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TANGAZA COLLEGE**

**Facts Finding Report**  
(Long Holidays Field Work)

**Project: "Good Samaritan"**

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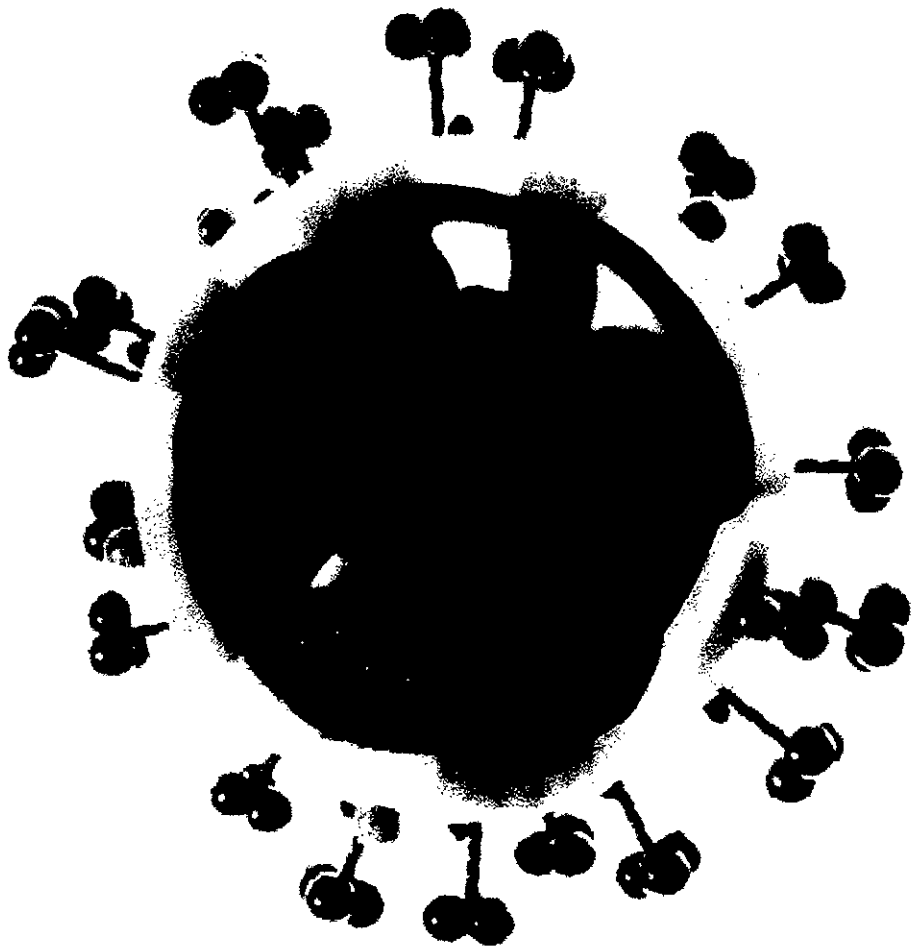


1999  
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Nairobi, Kenya

1999

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## **List of Abbreviations**

**DMO** - District Medical Officer.

**MOH** - Ministry of Health.

**STD/ACP** - STD/AIDS Control programme-Ministry of Health.

**UNAIDS** - Joint United Nations Programme on HIV/AIDS.

**UNCC** - Uganda National Council for Children

**UAC** - Uganda AIDS commission

**WB** - World Bank

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## Introduction

AIDS; the new scourge is taking the life of many human beings every day in the world. It is really a hidden sickness, we never know who is infected! The age is not a barrier for the disease, neither the colour nor religion. It affects everybody: rich or poor alike.

Today we find many people that fall in this difficult situation. Each one has his/her own history of love and hatred, of joy and suffering, of desolation and hope. HIV/AIDS is the problem affecting millions of people in the world. In Africa the number of cases is increasing day by day. The lack of information about the issue and the traditional practices, together with uncontrolled sexual behaviour, creates the fertile soil for the growing and proliferation of this disease.

The Christian group "Good Samaritan" tries to be as a light in the darkness and as the salt of the earth (Mt 5:13-16). The members of this group are the "Good Samaritans" of our days, taking care of those who are laying on the streets with the "leprosy" of our days.

I will look at the statistics of this widespread disease in the world, before considering the number of people infected in Africa, Uganda, and Gulu.

I will also present how this group is touching the people, including its organisational and financial structures.

I consider this research like a rose to be offered to the group "Good Samaritan". A rose like the one I was given when I started this work in Gulu. A rose that can symbolise the beauty and hope in life, and the many thorns experienced by those who are living with HIV.

# 1. AIDS: The new widespread scourge

## 1.1 Definition of HIV, AIDS and STDs

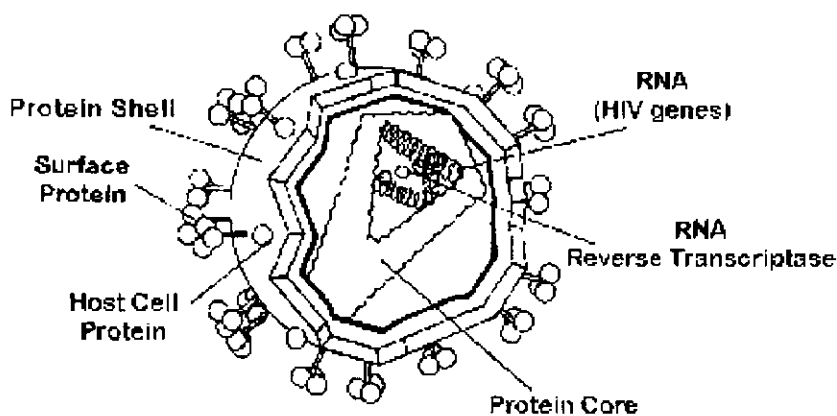
### 1.1.1 Definition of HIV

HIV stands for:

**H Human** means “of a man and woman”. HIV is only caught by humans and not by animals or insects.

**I Immune** means, “protected”. The body is normally protected against many diseases.

**V Virus** is a kind of germ, smaller than bacteria that can cause disease in people, animals, or plants.



**Surface Protein**- binds to receptor T cell and begins cell invasion.

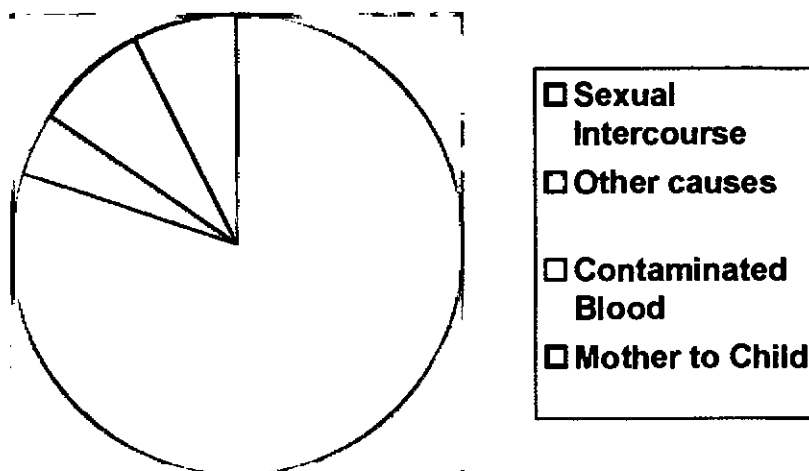
**Host Cell Protein**- when a new virus bursts out of a host cell the virus picks up proteins from the cell surface.

**RNA (HIV genes)**- contains all necessary information to make new HIV viruses.

**RNA Reverse Transcriptase**- changes RNA (HIV genes) into DNA and allows HIV to make copies of it.

The HIV virus attacks humans and causes a lack of protection against many diseases, which in turn lead to the AIDS, disease.

HIV is the deadly virus that can eventually cause AIDS. . HIV can be spread through sex, blood, shared needles, or from a pregnant mother to her unborn child.



(Graphic comparing different ways of transmission)

People infected with HIV may look well and healthy. Some people infected with HIV may not develop AIDS for ten years or longer. Like all viruses, HIV is very small. As many as 230 million of virus could fit on the head of a pin. While many other viruses are spread through casual contact, HIV dies when exposed to heat, water or air. That's why touch, hugs, food, doorknobs or toilets cannot pass HIV. The deadly virus is passed from person to person through blood, semen and vaginal fluids.

The immune system cannot destroy HIV once the virus enters the body and invades cells. Scientists are working on treatments, which, in the future, may destroy HIV.

HIV can be latent in the body for more than 10 years without causing AIDS. During that time, a person infected with HIV might not feel sick but can still pass the virus to other people. HIV eventually destroys many of the white blood cells, which protect the body against diseases. HIV infection leaves people helpless against many other serious infections and cancers.

### 1.1.2 Definition of AIDS

AIDS stands for:

**A Acquired** means, “to get from”. AIDS is acquired from other people who have AIDS. It is not inherited.

**I Immune** means, “protected”.

**D Deficiency** means, “lack of”. Humans with immune-deficiency have a lack of protection against many diseases.

**S – Syndrome** means “signs of a disease”. When people have AIDS, they have a syndrome of diseases. AIDS is a combination of illnesses caused by the HIV after it has broken down the body’s immune system.

### 1.1.3 Definition of STDs

STDs stands for:

**S - Sexually:** through sexual intercourse.

**T - Transmitted.**

**Ds Diseases.**

## 1.2 HIV and AIDS: the widespread scourge

Since the beginning of the epidemic in the late 1970s, AIDS has spread to over 190 countries worldwide, and more than 40 million people have been infected with HIV. At the end of 1997, 30.6 million people were still living with HIV infection and AIDS. Since 90% of these individuals live in developing countries, it has been estimated that at least 9 out of 10 infected individuals worldwide are unaware of their HIV status. AIDS can then be defined as “the hidden epidemic”<sup>1</sup>.

Of the 30.6 million people living with HIV/AIDS, 29.5 million are adults and 1.1 million are children; worldwide, 1 in every 100 adults in the 15-49 year age group is HIV-positive<sup>2</sup>. Approximately 42% of HIV-positive individuals are women, and this

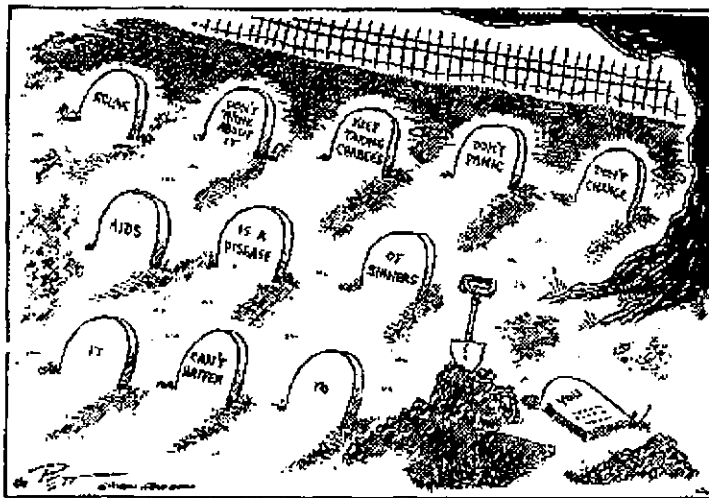
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<sup>1</sup> UNAIDS, Gulu-Uganda, 1999

<sup>2</sup> Ibid.

proportion is growing. The majority of newly infected adults are under 25 years of age<sup>3</sup>.

At the end of 1997, 12.9 million adults and children had developed AIDS, and 11.7 million of them had died of AIDS related death (9.0 million adults and 2.7 million children). This denotes that the cumulative number of HIV/AIDS deaths is equal to approximately one third of the number of individuals currently infected. In 1997 alone, 2.3 million HIV/AIDS related deaths occurred, including 460,000 children under the age of 15. Moreover, AIDS is emerging as a leading cause of death in adults aged 25-44 years in both developed and developing areas of the world<sup>4</sup>.



JOEL PETT  
Cartoonist Herald Leader  
USA

Still in 1997, approximately 5.8 million new HIV infections occurred (5.2 million in adults and 590,000 in children), with an average of almost 16,000 new infections a day (14,200 in adults and 1,600 in children)<sup>5</sup>. This means that the number of individuals newly infected in 1997 alone is about half of the total number of AIDS-related deaths in the entire epidemic.

The number of HIV-infected children is disproportionately high in developing countries, due to the high HIV prevalence among women, the high fertility rate, and the poor access to services for the prevention of prenatal transmissions, in part due to the anti-retroviral treatment of HIV-negative pregnant women and the availability of safe alternatives to breast-feeding. For example, it was estimated that in 1997 fewer than 1,000 children under the age of 15 were infected with HIV in West Europe and in

<sup>3</sup> Ibid.

<sup>4</sup> World Bank, Gulu-Uganda, 1999.

<sup>5</sup> UNAIDS, Gulu-Uganda, 1999

North America. Furthermore, since the beginning of the epidemic, there have been 8.2 million AIDS orphans worldwide, most of them in developing countries<sup>6</sup>.

### 1.3 AIDS across Sub-Saharan Africa

Sub-Saharan Africa is the world's most severely affected region. The 15 countries with the highest HIV prevalence rates are located in the region, where the average prevalence in adults aged 15-49 years is 7.4%<sup>7</sup>. Moreover, 19 countries in Sub-Saharan Africa have reached the "generalised", or most advanced, stage of epidemic, indicating that HIV is widespread among the general population, and at least 5% of the pregnant women attending antenatal clinics are infected<sup>8</sup>. Worldwide, only two other countries, Guyana and Haiti, have reached this generalised stage of epidemic.

At the end of 1997, 20.8 million people were living with HIV/AIDS in Sub-Saharan Africa, representing about two thirds of the world's total. In contrast to the rest of the world, the male-to-female ratio is close to 1:1<sup>9</sup>.

In 1997, approximately 3.4 million new infections occurred among adults in Sub-Saharan Africa, mostly through heterosexual transmission, accounting for almost 60% of the world's total. During the same year, 530,000 new infections were reported among children, representing about 90% of the world's total.<sup>10</sup>

The AIDS epidemic is particularly severe in East and Central Africa, accounting for about one half to two thirds of the HIV infections in Sub-Saharan Africa, but only for one-sixth of the total population<sup>11</sup>. Surveys carried out in different Eastern and Central African countries have shown that over 10% of the women attending antenatal clinics in urban areas are HIV-positive, with rates exceeding 30% in some of these surveys.

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<sup>6</sup> Ibid

<sup>7</sup> Ibid

<sup>8</sup> WB, Gulu-Uganda, 1999.

<sup>9</sup> UNAIDS, Gulu-Uganda, 1999.

<sup>10</sup> Ibid.

<sup>11</sup> U.S. bureau of the census, 1995.



In the most severely affected countries, AIDS is the leading cause of adult deaths, with more than half of adult mortality attributable to HIV infection<sup>12</sup>.

## 1.4 Uganda and the bone of AIDS

Uganda has an area of 241,038 sq. Km, a population of over 20 million inhabitants, and a GNP per capita of 240 US\$<sup>13</sup>. Uganda is bounded on the North by the Republic of Sudan, on the East by Kenya, on the South by Tanzania, and on the West by the Democratic Republic of Congo.

Health indicators such as infant and maternal mortality rates and life expectancy are much worse than those in most other parts of the world. In particular, “the infant mortality rate is 97‰ live births; the maternal mortality rate is 506 per 100,000 live births, and life expectancy at birth is below 50 years. The total fertility rate is 6.9”<sup>14</sup>.

The ten leading diseases in terms of morbidity and mortality in Uganda are, in descending order, malaria, HIV/AIDS, diarrhoeal diseases, tuberculosis (TB), pneumonia, upper respiratory tract infections, malnutrition, anaemia, intestinal worms, and measles<sup>15</sup>. Malaria accounts for over 20% of all deaths in the general population<sup>16</sup> and up to 30% of deaths occurring in health care facilities among children 2-4 years of age<sup>17</sup>. AIDS is responsible for up to 12% of annual deaths<sup>18</sup>.

Uganda is one of the countries most affected by the AIDS epidemic and it was among the first countries in Sub-Saharan Africa to respond with open and concerted efforts in

<sup>12</sup> WB, Gulu-Uganda, 1999.

<sup>13</sup> *Ibid*

<sup>14</sup> MOH, data collected from office, Gulu-Uganda, 1999

<sup>15</sup> *Ibid*.

<sup>16</sup> *Ibid*.

<sup>17</sup> UNCC, Gulu-Uganda, 1999.

<sup>18</sup> MOH, data collected from office, Gulu-Uganda, 1999

order to control the spread of HIV<sup>19</sup> using a multi-sectoral approach<sup>20</sup>. The principal activities carried out include information and education for behavioural change, implementation of a safe blood transfusion system, medical and socio-psychological support to people living with HIV/AIDS, promotion of voluntary HIV testing, epidemiological and biomedical research, and decentralisation of AIDS activities to the area's districts, with capacity-building at the district level for confronting HIV/AIDS.

As for the end of December 1997, a cumulative total of 53,305 AIDS cases<sup>21</sup> had been reported to the Ministry of Health; 49,432 (92.7%) were aged 12 years or older and 3,874 (7.3%) were children under 12 years of age<sup>22</sup>. The most affected age-group is individuals of child-bearing age<sup>23</sup>, and the high frequency of HIV-related deaths in this age group results in an increasing number of orphaned children, estimated at 1.2 million in 1998. The extended family network seems to have absorbed these orphaned children according to traditional rules, but the coping capacity of this support system is becoming overstretched, aggravating the social and economic impact of HIV/AIDS in Uganda<sup>24</sup>. The orphan burden is a window for the potential social breakdown resulting from high AIDS-related mortality<sup>25</sup>.

The main routes of transmission include heterosexual transmission (accounting for more than 75% of new infections), mother-to-child transmission (about 20%), transmission through infected blood (less than 2%), and, even more rarely, through non-sterile sharp-piercing instruments<sup>26</sup>.

AIDS has exceeded malaria and other conditions as the leading cause of deaths among individuals 15-49 years of age<sup>27</sup>, and approximately half of adult mortality is attributable to HIV infection<sup>28</sup>. One of the areas most affected by the HIV epidemic in recent years has been the northern region: Gulu is presently second to Kampala in HIV prevalence. This high prevalence may be related to the civil conflict (war), the population displacement, the social disruption, and the breakdown of the health infrastructure in the district.

19 UNAIDS. Gulu-Uganda, 1999.

20 UAC. Gulu-Uganda, 1999.

21 MOHL data collected from office. Gulu-Uganda, 1999.

22 STD/ACP, data collected from the office. Gulu-Uganda, 1999.

23 Opiyo, Gulu-Uganda, 1999.

24 Kagrum, Gulu-Uganda, 1999.

25 Hunter, Gulu-Uganda, 1999.

26 UAC, data collected from office, 1999.

27 WB, Gulu-Uganda, 1999.

28 Ibid

## 1.5 Gulu district and the plague of AIDS

Gulu is one of the nine districts in Northern Uganda; it is bordered by the Republic of Sudan on the North and by the district of Kitgum on the North East and East, Apac on the East, Masindi on the South, Nebbi and Arua on the West and Moyo on the North West. The district has a total area of 11,734 sq. Km, and a mid-1997 projected population of 426,900, with 89% of the population living in rural areas and 11% in urban areas<sup>29</sup>. Gulu Municipality is the district's capital city and is situated at a road distance of 340 Km North of Kampala, the country's capital city.

There are a total of 37 health facilities in Gulu district, both governmental and non-governmental, of which four are hospitals, five are health centres, two are dispensary maternity units, five are dispensaries, and 21 are sub-dispensaries. Only 30% of the population live within a 5-Km radius of these facilities. Qualified staff is insufficient in the hospitals and especially in rural health units; in fact, staff trained on the job is about 60% of the units<sup>30</sup>

St. Mary's Hospital Lacor (better known as "Lacor Hospital") is among these facilities and it is located 6 Km from Gulu Municipality on the road to Sudan. The Hospital is a non-profit, charitable institution dedicated to delivering health care to the most disadvantaged social groups, such as women, children, people in destitute conditions, and people affected by chronic diseases who are unable to provide for themselves (i.e. persons with AIDS and TB).

In this hospital is going on a project called "Global Support to the National Plan for HIV/AIDS Control in Uganda". It supports the HIV-related activities of other health projects of the Italian co-operation in Uganda. In this Project, health service research and applied epidemiology are integrated with public health interventions and clinical care. In particular, health service research focuses on evaluating the impact of preventive and curative interventions and the implementation of cost-effective health services. They are also studying HIV variability (including HIV-2 prevalence) and the

<sup>29</sup> DM(O) data collected from office. Gulu-Uganda 1999

<sup>30</sup> Ibid.

immunologic response to HIV infections (i.e., cytochrome, viral load, and activation markers) in the context of the international efforts for developing an HIV vaccine.

## **2. Good Samaritan project: an answer to the lethal disease**

### **2.1 Brief history and purpose**

The increasing number of HIV-positive and AIDS patients, the war and poverty, created all the conditions for the challenge accepted by the Gulu community/parish. Dr. Mathew Lokwiya encouraged the Christians to face the situation. In February 1992, 20 people started a group called "Good Samaritan". At that time the aim of the group was to cope with the large number of sick people living with HIV, helping them, caring for their treatment and weekly control and providing them with moral and spiritual support. They also used to gather together the sick people of the parish for prayer and sharing

Today the Good Samaritan is an institution. Every morning about 10 of the members come together for prayer and planning in order to get motivations and a sense of direction in their ministry. This institution added more ideas and projects to help the sick living with HIV, their orphans and to prevent the youth from falling in such problems. The following members lead the group:

- 1) Co-ordinator. Sr. Dr. Dorina Tadiello (Comboni Sister).
- 2) Chairperson: Mr. Michael Opiro (In-charge of Youth Alive Unit).
- 3) Vice-Chairperson: David Luboyo (In-charge of Counselling Unit).
- 4) Secretary: Charles Boya Ocaya.
- 5) Treasurer: Miss Santa Layet (attached to Orphans Unit that is headed by Irene Labwot).

The demand for different activities and different places was high and the group was divided in three units in order to provide better services. The units are:

- 1- Counselling Unit
- 2- Orphans Unit
- 3- Youth Alive Unit

I will explain each one of the units as an independent part, but, in fact, they are a whole and interrelated.

## **2.2 Activities of the project**

### **2.2.1 Counselling Unit**

This unit it is managed by two counsellors that are in-charge of counselling, visiting the sick (clients) at home and care for them, go to the hospital trying to answer their needs. Some small projects were launched with the aim of helping the clients to generate some income. The projects were “goats” and “chickens rearing”. Unfortunately they failed due to lack of experienced expert in project managers.

The counsellors are in-charge of preparing the monthly group session where clients get moral support from the word of God and from the sharing among themselves. This group session takes three days and clients discover the power they have to fight against unnecessary worries and anger. Up to now, 80 monthly meetings for PLWA (people living with AIDS) and 8 seminars about positive living have been organised. Over 350 people have approached this Unit for counselling.

In a counselling session the counsellor offers pre-test counselling and post-test counselling, namely counselling before and after the client goes for an HIV blood test. The pre-test counselling situation is often the person's first contact with a counsellor and it is the starting point for ongoing support.

Pre-test counselling can be defined as the counselling offered to people before they have a HIV antibody test.

The aims of pre-test counselling are:

- 1) To help a person make an informed decision for him/herself about whether they wish to have an HIV antibody test.

- 2) To help a person prepare him/herself for a positive or negative HIV antibody test result.

Pre-test anxiety is usual in most people who may be worried and frightened about the outcome of the test, the implications for themselves and their families, who will know that they have come for a test, and so forth. They may be reviewing their past life, particularly speculating on how they might have been exposed to HIV.

A person who is restless and impatient and does not want to talk may be acutely anxious. A person may not be able to recall information the counsellor has shared with him/her. Anxiety in a pre-test situation can be helpful. It can help people to prepare themselves for a possible tragedy or bad news. The counsellor should try to help the person speak about his/her anxieties. Often people experience some relief by “ventilating” their worries, anxieties and fears, and finding that someone else understands their problems and is prepared to help them resolve or cope with them.

After the HIV antibody test the counsellor is called to help the client with the so-called post-test counselling.

Post-test counselling can be defined as the counselling offered to a person after he/she has been informed that he/she has been diagnosed as having AIDS.

The aims of post-test counselling are:

- 1) To provide emotional support to help the person cope with the news.

Post-test counselling provides the opportunity for a person to share worries and concerns, to find out more about HIV/AIDS, to consider what HIV status means emotionally and socially, and to start planning accordingly.

- 2) To discuss prevention of infection.

Post-test counselling when someone is HIV antibody positive involves a number of interviews.

When a person has just learnt that she/he is HIV antibody positive it is probable that she/he may be in a state of shock or denial. She/he may not want to talk and may wish to be left alone. She/he may feel very confused.

It takes time for a person to adjust to the news of being HIV antibody positive. The counsellor should let the person know she/he is available for further counselling interviews. Each post-test counselling situation is different, individuals have widely different responses and needs.

The counsellor will continue to have sessions with the client as an ongoing support. In these interviews the counsellor will help the client to cope with moments of

psychological adjustments. These reactions are sometimes “loss reactions” and they appear as follows:

- Shock
- Denial
- Anger
- Bargaining
- Depression
- Acceptance
- Coping or positive living

The home visit is a great encouragement for the clients. They feel that somebody is caring for them and see in them the persons they are and not only the sickness that makes other run away from them.

The tradition of gathering together the clients every month for three days is a very important moment for the clients. The possibility of sharing sufferings and consolations makes the clients feel that they are not alone in facing their problem. They come to know that many people are living with HIV and they are living happily. The word of God is an important point in these meetings and all feel somehow spiritual consolation.

The seminars that this Unit prepares for the clients help them cope with their own anxieties, and deal with the feelings that can appear as a reaction in front of the sickness. They are also helped to realise their role in society, their relations with other people, and to make a programme to live according to their condition, but with a positive attitude.

I would like to present some of the stories of the clients, as a sign of solidarity and profound sharing with them. (This reproduction of the stories of the clients was authorised):

Mighty is 37 years old and has five children. Her first husband died two months after being admitted to St Mary's Hospital Lacor in 1990. After two years she got married

to another man Her health was fine. A year later, and after the death of the first wife of her man, she began to feel sick A friend suggested her to that she go for a blood test. While she was waiting for the results the thought that came in her mind if the results were positive was to poison her children and then to commit suicide. She had no relatives to care for her and her children, as the sickness would worsen.

Fortunately she was advised to visit a group in the parish called "Good Samaritan".

There she found many people who were also seropositive, but were very happy. From that moment she abandoned her suicidal plan. She has been living with the virus for seven years without showing any sign of sickness. Now her main problem is to meet the school requirements for her children since her in-laws deprived her of her husband's bank book and husband's land.

Jannet is 30 years old and has four children. One time her mother was sick and she had to leave home and take care of her. Some months later she came back and found that her husband had another wife. This woman looked sickly. Jannet chased her away. Afterwards, this woman was getting worse and eventually died in 1992. Jannet tried to convince her husband to go for a blood test but he refused claiming that his other wife had died of syphilis.

In 1994 Jannet began to feel sick more and more frequently. Some friends of her suggested her to go for an HIV test, which she did in 1995. When she communicated to her husband that she was seropositive he told her to get treatment and not to worry so much. Later on he changed his way of life. He began to drink heavily and denied having the virus. Moreover, he blamed Jannet as the responsible of bringing the sickness. His rate of drinking is going higher and higher and he does not care for the education of the children.

John is 30 years old. He had no child when the sickness got him. It was after admission for two months in TB ward, without getting properly healed that he decided to have an HIV test. When he returned home after having the test he became so much worried. His major fear was how he would tell his wife. When he went to collect the result he was told that the HIV virus was in his blood. He felt cold and paralysed. After some times he managed to convince his wife to go for the same test. Her result

was positive too. There was no communication in the house for two days. After some time they began to talk about the issue and they decided to go back to their respective people. It was a peaceful separation and up to now they are apart but in good terms with each other.

What worries John most is the fact that this sickness comes into his life before he had a child. It is painful to die without leaving offsprings!

## **2.2.2 ORPHANS UNIT**

As a result of many adult deaths due to AIDS, many children are becoming orphans. As it was previously said the extended families are not able, anymore, to "absorb" these orphans in their own families. The number is increasing every day and it is a heavy burden to the country. A big number of children were abducted by the rebels and made soldiers by force. Others are going around without education or protection. The war brought many orphans too. In Gulu it is easy to find children without families. Many small orphanages are coming up, fruit of altruism of some women who are trying to give a home to the orphans.

The Unit for orphans started as an answer to the request of the sick people living with HIV whose main worry was the future of their children, who would remain without protection, studies, and home. This Unit tries to sponsor the children paying their school fees and counselling them. Some help is given for the food and clothing of the orphans to their guardians in order to alleviate the family burden.

In 1995 the Unit started with 47 orphans. In 1999, the Good Samaritan is sponsoring 400 orphans.

During school holidays the orphans come together for a two-day seminar to discuss their own problems and difficulties and to receive counselling and encouragement. During this time they are asked to contribute with some work:

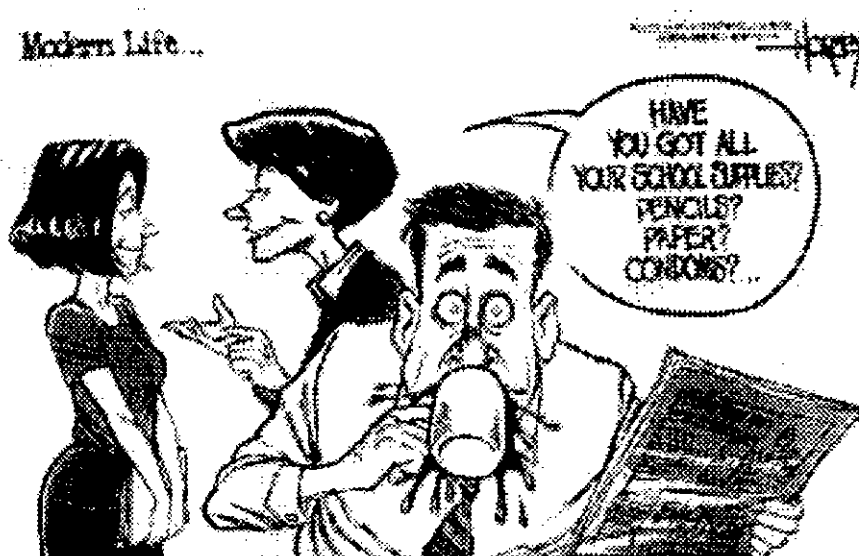
Making bricks for sale: it is a tradition in this part of Uganda to make bricks for the building of houses. Thus the orphans are helping the programme to generate some income. The preparation of 12,000 bricks is helping in the construction of the new building of the Good Samaritan.

Planting: the orphans Unit are in-charge of a plot of four acres belonging to the Archdiocese of Gulu. During the holidays and Saturdays the orphans (according to their age and physical capabilities) are asked to contribute some hours of work on this field. They do the job with joy and as a sign of thanks for what the Unit is doing for them. Part of the agricultural produce are used to feed the orphans and clients during seminars, part are also given to the clients that cannot work on their "shamba" anymore.

### 2.2.3 The Youth Alive Unit

This Unit deals with prevention of HIV/AIDS virus among the youth. Its aim is to create awareness among the young people about the problem that is affecting a great number of persons in that area. With the problem of war the family structure changed radically. The traditional values that were learned with the family around the fire at night are not there anymore and the youth is growing without values or with imported values that confuse them

The Acholi culture was teaching that they are a community where everybody is responsible for the other that a girl must be virgin until the day of marriage and must say no to the boy for a long time. The girl used to have the help of her brothers to protect her from boys. Tabus were ways for the prevention of many diseases and problems. Today the war makes the youth leave their homes without the fire of sharing and transmission of culture. The youth are growing by themselves confusing love with sex and without hope in the future.



This Unit is carrying out a programme for both rural and urban youth through the word of God and by using drama, songs, videos, etc. to suggest behavioural change.

Normally, the group moves from school to school to present a new way of prevention against HIV/AIDS, different from condoms. This prevention of AIDS is a call to life, the life of the whole person. This person is a sexual being, not just a person who has sex. Thus, any effective preventive programme must take into account and deal with the person's whole life.

The process used is based on the "helping skills" model of Gerard Egan <sup>31</sup>, a behavioural and problem-solving model. The prevention of AIDS requires in most cases behavioural change and this is not easy to achieve. This process is designed to facilitate a person's movement through the various stages of behavioural change: identifying the problem, choosing goals, and planning action. In the "Youth Alive" program, the model is used to help individuals examine their lives and especially their sexual behaviour, determine what behaviour is safe and possible for them, and then commit themselves to action. The Unit group helps in clarifying the problem and increasing commitment.

This process can be summarised as follows:

Stage I - Exploring life

- a. telling the story
- b. focussing
- c. looking to what has been overlooked

Stage II- The new picture

- a. looking for alternatives goals
- b. criticising these alternatives
- c. choosing and committing oneself

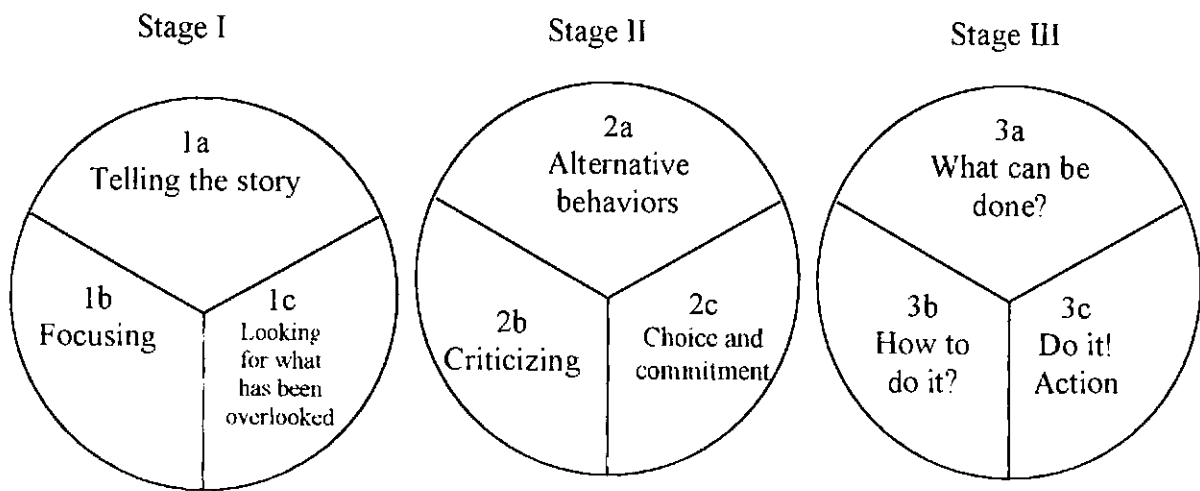
Stage III - Action

- a. identifying ways of action
- b. making plans
- c. acting

When this is made more specific in the "Youth Alive" program and diagrammed, it looks like this:

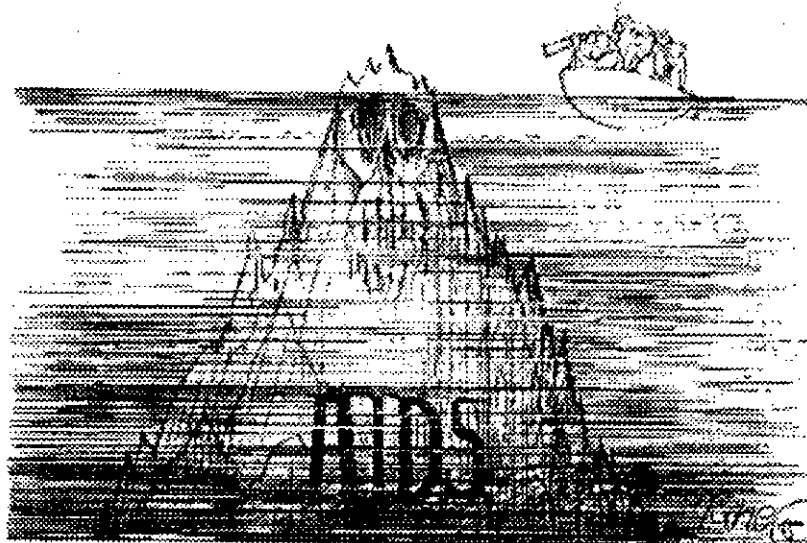
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<sup>31</sup> Egan, Gerard. "The Skilled Helper". Books/Cole Publishing Company. Monterey, California, 1986.



This type of Seminars brings reactions from the side of the youth. The following are some of the letters written to the group:

What I have learned from the team, helped me a lot. I found that there is a change in my life, and now I always praise God to keep me away from any temptation. I have learned that sex is something very serious, and you cannot play with it. It is for marriage. It is a gift from God, not to be misused, but to be kept for the proper time. I have learnt that girls have to be strong and firm when they have to say "no" to boys, and a "no" should remain a "no", otherwise you will have to pay the consequences. After the course I met a friend of mine who wanted to have abortion. What I have learnt from you I explain to my friend, and she decided not to do it. (Olimpia R. A.)



WALTER HANSEL

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I am here to convey my sincere thanks to the "Youth Alive" for what they gave us the last term, for the wonderful plays you made for us, as well the video. I am very much interested in your club, as well as helping the youth of these days living without guidance. I want to share with you what happened during my last holidays.

My brother, who is at school, has a friend. She got pregnant, and both decided for abortion.

I gave my advice, but they refused. So they approached an old woman that gave some herbs, but failed. They bought some drugs, but no result. They paid Ush 100,000/- to a medical staff, without the notice of both parents, but all failed. They went to buy medicine and she was injected. She had abortion when she was already four months pregnant. She had complications and was taken to hospital.

Now please, can you extend your programmes to other schools and rural youth? I am appealing to you to open a branch of your group in my school, and to have leaders on this programme

I am very sorry for what happened to my brother, and I pray God to forgive him for breaking the law of live.

I would like to thank you again. I do not want to add more, but be sure that I will always remember your programmes. (M. O. Koch Goma SS)

My advises to all the youth.

Abstinence is the best protection against STD/HIV and unwanted pregnancy.

Be wise youth, nobody had die of abstinence from sex until marriage.

Girls do not be easy going, as the Bible says, there is a time for everything. Be patient.

Patience pays, take your time, study your partner and do not fall in love because of money; poverty does not kill.

Time is a very important factor for a proper choice.

N.B Remember that whatever you do, will be back to you.

Be aware of the present world! (A. M. Secondary School Gulu)



### 3. FINANCES OF THE PROJECT

#### 3.1 Budget Proposal 1999 – Counselling Unit

Kenya shillings 1 = Uganda shillings 20

ACTIVITIES	AMOUNT
<b>1. Counselling</b>	<b>Uganda shillings</b>
Tea- 6 people x 250 x 2 times a day x 52 weeks	156,000
<b>2. Home Visits</b>	
Bicycle maintenance 3 x 2,000 x 12 months	72,000
<b>3. Meetings of Clients</b>	
Tea 250 x 250 people x 12 months	750,000
Allowance to cooks 3 x 1,000 x 12 months	36,000
Facilitators allow. 3 x 1,500 x 12 months	54,000
Volunteers allow. 10 x 1,000 x 12 months	120,000
Firewood 2,000 x 12 times	24,000
<b>4. Meetings of volunteers</b>	
Tea 20 people x 250 x 12 months	60,000
Firewood 2,000 x 3 times	6,000
<b>5. Salaries and Wages</b>	
Counsellor 80,000 x 12 months	960,000
Storekeeper 20,000 x 12 months	240,000
<b>6. Assistance to people living with AIDS</b>	
Salt 2 bags x 12 months x 18,500	444,000
Sugar 3 bags x 12 months x 55,000	1,980,000
Soap 3 bottles x 12 months x 19,000	684,000
5 packets "black kavera" x 12 months x 2,500	150,000
2 packets x 1,500 x 12 months	36,000
<b>7. Seminars for victims</b>	
Tea 35 people x 250 x 4 days x 4 times	140,000
Foods 35 people x 1,500 x 4 days x 4 times	840,000
Transport 30 clients x 2,000 x 4 times	240,000
Facilitators allow. 3 x 5,000 x 3 days x 4 times	180,000
<b>8. Seminars for Volunteers</b>	
Tea 20 people x 250 x 3 days x 4 times	60,000
Food 20 people x 1,500 x 3 days x 4 times	360,000
Transport 20 people x 2,000 x 4 times	160,000
Facilitators allow. 3 x 5,000 x 3 days x 4 times	180,000
<b>9. Building Contribution</b>	1,000,000
<b>10. Canteen Business</b>	1,300,000
<b>11. Unforeseen</b>	268,000
<b>TOTAL</b>	<b>10,500,000</b>

### 3.2 Budget Proposal 1999 – Orphans

This Unit is the most "expensive" as we can infer from the 1999 Budget Proposal.

Kenya shillings 1 = Uganda shillings 20

ITEMS	QUANTITY	AMOUNT
<b>A. Administration</b>		<b>Uganda shillings</b>
Salaries	2 Counsellors x 80,000 x 12 months	1,920,000
	Christine (worker)	500,000
Facilitators	4 x 5 Facilitators x 10,000 x 3 days	600,000
Cooks	4 x 3 Seminars x 3,000 x 3 days	108,000
Repair of Bicycles	2 x 5,000 x 12 months	120,000
Vehicle Hire	3 x 40,000	120,000
Audit Fee	1 x 200,000	200,000
	<b>Sub-Total</b>	<b>3,568,000</b>
<b>B. Office Building</b>		
Building	Land and Material Cost	4,000,000
	<b>Sub-Total</b>	<b>4,000,000</b>
<b>C. Stationary</b>		
Stamps (Italy)	180 Pupils/Students x 700	126,000
File Covers	10 x 3,000	30,000
File Cupboard	1 x 400,000	400,000
Vouchers and Receipts	General	300,000
Envelopes and Cards	General	200,000
Reams of Paper	General	200,000
	<b>Sub-total</b>	<b>1,256,000</b>
<b>D. Orphans Care</b>		
School Fees		
Primary School	200 Pupils x 35,000	7,000,000
Secondary Level	20 Students x 130,000 x 3 Terms	7,800,000
Good S. Orphans (partly sponsored)	10 Pupils/Students x 90,000 x 3 Terms	2,700,000
Students/Pupils helped by Fr. Igino Leso	60 Pupils/Students x 45,000	2,700,000
Uniforms	290 Pupils/Students x 13,000	3,770,000
Christmas Gifts	General	1,500,000

Hospital (Fr. Leso)	Bill	General	1,000,000
		<b>Sub-Total</b>	<b>26,470,000</b>
<b>E. Formation/Seminars</b>			
Orphans Seminars	120 Participants x 1,500 x 3 days		540,000
Staff			
Formation/Retreats	General		1,200,000
Book Keeping			
Lessons	General		200,000
		<b>Sub-Total</b>	<b>1,940,000</b>
<b>F. Income Generating</b>			
<b>Activities</b>			
Cultivation	6 acres x 25,000		150,000
Weeding	General		200,000
Harvesting	General		200,000
Empty Sacks	30 x 700		21,000
Transport	3 x 50,000		150,000
		<b>Sub-Total</b>	<b>721,000</b>
<b>G. Seminarians</b>			
Seminarians	General		2,000,000
		<b>Sub-Total</b>	<b>2,000,000</b>
<b>H. Catechists</b>			
<b>Education of Children</b>			
Cathedral Parish (Fr. Gabriel)	General		2,000,000
Awach Parish (Fr. Remijo)	General		1,000,000
Lacor Parish (Fr. Sebastian)	General		1,000,000
		<b>Sub-Total</b>	<b>4,000,000</b>
<b>I. Emergency</b>			
Emergency	General		1,000,000
		<b>Sub-Total</b>	<b>1,000,000</b>
<b>J. Miscellaneous</b>			
Miscellaneous	General		2,045,000
		<b>Sub-Total</b>	<b>2,045,000</b>
<b>TOTAL</b>			<b>47,000,000</b>

This programme is sponsored by a group from Italy called "Buon Samaritano" through adoption at distance. A photo of the orphan is sent to Italy and the "Buon Samaritano" look for a family that can "adopt" the child contributing yearly 500,000

lire per child. All the money is sent to Gulu to the Procure of the Archdiocese, put in a common pull and used according to the needs of the orphans. All the records are kept according to the rules of accountability in use, and correspondence by letter is kept regularly as a link between the child and the adoptive family.

### 3.3 Budget 1999 – Education for life programme

The following is the budget of the Education for Life Programme for the current year.

Kenya shillings 1 = Uganda shillings 20

ACTIVITIES	Amount
<b>1- Seminars and Workshops</b>	<b>Uganda shillings</b>
Tea 30 people x 250 x 2 days x 34 times	510,000
Lunch 30 people x 1,000 x 2 days x 34 times	2,040,000
<b>2- Stationary</b>	
News print 8 rolls x 5,000	40,000
Markers 2 boxes x 12,000	24,000
Pens 5 boxes x 5,000	25,000
Envelopes 250 x 100	25,000
Cello tape 20 rolls x 600	12,000
File covers 50 x 1,500	75,000
<b>3- Administration</b>	
Salary and wages 1 x 80,000 x 12 Months	960,000
Facilitators allowances 3 x 10,000 x 34 x 2 days	2,040,000
Bicycle Services 2 x 4,000 x 12 Months	96,000
“Boda boda” hire (general)	200,000
Instrumental spare parts (general)	200,000
<b>4- Unforeseen Expenses</b>	<b>1,753,000</b>
<b>TOTAL</b>	<b>8,000,000</b>

This Unit it is financed by a family from Italy. This family decided to sponsor the Unit to remember Helena, their only child who died at the age of 20. Their aim is to help young people to live better and be aware of the challenges of this world.

## **4. Strengths and weaknesses of the project**

### **4.1 Strengths**

I believe that one of the strengths of the project is the approach to the person in his/her wholeness. What makes this project unique is the psychological and religious support added to treatment and medicines.

The word of God is the channel of unity to the person and gives meaning to sufferings and hopes.

Prevention is the activity that among the youth has been welcomed as a very positive one. This "institution" is talking to the youth through their own acholi proverbs, and culture proposing them a behavioural change as a sign of reconciliation with their roots.

The ongoing formation of the staff is also positive because creates continuous updating of information about AIDS and its developments. This is helpful for a better planning and interaction with the people (patients, youth, orphans, etc).

### **4.2 Weaknesses**

Although this project is very well "equipped" and organised. I would like to stress a few points that can be improved.

At the moment the project is sponsored mainly by foreigners. There is a need to create small-scale projects in order to reduce foreigner dependency, and to involve the people in income generating projects.

Offices and stores are scattered around the place. The project is a Unit made of Units. A new building that assembles all the units together can save space, time and also prevent robberies.

## **5. Recommendations**

I would like to suggest some points for the development of the structure and action of the project "Good Samaritan" as follows:

1 – I see the need for this project to become an institution. The reality is that "Good Samaritan" cannot continue depending on the structure provided by the parish. Hence it needs to archive stability and identity.

2 -- I see the need for another staff member to be academically prepared (e.g. Social Minister) to co-ordinate, follow the projects and guide them to success and profitability.

3 - I see the need of involving the Small Christian Communities in the process of prevention and teaching the people about AIDS. Ignorance is the biggest poverty among the people. It is not enough to cure (in this case there is no cure at all), prevention is the solution that can work with youth and adults

## **Conclusion**

HIV/AIDS is not only a question of virus that destroys the defences of the human body. This disease affects the person in his/her wholeness and as a social being. We are tempted to offer things as solutions (e.g. condoms). However, the solution is in the person as an individual and as a social being. A "correct" behaviour is the winning weapon preventing people from contracting the disease. I believe that if the behaviour does not change the lives of countless individuals will continue to be devastated by the disease and by its social, economic and moral effects.

To be well informed and open to change is a must!

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