320 1. Yes 2. No |
| | | Other/ Miscellaneous Spices seasonings | 321 1. Yes 2. No |

Question: Which foods are eaten in your household? How often (Use scale below)

| Food group | Frequency of consumption | | | | | | |
|---|---|---|---|---|---|---|---|
| *(Clarify using examples above and tick where appropriate)* | >Once daily | Once daily | >Once weekly | Once weekly | >Once monthly | Once monthly | Never |
| 322 Tubers | | | | | | | |
| 323Cereals | | | | | | | |
| 324 Legumes | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 325 Meat and meat products | | | | | | | |
| 326 Fish | | | | | | | |
| 327 Milk and milk products | | | | | | | |
| 328 Eggs | | | | | | | |
| 329 Poultry | | | | | | | |
| 340 Vegetables | | | | | | | |
| 341 Fruits | | | | | | | |
| 342 Sugar, Honey, Molasses | | | | | | | |
| 343. Matooke | | | | | | | |

## Section 4: Knowledge of the nutrition strategy for living positively

INSTRUCTIONS***: The respondent is the primary beneficiary or caregiver***

401.Do you know what type of foods are good for PLWHA ?

1 Yes (If Yes fill in table below)

2 No (Go to next section)

| Types of Food. What types of food do you know? (Tick food gp below) | Reasons (Why is this food important? Write reason below) | | | |
|---|---|---|---|---|
| | Reason 1 | Reason 2 | Reason 3 | Reason 4 |
| 402 **CEREAL:** Maize ,Millet, Sorghum Rice, wheat,, **CSB** | | | | |
| **403 ROOTS / TUBERS:** Potato, sweet potato, Cassava Yams Irish potatoes | | | | |
| 404. **FISH: Mukene, Mputa,** | | | | |
| 405 **OIL /FAT:** Ghee, Eshabwe, Simsim, Sunflower **USA veg oil** | | | | |
| **406 LEGUMES:** Peas, G.nuts, Soya, Beans Pigeon Peas **CSB** | | | | |
| 407 **MILK / MILK PRODUCTS** | | | | |
| 408 **EGGS:** | | | | |
| 409 **MEAT** Beef, mutton, pork rabbit ,Goat Meat Offals | | | | |
| **410 FRUITS:** Water melon, Banana, mango, papaya, pineapple, guava, jackfruit, orange, | | | | |

| | | | | |
|---|---|---|---|---|
| **411 VEGETABLES:** Ovacado, Carrots, Cabbage,Onion, Greens, eggplant, pumpkin, tomato, squash | | | | |
| **412 POULTRY: Chicken, Turkey,** | | | | |
| **413 SUGAR / HONEY / MOLASSES:** | | | | |
| Matooke *(Ask about Matooke separately)* | | | | |

| | |
|---|---|
| 414. Where did you get that information? ***(Mark all that are mentioned)*** | 1: Community volunteer / counselor |
| | 2: Health worker |
| | 3.Herbalist |
| | 4 General Knowledge |
| | 5.Mass media |
| | 6. Other (specify) |
| 415. What kinds of eating habits are good for PLWHAs? ***(Mark all that are mentioned)*** | 1: Eat small but frequent meals |
| | 2: Eat a variety of foods |
| | 3. Drink plenty of fluids (including water) |
| | 4. Eat plenty of fruits |
| | 5 Same as non HIV+ |
| | 6. Other (specify) |
| | 7: Don't know -> **Go to Section 5** |
| 416Where did you get that information? ***(Mark all that are mentioned)*** | 1: Community volunteer / Counselor |
| | 2: Health worker |
| | 3.Herbalist |
| | 4.Mass media |
| | 5: Other (specify)_____ |

## Section 5: Ration utilization

***INSTRUCTIONS: The respondent is the person responsible for food preparation for the household.***

| # | Questions | Code |
|---|---|---|
| 501. | How long have you used CSB flour? (Write period in years) | |

| | | |
|---|---|---|
| 502. | How many times a day do you use it? (Write number) | |

| | | |
|---|---|---|
| 503. | What recipes do you know? *(Mark all that are mentioned)* | 1: Porridge |
| | | 2: Sauce |
| | | 3. Posho |
| | | 4:Mandazi/doughnuts |
| | | 5.Samosas |
| | | 6.Pancakes |
| | | 7.Other (specify) |

| | | |
|---|---|---|
| 504. | Who taught you the different recipes? *(Mark all that are mentioned)* | 1: Community leader |
| | | 2. Community worker |
| | | 3: Health worker |
| | | 4. Food Project officer |
| | | 5: No one |

| | | |
|---|---|---|
| | | 6: Other (specify) |

505(a) Has CSB changed your diet? 1. Yes 2. No *(If No Continue with 505(c))*
505(b) If Yes, in what ways has it changed _____
_____50
5(c)_If No why do you think it has not changed_____

**Section 6: Household expenditure**

*(The enumerator will work with the respondent to get the total of the money spent on the items for mentioned below for the specified period*)
***INSTRUCTIONS: The respondent is the beneficiary or person responsible for food preparation for the household.***

600(a) Is there anyone in this household who is employed /earns some wages regularly? !. Yes 2. No
b) If yes what kind of employment is this _____ **(If there are more than one include for all.) _____**
c) Do you receive any assistance (e.g financial assistance ) from a child or any other relative? 1 Yes 2 No
If Yes what kind of assistance?_____

| Questions | | Amount Spent |
|---|---|---|
| How much did the household spend last week for …?<br>*(write in amount in local currency)* | 601. Food (include tealeaves, salt, sugar ) | |
| | 602. Water | |
| | 603. Fuel (Parrafin, charcoal) | |
| | 604. Transport | |
| | 605.Soap toothpaste toilet paper, other toiletries | |
| Questions | | Amount Spent |
| How much did the household spend in the last 3 months for …?<br>*(write in amount in local currency)* | 606. Clothes | |
| | 607. Health | |
| | 608. Rent | |
| | 609.Household supplies Pans, Jericans, Brooms, Plates, Cutlery ,Pots | |
| | 610.Other locally important item e.g security | |
| Questions | | Amount Spent |
| How much did the household spend in the last 12 months for …?<br>*(write in amount in local currency)* | 611 Education | |
| | 612. House repairs | |
| | 613. Funeral savings or expenses (Munnomukabi) | |
| | 614. Insurance/Saving | |

## Section 7: Hygiene

***INSTRUCTIONS: The respondent is the beneficiary or caregiver.***

| # | Questions | Code |
|---|---|---|
| 701(a). | Where does the household collect its water?<br>*(Mark all that are mentioned)* | 1: River/Spring |
| | | 2: Well |
| | | 3: Protected Spring/Well |

| | | |
|---|---|---|
| | | 4: Borehole |
| | | 5: Tap |
| | | 6: Other (specify) |
| 701(b) | Are there any months when water is scarce? 1.Yes 2.No | 1.Less meals<br>2.Less washing and cleaning |
| 701(c) | If Yes what does this water scarcity lead to? (Tick all mentioned) | 3.Walking long distances<br>4. Other specify _____ |

| | | | |
|---|---|---|---|
| 702. | Can you please show me where you store your drinking water and CSB? | 1: Yes | 2: No -> **Go to 711** |

| | |
|---|---|
| 703(b) | If Yes is the container for water separate ? 1…Yes 2..No |
| 703(c) | Where is CSB stored? (Write what you observed _____ |

| | | |
|---|---|---|
| 704. | What container is used to store drinking water<br>*(Tick what you observe)* | 1. Small Jerican |
| | | 2. Bucket |
| | | 3. Pot |
| | | 4. Saucepan |
| | | 5. Other (specify) |

| | | | | |
|---|---|---|---|---|
| 705 – 707. | **Observe** if the container is<br>(*Tick what you observe)* | 705. Clean | 1. Yes | 2. No |
| | | 706. Covered | 1:Yes | 2: No |
| | | 707. Put on Shelf/stand | 1. Yes | 2. No |

| | | |
|---|---|---|
| 708. | How is the water drawn from the container?<br>(*Tick what you observe)* | 1: Using a long handle dip |
| | | 2: Tilted and poured |
| | | 3. Using a cup |
| | | 4: Other (specify) |

| | | | |
|---|---|---|---|
| 709 | Is the water in this container used for other purposes? | 1. Yes | 2. No -> **Go to 711** |

| | | |
|---|---|---|
| 710. | if yes what?<br>*(Mark all that are mentioned)* | 1: Cooking |
| | | 2: Cleaning |
| | | 3: Other (specify) |

| |
|---|
| 711 Why do you call it drinking water? |
| |

| | | |
|---|---|---|
| 712 | <u>where did you get this information?</u><br>(*Tick all that are mentioned*) | 1: Community volunteer |
| | | 2: Health worker |
| | | 3: Other ( Specify) |
| 713.<br>When did you wash your hands yesterday?<br>*(Tick all that are mentioned Do not prompt)* | | 1.After gardening |
| | | 2.After doing household chores |
| | | 3.Before food preparation |
| | | 4.Before eating |
| | | 5. Before feeding children |
| | | 6. After visiting the toilet |

| | |
|---|---|
| | 7.After eating food |
| | 8.Other specify |

| | | | |
|---|---|---|---|
| 714 | Can you show me how you wash your hands? | 1. Yes | 2. No<br>-> **Go to 719** |

| | | | |
|---|---|---|---|
| 715<br>719. | Observe the washing techniques and tick yes if you see this technique. Tick no if you do not see this technique | | |
| 715 | Uses soap or ash | 1. Yes | 2. No |
| 716 | Washes both hands | 1. Yes | 2. No |
| 717. | Rubs hands together at least three times | 1. Yes | 2. No |
| 718. | Dry hands hygienically by air drying or using a clean cloth | 1. Yes | 2. No |
| 719.<br>What is the importance of washing hands with soap before eating or handling food? | | | |

| | | |
|---|---|---|
| 720. | Where did you get this information? | 1 Community volunteer |
| | | 2 Health worker |
| | | 3.Mass media |
| | | 4 Other (specify) |

721. Have you been taught about sanitation this past year? 1. Yes 2. No (If No continue )
(b) If yes what did you learn about?_____
_____c)
who taught you_____

| Household sanitation |
|---|

Take a look around the household and **observe** which of the following items listed below are available

| **Item** | **Present** |
|---|---|
| 722. Drying rack for cups and plates | |
| 723. Hand washing facility possibly near latrine | |
| 724. Compost pit | |
| 725. Pit latrine/Toilet | |
| 726. Kitchen rack/shelf/cupboard | |

## Section 8: Health condition

***INSTRUCTIONS: The respondent is the HIV+ or the caregiver if the HIV + is very sick.***

**If the beneficiary is an** orphan child < 15 go to section 10
If the beneficiary is an **orphan >15 go to section 9**

| | | |
|---|---|---|
| 801. | How many times has_____(name of the HIV+ beneficiary) been sick in the last two months?<br>*(write in the number of times in right column)* | *# times* |

| | | |
|---|---|---|
| 802. | Where did _____(name of HIV+ beneficiary) go for the treatment?<br><br>*(Mark all that are mentioned)* | 1. Health centre/Hospital/clinic. |
| | | 2.PVO clinic |
| | | 3.Alternative therapy |
| | | 4. No treatment |
| | | 5. Own treatment |
| | | 6 Other (specify)_____ |

802 (b) Are you accessing any different treatment (ARVs) ? (DAAD. ) 1. Yes 2. No
c) If yes when did you start accessing this treatment?(*Month and year*) _____
d) Has it affected you in any way ? Include any details especially as regards the two main areas; diet _____ or health _____
_____
_____

| | | | |
|---|---|---|---|
| 803. | Has _____(name of the HIV+ beneficiary) been unable to work in the past two months due to illness? | Yes: 1 | No: 2-> Go to section 9 |

| | | |
|---|---|---|
| 804. | If yes how many times?<br>*(write in number of times in right column)* | *# times:* |

| | | |
|---|---|---|
| 805. | What was the longest period you were unable to work?*(write in number of days in right column)* | *# days:* |

## Section 9: Attendance in non-food aid services

***INSTRUCTIONS: The respondent is the beneficiary (HIV+ or orphan above 15 years .)***
If the HIV+ beneficiary is very sick, the caregiver may answer these questions.

900. Do you receive any other services provided by the IP apart from receiving food? 1. Yes 2. No
901 – 913. If Yes, which of these activities have you attended in the last two months and how many times have you attended them? (Fill in responses in table below)
If No, why haven't you attended other services.? (Fill in responses in table below)

| **Activities** | **No. of Times** | **Reason for not attending** *(Check the appropriate box)* | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | **1. Too Sick** | **2. Too Much Work** | **3. Not Interested** | **4. Too Far** | **5. Not Available** | **6. Never Heard of Service** | **7. Other (specify)** |
| 901. Medical services All | | | | | | | | |
| 902. Testing for HIV | | | | | | | | |
| 903. Counseling sessions | | | | | | | | |
| 904. Nutrition talks | | | | | | | | |
| 905. Demonstration of food preparation | | | | | | | | |
| 906. Health talks | | | | | | | | |
| 907. AIDS awareness seminars | | | | | | | | |
| 908. Micro finance: (Revolving Funds, loans) | | | | | | | | |
| 909 Mobile farm school | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 910.Vocational skills training | | | | | | | | |
| 911. Agriculture Extension | | | | | | | | |
| 912.Legal services | | | | | | | | |
| 913.Child/Orphan support | | | | | | | | |
| 914..Other (specify) | | | | | | | | |

915. Do you receive any assistance from other Community Based Organizations?

1.Yes 2.No -> **Go To Section 10**

916. If Yes, outline the nature of assistance received._____

_____

_____

_____

**Section 10: Anthropometry**

***INSTRUCTIONS: Collect information for all the children below five in the household.***

This section can be skipped if there is no child under five in the household

| | Sex | Reported age (in months) | Date of Birth | Weight (kg) | | Height (in cm) | |
|---|---|---|---|---|---|---|---|
| 1 Child | | | | | | | |
| 2 Child | | | | | | | |
| 3 Child | | | | | | | |
| 4 Child | | | | | | | |
| 5 Child | | | | | | | |

Some events that will help you ascertain the ages include;

- **1999** Kabaka's wedding
- **March 2001** Presidential elections
- **Sept 2002** Population Census

**FOCUS GROUP DISCUSSION QUESTIONS – MID TERM EVALUATION**

Qn 1. Have you received any training in hygiene during the food distributions?

Qn 2. What was involved in this training?

- Anything about hand washing
- Anything about hand washing facilities?
- Anything about storage and usage of drinking water?
- Anything about refuse disposal?
- Anything about usage of racks?

Qn 3. Have you found this information useful?

Qn 4. Have you found this information easy to apply in your homes?

Qn 5. Is the information difficult to use or apply in any way?

Qn 6. Have you received in any training on vegetable growing?

Qn 7. Do you have vegetable gardens at home?

Qn 8 If so how have they been helpful in you meal preparations?

Qn 9. If you do not have gardens what are the major hindrances?

Qn 10. Many beneficiaries reported eating more vegetables than the years before why do you think so?

Qn 11. Do you feed your children on exactly what you eat or are they some changes in their diet?

Qn 12. If there are some differences what are these differences?

Qn 13. Are any of these affected by the food you receive or the nutrition education you get?

Qn 14. How have your lives changed since you started getting food – as regards your health, productivity, income/expenditure?

Qn 15.Does it have to do with the food you get or is there anything else you can associate this change to?

Qn 16. Do these changes have any impact on the education of your children?

Qn 17 How has your attendance of non food services been affected by the food distribution programme? Do you attend counseling, nutrition education, capacity building services more or less? What are the reasons for these changes?