NYAPEA SAFE MOTHERHOOD AND CHILD CARE ASSOCIATION

(NSMCCA)

3-YEAR STRATEGIC PLAN 2004 - 2007

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Foreword

Nyapea Safe Motherhood and Child Care Association was formed in 1992. As a civil society organisation, the association has been operational in Okoro county with the vision of improved health and education of Okoro community. The achievements so far scored, as detailed in the plan document, emanated from the action plans that were drawn annually, but without self-evaluation. This was the basis for undertaking this strategic planning that will among others facilitate implementation, performance monitoring, and resource mobilisation.

This document is, therefore, a move forward in the institutional growth and development and is a reflection of the commitment to the community of Okoro. Special recognition, thus, go to Action Aid Nebbi (AAN) and Agency for Accelerated Regional Development (AFARD) for the financial and technical support provided during the preparation of this plan.

We, therefore, hope that this plan will help to organise and market the association's operational programmes to the sub counties were we will focus our attention in the upcoming three years. The commitment of the leadership of these sub counties, as demonstrated during the feedback workshop, will take a step forward such partnership.

It is time we got our priorities right. No terrorist attack and no war have ever threatened the lives of Okoro community. AIDS and Illiteracy does. We bear the full responsibility to address it for what it is, with maximum conviction and understanding that we command.

Richard Ubedgiu Aure
Chairperson/NSMCCA

ACRONYMS

AAN	=	Action Aid Nebbi
AAU	=	Action Aid Uganda
AFARD	=	Agency for Accelerated Regional Development
AIDS	=	Acquired Immune Deficiency Syndrome
ASO	=	AIDS Service Organisations
BCC	=	Behaviour Change Communication
BP	=	Best Practices
CBO	=	Community Based organisations
CDA	=	Community Development Assistants
CHAI	=	Community HIV/AIDS Initiative
DAT	=	District AIDS Task force
DHAC	=	District HIV/AIDS Committee
HIV	=	Human Immuno-Deficiency Virus
IEC	=	Information, Education and Communication
NASON	=	Nebbi AIDS Service Organisations Network
NSMCCA	=	Nyapea Safe Motherhood and Child Care Association
OI	=	Opportunistic Infections
OVC	=	Orphans and Vulnerable Children
PMTCT	=	Prevention of Mother-to-child Transmission
PTC	=	Post Test Club
STD	=	Sexually Transmitted Disease
STI	=	Sexually Transmitted Infection
TB	=	Tuberculosis
UNASO	=	Uganda Network of AIDS Services Organisations
VCT	=	Voluntary Counselling and Testing

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1.0 INTRODUCTION

From its inception, NSMCCA kept on operating on a more ad hoc basis. Action Plans were drawn annually and no critical reviews and self-evaluations were done. By late 2003 it was realized that there is need for a strategic plan that will guide the Association's activities, and provide a basis for resource mobilisation, progress and impact monitoring, among others. This strategic plan is a result of that need.

Worth mentioning is that the strategic planning approach used an impact-oriented approach where the focus is on results (outcome) rather than output. Thus, for clarity, a thematic layout is used to present the three main components NSMCCA is grappling with i.e., HIV/AIDS, Education, and Child Sponsorship.

The first part of the document presents the background information about: Nebbi district and Okoro county where NSMCCA operates; and the context within which it is operating. The second part presents a background of NSMCCA, and finally the last part details the strategic plans for the next three years.

1.1 BACKGROUND INFORMATION

1.1.1 About Nebbi district

Nebbi district, located in North-western Uganda, is one of the 56 districts of Uganda. It is bordered by Arua district to the north, Gulu district to the east, Masindi district to the southeast and the Democratic Republic of Congo to the West and South. The district is composed of 3 counties (Jonam, Padyere and Okoro) subdivided into 16 sub counties and 3 town councils, 87 parishes and 1222 villages.

The district is a polyglot society with many ethnic groupings. The majority of the population is of Nilotic Origin (98%). Of this, 91% are of Alur ethnicity. The total population is 433,600 composed of 48% males and 52% females; distributed as 90 % rural and 10% urban; and is predominantly a young population with a high total dependency ratio (98%).[1]

The people of Nebbi district are basically rural, poor, and have a low quality of life. It can be observed that, a typical person from Nebbi district would have a home in a rural area with agriculture as the main occupation. S/he would be a member of a family of about six people depending on food and cash crops cultivated using hand hoes on a 0.5-hectare of land. The home would be a temporary hut made of wooden poles, mud walls, and grass-thatched roof. A woman would have a relative risk factor of about 7 times of being illiterate and faces the brunt of bearing about 6 children. Only three people out of ten in the village would have pit latrines. Doctors are virtually inaccessible. It is, therefore, not surprising that at least two children per family would not live to be five years old, and on average, a person should be dead at 45 years of age. The usual mode of transport is on foot or by bicycle. Very few people have access to a FM radio station launched in 1998 and a mobile telephone network that became operational in 2000.

1.1.2 About Okoro county

Okoro is one of the three counties of Nebbi district. Administratively, it has 1 town council (Paidha – where the county headquarter is located) and 6 sub counties sub divided into 36 parishes and 579 villages (i.e., local council II and I respectively). In terms of population, the county has 44% of the

[1] See UBOS (2002) *Population and Housing Census, District Preliminary Results*, Entebbe. Assuming the same growth rate, the population is projected to 514,981 by 2007.

433,600 district total population (2002 Census) largely (98%) rural, densely distributed (at over 200 people per square kilometre of arable land area), and predominantly young.

The main economic activity of the people is farming which is subsistence oriented and gendered. With numerous trading centers and seasonal makeshift markets and beer clubs, much time is devoted to petty trade in these areas on market days and weekends. Elders and youths alike scramble in these areas while school attendance is reduced and the advances and urge for sex is increased.

Access to basic social services is limited. Okoro has 15 health units, and 99 schools, a low safe water coverage; and inaccessible feeder road networks for most of the year. This limitation, in part, contribute to the high attendance to traditional medicine with almost every village having a herbalist; low literacy status since distance affects children enrolment and participation in schools; and limited exposure to external forces, thus this isolationism in this case breeds resistance to change.

2.0 ABOUT NSMCCA

2.1 History

Nyapea Safe Motherhood and Child Care Association (NSMCCA) was formed in 1992 with a membership of 8 people who were all employees of Nyapea Hospital. The Association was formed, then, to solve problem of malnutrition that was common especially among pregnant mothers and children. Nutrition education was provided basing on locally available foodstuff in the community. However, when members realized the hardship associated with grant seeking, knitting and handcraft were introduced as income generating activities. The proceeds from products sales were invested in procuring more production inputs and for carrying out community education. Overtime, brick making was also adopted and this provided part of the bricks that were later used for building the wall structure of the Association office, yet to be completed.

From 1994 when HIV/AIDS emerged as another major problem in Okoro county, the Association adopted HIV/AIDS prevention activities. At this time membership increased to 25 people since it was realized that there was need to expand coverage of activities while balancing with the hospital work. In this venture, linkages and partnership with STI Project and Action Aid-Northern Uganda SFA programme. Similarly, with the realization of plague pandemic, hygiene and sanitation promotion was taken on board. Support was solicited from Nebbi district local government. Visible results from these activities include the decline in child malnutrition rate, reduction in maternal mortality, increased supervised health unit based delivery, increase antenatal and post –natal care attendance, reduced outbreaks and infection rate of plague epidemic, and increased community awareness of safe water chain. The details for HIV/AIDS is handled under theme 1.

By 2000, activities of the organisation increased in coverage. This increase was accompanied by an increase in the membership to 30 people. Both employees of the hospital, as was the case at the start, and outside people joined the Association and are working harmoniously.

In 2002, the Association adopted education campaign in conjunction with Action Aid and Local Government targeting especially Girl Child Education (GCE).

To date, NSMCCA, a registered CBO, is a subscribed member of Uganda Network of AIDS Services Organizations (UNASO); Network of AIDS Services Organisations in Nebbi (NSMCCA); and Nebbi District NGO Forum.

2.2 Focus and challenges

The involvement in a multitude of activities have been enriching for the Association. Individual members apart from gaining various skills have learnt that 'the best facilitator is one who practices what s/he says' rather than do as I say and not as I do. This is because members are role models in the community of operation and whatever divergence they show makes it hard for the community to accept what is said. Members have also learnt that voluntarism is at the core of a successful self-help group that has no enough resources of its own.

At the organizational level, lessons learnt includes the fact that it takes time, commitment and patience for any organization to grow, be known, accepted and respected. Further, with this time, certain predisposing practices such as sexual promiscuity, and widow inheritance, etc can be curbed. Besides, it is impossible to meet all the needs of the community such as the high demand and expectations of PLWA without engaging the people in self-problem solving strategy. Finally, the Association has learnt that without a strategic plan, no organization can conduct a critical self-audit of its performance vis-à-vis its vision.

In spite of these positive lessons, enormous challenges stake the continued effective delivery of services to the community in order to achieve the Association's vision. These challenges are summarized in the box below under individual, programme and organizational constraints.

Individual constraints	**Organisational constraints**
- Time management. - Management skills. - Tiresome. - Voluntarism. - Language barriers.	- Lack of transport. - Donor funds dependence. - Lack of office space. - Lack of a permanent staff(coordinator). - Unclear programme mainstreaming.
Programme constraints - Clients – PLWA- ask for support (cash, medicine). - Parents want gifts under child sponsorship. - Geographical landscape. - Community mobilization. - Community leaders demand for allowances. - Selling photos of kids (community complaint) - Training skills is inadequate. - Fund inadequacy. - Bad weather/natural hazards. - Lack of interest in the community towards our programme. - Poor IGA (Income generation). - Time conflict with Hospital work. - Inadequate facilities e.g. drama kits.	

2.3 Genesis of the Strategic Plan

This strategic plan was formulated in a participatory manner. In late June 2004, Action Aid Nebbi (AAN) contracted Agency for Accelerated Regional Development (AFARD), to facilitate the planning process. Three workshops that did both planning and counselling were conducted.

From the planning workshops, a draft plan was produced and this was circulated to all potential stakeholders. In July 2004 a one-day feedback workshop was held involving all the Association members, the Nyapea hospital officials, and members from the sub county local governments i.e., Nyapea, Jangokoro, Kango, Atyak, and Zeu where this plan implementation will concentrate. The Sub county chief, Sub county Chairpersons, Sub county Women Council Chairperson, and Sub county secretaries for social services (where health and education directly fall) attended the workshop. Other than reviewing the draft plan that was presented by the consultant, the workshop

acted as an advocacy and lobby table for ensuring that the sub county local government officials and the hospital staff make a dedicated commitment to furthering what the Association is engaged in.[2]

3.0 STRATEGIC DIRECTION 2004-2007

3.1 Vision

NSMCCA envisage a future in which there is '***a healthy and educated Okoro community***'.

3.2 Mission

To work with all categories of people towards health and education promotion through community education, advocacy and lobbying, child sponsorship, income generation, networking, and organizational strengthening.

3.3 Core values

To work with and in the interest of Okoro community, NSMCCA is guided by its cherished and shared values. These values relate both to the intra- and inter- organizational relations. It stipulates the guiding principles upon which members are committed in the day-to-day running of the Association. The values are:

- Teamwork, cooperation and one voice that are manifested in togetherness, harmony, being in agreement, and understanding each other.
- Transparency and accountability within the group to members, and to the outsiders such as the Government, Donors and the entire community.
- Honesty, discipline and obedience to the constitution, vision, and leadership.
- Learning and sharing through cross utilization of members knowledge and skills.
- Commitment and dedication to work with the highest degree of voluntarism and active participation in all the activities of the Association.
- Being trust worthy so that non-members and the entire clientele can also trust the Association.
- Ensuring gender sensitivity in leadership, role allocation, and analysis of operational strategies.
- Being God loving in order to offer the 'love we so deserve to others' and ensuring moral ethics in our undertakings.
- Confidentiality as we deal with clients whose status and conditions are beyond our public pronouncement as well as the exposure of organizational information other than those relevant to our execution of duties.
- Ensuring self-reliance by first looking inwardly at what we are, have and can have and so looking at external support as only complements.

3.4 The direct beneficiaries: Okoro community

This strategic plan targets the selected sub counties in Okoro county namely Nyapea, Jangokoro, Atyka, Kango and Zeu. The focus on these sub counties is based on the fact that there are already standing activities such as those under agreement with TASO in the areas and the need to create

[2] Fundamental in this feedback workshop were the commitments of the sub counties to integrate the Association plan in their three year rolling plan. It was noted that the Association should take a proactive role in ensuring that they participate in the sub county planning process. It was also noted that supplementary budgets would be made to accommodate what the association is doing because they were activities in line with the mission statements and annual plans of the various councils.

visible results. By sector, its focus is on health particularly HIV/AIDS, and education where credible expertise has been developed and a sort of 'name tag' built in the community.

3.5 Intervention focus

NSMCCA will, over the next three years, 2004-2007, position itself strategically in the fights against HIV/AIDS and child Illiteracy. The Association will partner with Okoro based organisations, local government, and the entire civil society and donor community to ensure that it entrenches the results so far created. With this in mind, NSMCCA practical goal that operationalises its vision and mission is as stated below.

Goal: *A sustainable NSMCCA capable of empowering the community to prevent HIV/AIDS and its effects as well as promote primary education.*

Indicators

- Having a fully functional secretariat.
- Increased community knowledge and improved practice towards HIV/AIDS prevention and mitigation and educational support.
- A community able to fund and police current roadblocks to improving positive knowledge, attitude and practices of HIV/AIDS and education.
- Increased political and social commitment to HIV/AIDS control and education promotion.

Strategic Interventions

To achieve the above goal, a number of objectives (that is short term results) with accompanying activities will be pursued. These are outline hereunder in primarily three themes: HIV/AIDS, primary education and chills sponsorship. The last theme, reflects on the capacity and capability of the organisation to deliver its desired products with the quality and values it so cherish.

Theme 1 Health Sector: HIV AIDS

HIV/AIDS STATUS IN NEBBI DISTRICT

There is no clear information about the gravity of the situation of HIV/AIDS in the Nebbi district. Figures for Nebbi district are scanty and incomplete. Reports from the STD/AIDS Control Programme, show a constant scenario[3] a situation that needs cautious reading due to reporting errors.

As a result, the district has responded, in line with the Multi-sectoral AIDS Control Approach (MACA) developed by Uganda AIDS Commission (UAC), establishing Multi-sectoral Committees (DAT and DHAC) that promote government-private –civil society partnership. The role of CBOs in the fight is thus catered for.

CBOs have accordingly responded by engaging in numerous interventions that include ongoing awareness raising for behavior change through the provision of IEC on HIV life; the promotion of abstinence from premarital sex and mutual faithfulness among and between sexual partners;

[3] STD/AIDS Control Programme, Ministry of Health (June 2001 and June 2003) *HIV/AIDS Surveillance Report.* Kampala.

strengthening consistent and correct use of condoms; and the promotion of community-based care and support for HIV/AIDS infected and affected persons. Only few cases are involved in support for PLWA and Orphans.

NSMCCA's HIV/AIDS Intervention

From 1994 when HIV/AIDS prevention, control and mitigation was adopted by the Association, a number of works were done. Community education, counselling, Posttest club, and condom promotion have remained high on the agenda. As a result, in the health sector, the Association has been able to produce the following observable results:

- HIV/AIDS is no longer a secret. People, especially the youths, now have open discussion and testimony on HIV/AIDS.
- PLWA's are slowly adopting positive living e.g. through prompt treatment of opportunistic infections.
- Reduced rate of sexual promiscuity especially among adults.
- Rising free will in the community for VCT services. Some couples are now taking pre-marriage HIV/AIDS test, and some pregnant mothers are also taking pre-delivery test.
- A total of 72 PLWA are actively participating Post Test Club.
- Increased condom consumption especially among the youths.
- Reduction of cultural practices that can promote HIV/AIDS spread e.g., inheritance, sharing of sharps, myths of AIDS as witchcrafts.
- Traditional healers adopting proper practices that prevent predisposition to HIV/AIDS infection and are referring some clients for counseling.
- Trained TBAs are practicing modern maternal delivery techniques and are referring mothers for health unit based post-natal services.
- PLWA's are now agents of change through community sensitization and sharing experiences.
- Community acceptance of and support to PLWA's is slowly increasing.

Persisting problems that warrant attention

Despite observed results in the community, there is a slow pace and magnitude of positive behavior change in AIDS prevention and control. The realization of NSMCCA vision is thus still obstructed by some noticeable challenges, namely:

- Elders are resistant to condom use. It is noted that the elders believe that they are safe and not predisposed to infection because they are not sexually active like the youths yet in essence most of them go with the youths. For instance, widows are now grabbing young boys.

- There is continuation of some bad predisposing (cultural) practices e.g. widow inheritance, teenage sexual activity, de-tooting and tattooing, rape, criminal suicidal abortion, exchange of Agwara (by the opiga) when their mouths is bleeding, cultural care for the sick without preventive wears, sharing of sharp instruments e.g. in saloons, unsupervised home based delivery, and bad video shows (without age segmentation).

- There is also a low response to VCT especially by couple, and elders. The free will to drive HIV testing is still low. Few people are also taking pre-marriage and pre-delivery HIV test. Compared to those who have tested, this makes a community largely of those who do not know of their HIV sero-status.

- Disjointed counseling that fails to link clients to access ARV. Although the Association, is among the few that, provide comprehensive counseling –pre-test and post-test counseling – it is unable to secure a furthered lifespan of PLWA due to the inability to access antiretroviral drugs.

- PLWA have a low response to positive living. Majority still deny their status. This is compounded by stigmatization by both the PLWA themselves and by the community. This will continue to reduce their lifespan, lessen their ability to plan and pursue the future with optimism, and associate freely with the wider community.

- Religious influence is still strong in the community. With the Christians refusing condom use, many parents are forced to deny their children the condom information and encouragement to use condoms. And that abstinence is next to impossible among the youths the tendency to have unsafe sex is high.

Practical Objectives

To contribute towards entrenching the results so far achieved and impacting on behavior change, the below results will guide the interventions in the thematic area of HIV/AIDS.

Expected results

- *Girls and boys are willfully able to say Yes/No to sex.*
- *Free public discussion on HIV/AIDS without any shyness.*
- *Free interaction with and acceptance of PLWA.*
- *Increase in VCT (especially pre-marriage, pre-delivery, and pre-sex cases).*
- *Flexibility of religious leaders on sex education and condom use.*
- *Improved mother -to-girl child relationship.*
- *Increased response to peaceful positive living by PLWAs.*
- *Reduction of school dropouts due to teenage pregnancies.*

To achieve these results (outcomes), the following objectives will be pursued:

Objective 1: Increased positive sexual behavior change in the community

Behavior change communication is the focus of this objective, aimed at increasing coverage and deepening current knowledge and practices. The implementation of proposed activities will involve the active participation of PLWAs who are members of the Association and the PTC that is being run in Nyapea hospital. Effort will be made to encourage PLWA who have publicly declared their status to accompany the Association team particularly in their home areas to testify to the public so that the usual community silence is broken.

1.1 Two peer educators per parish will be trained. These will be selected from all social categories while recognizing individual age, sex, and status.

1.2 Seventy traditional healers, ten from each town council/sub county level- will be trained on health ethics and made aware of causes, symptoms and prevention of HIV/AIDS.

1.3 Two teachers, one male and the other female- will be sensitized on HIV/AIDS and encouraged to model school children out of the danger of infection.

1.4 At least one visit will be made, per term, to the 56 primary schools, 8 secondary schools, and 2 tertiary institutions to create AIDS awareness and provide problem-based behavior change counseling to pupils and students.

1.5 Community AIDS education meetings will be held in beer clubs, markets, and villages with parents, opinion leaders, and out of school youths to create awareness on HIV/AIDS.

1.6 Radio talk shows will be run quarterly on HIV/AIDS causes, symptoms and preventive measures as well as best practices that are now available to the affected and infected.

1.7 Radio spots in the form of jingles, poem and songs will be run quarterly and radio drama will be run biannually.

1.8 Awareness workshop will also be organized in the 36 parishes for at least 30 mothers each on maternal-girl child relation. This aims at breaking the silence of mothers to their daughter under the pretext that their aunties will pursue the job, when even current young aunties are in need of counseling help.

1.9 Holding parish based life skills training for 30 boys and girls on assertiveness, responsible living, sex and sexuality, among others per sub county.

1.10 Drama shows will be held at public places at parish levels monthly on the various themes that have been touched by verbal communication. The shows will be in the local language so that people understand the inherent message in them. PLWA who are members will be integral part of the show team.

1.11 Video will be shown on HIV/AIDS in at least 90 villages on various theme such as basic facts, VCT, PTC, PMTCT, etc to reinforce other attitude change communication.

Objective 2: Improved community-counseling services.

The center of this objective is on a comprehensive community counseling services that includes, pre-sex, pre-marriage, pre-delivery and HIV sero-status pre-test and post-test counseling. This will be done with non-positive, sero-positive and persons affected by HIV/AIDS both individually or collectively. It will involve:

2.1 Training 2 community-counseling aides per parish in order to maintain a close chain of counseling with prospective and already tested people. This will also reduce the work burden on the few counselors who will largely handle referral and supervisory cases.

2.2 Training 10 new counselors within the Association to add on the existing ones.

2.3 Training senior female teacher and a model male teacher to become school based counseling aides.

2.4 Holding a monthly sensitization on VCT in schools, markets, beer clubs, and public functions.

2.5 Holding weekly home visits to already tested clients who are sero-positive to provide post-test counseling services to them an their immediate kins.

2.6 Forming post-test clubs in 5 health facilities in the county to bring together PLWA and their well-wishers. In these PTCs the following will be conducted:

2.6.1 Weekly nutrition education
2.6.2 Weekly recreational activities
2.6.3 Weekly prayer meetings
2.6.4 Weekly income generation activity such as knitting, making cakes and mats for sale.

Objective 3: Increased condom use among both elders and the youths.

Condom use marketing and promotion will be core in meeting this objective. Activities to be executed include will include condom education that will be integrated in behavior change communication under objective 1. Linkage will be built with ARUDA a local CBO involved in condom distribution in the area to widen access levels.

Objective 4: Strengthened community based care and support for PLWA

Community based care and support for PLWA and their next of kins is important because the acceptance and reduction of stigmatization will on the integration of PLWA and their families in their communities. This will also require that PLWA are made firm of life management. Thus, NSMCCA will conduct:

4.1 Community sensitization on community based home care and support for PLWA and their next of kins. This activity will be integrated with all the sensitization activities under objective 1.

4.2 Weekly home visits – as is in 2.5 above.

4.3 Provide material support to PLWA at an estimated rate of about 500 per annum.

4.4 Training PLWA in life management skills especially will writing and memory book so that they can prepare themselves with their families ahead of any disaster to come. This will be conducted in the five new and the 1 already existing PTC.

4.5 Training of caregivers to PLWA starting with those in PTCs so that they practice safety measure when handling PLWA to prevent infection. They will also be trained on emotional support, nutritional management, and the general hygiene.

Objective 5: HIV/AIDS friendly policies lobbied and advocated for.

NSMCCA realises that on its own it cannot do much. Faced with resource constraints, and broader environmental enabling factors to infection, there is need to integrate the various power centers of public policies such as government, traditional and religious leaders and donors in the fight. To do so requires advocating and lobbying these institutions to support the initiative of the Association. This will be done through:

5.1 Lobbying and advocacy meeting. Such meetings will be held with local government at sub county levels so that they integrate NSMCCA into their plans and budget. NSMCCA will also participate in local government planning process to take a grip of its interest and that of its clients.

5.2 Dialogue meetings will be held with religious and traditional leaders at sub county levels to solicit their support on contentious issues like condom promotion, peer education, policy processes and mobilisation for HIV/AIDS control and mitigation.

5.3 Train community leaders on community mobilisation, advocacy, resource mobilisation, and planning for HIV/AIDS at sub county levels. This training will take place at the parish level where every local government planning process starts to ensure that during every annual planning process care is taken on HIV/AIDS issues.

5.4 Participating in World AIDS day at whatever center the district chooses as the main ground for celebration. The association will travel to the center and, among others, march, show its activities through brochures and buntings, etc. so as to gain recognition from the district leadership and other actors in the field of HIV/AIDS.

Theme 2: Primary Education Sector

Okoro county, compared to other counties, tails in all indicators of formal education in Nebbi district. Enrolment, retention, performance and inter-cycle progression is the lowest. Thus, many people are illiterate. Majority of children of school going age, especially girls, are not enrolled in schools. Contributing factors are numerous ranging from government policy through schools, parents, children and the wider community.

The intervention in this sector has been aimed at building acceptance among children of and good attitude among parents towards education. A multifaceted approach was used to target all the players. The visible results produced, thus far include, among others:

- Increased girl-child enrolment and participation in schools.
- Parents slowly acting responsibility e.g. defilement, provision of school materials.
- Re-enrolment of some dropout girls.
- Reduced rate of in-school teenage pregnancy.
- Reduced market, beer clubs, and discos attendance by school going children during school days.
- Limited attendance of dowry celebrations by schoolgirls.
- Policy makers in Nyapea and Jangokoro sub counties have enacted education byelaws awaiting approval by the district council.
- Declining discrimination towards disabled children both in homes and in schools.
- Senior women teachers' established and active –providing care and counseling to girls in some schools.
- Involvement of teachers in continuous pupil mobilization for education.
- Reduction in pupils' sexual exploitation by teachers.
- Increased PLE division I pass.

Persisting problems that warrant attention are summarized in the table below categorizing the various actors with their contribution to inadequate adaptation to formal education. The table presents both the views of the children as identified during the 2004 Global Campaign for Education missing out map process and those that members faced in their implementation of education promotion in the county.

Table 1: Common problems

Caused by children • Early sexual engagement • Rampant drinking and smoking • Peer pressure • Involvement in petty trade • Low self esteem	Caused by Parents • Too much domestic work • Parents support early marriages • Girls preferred for baby sitting • Parents do not buy necessary scholastic materials
Caused by Schools Facilities • Absence of adequate class room blocks • Inadequacy of desks • Poor sanitary conditions • Inadequate scholastic materials • Inadequate games and sports • Dusty classrooms causing sickness	Caused by the community • Child abuse • Bad cultures keep some children out of school especially the girls • Bad attitude towards education by the local community • Impassable roads during rainy season
Management (DEO, PTA, SMC, Headteachers) • Many unqualified teachers • Poor motivation of teachers • Lack of senior women teachers • Corruption of education funds • Lack of learning materials for disabled children	Caused by government policies • Lack of bursary schemes • Corruption of education funds • Distant schools • Disabled children have to move a long way to special needs schools
Teachers • Defiling pupils • Teachers engage in other businesses instead of teaching • Arrogance while teaching	

Cf: Global Campaign for Education Summary Report,2004.

Practical Objectives

To realize an improved status in the education cycle in the county, NSMCCA will endeavor its effort in producing the below results as a focus of its investment and resource mobilization for the sector.

Expected results

- Increased equitable enrolment of boys and girls in schools.
- Reduced drop out of especially girls from school.
- Cultural acceptance of girl child education.
- Improved school infrastructure.
- Improved children – parent – teacher relations.

To achieve these results (outcomes), the below objectives will be pursued:

Objective 1: Increased equitable access to, retention in, progression within the education system for boys and girls

Continued efforts will be made to ensure that both boys and girls have equal chances of entering and remaining in schools and proceeding to upper educational levels. Attention will be made on working with all stakeholders to realize this target. This will be done by:

1.1 Holding a countywide sensitization seminar to increase community awareness on the status and challenges to education in the county as well as to mobilize the community for supporting education of children. This will be done for specific categories such as:
1.1.1 Monthly community talk for parents held at some selected village levels.
1.1.2 Quarterly education talk with children out of schools at parish levels.
1.1.3 Holding quarterly seminars with community leaders – Rwoths, elders, church and opinion leaders at sub county levels.

1.2 Conducting drama shows in main markets and beer clubs on various themes that depict the status - current and desired - of education.

1.3 Showing videos in selected villages and this will be complemented with an education talk.

1.4 Holding quarterly radio talk shows on education issues in the county. Participants in the show will be mobilized from government, civil society and private sector as well as from the local institutions.

1.5 Following up the sub county byelaws of Nyapea and Jangokoro that has now taken too long at the district levels without approval.[4]

1.6 Carrying out school outreach to schools both as a role model and monitors to ensure that children who are in school do not drop out and that schools are enjoyable for the children to live in. this will involve:
1.6.1 Termly visits to schools for in-school children. This will involve senstization and counseling of children to remain in school.
1.6.2 Termly seminar with teachers to sensitize them on their roles and community experiences.

1.7 Strengthening school management committees and parent teachers' association executives to execute their roles. The will be trained on their roles.

Objective 2: Sub county local governments lobbied to support primary education

While awareness creation focused on in objective one above provides for increased knowledge and to some extent change of attitudes, there is need to gain support from other actors with stronger community power positions so that issues of broader concern can be handled within acceptable policy frameworks. To do this the following will be undertaken:

2.1 Conducting termly missing out map and taking politicians to schools. This process will investigate the problems on the ground in regards to education as per those experiencing the real situation. It will be done in selected schools within a sub county, especially those in problem

[4] The Sub county chiefs during the feedback workshop pointed that the District Council Social services Committee is drawing an Ordinance for approval by the Council. Before this is done the byelaw cannot be implemented.

areas as identified by education department of the district. The involvement of sub county politicians together with those of the villages within the school catchment areas will echo the voices of the marginalized.

2.2 Politicians will be lobbied to increase their support for education through increased funding, community mobilization, policy settings such as the byelaws, and setting up bursaries that supports the needy and girls.

2.3 School management committees and Parent teachers' associations' executives will also be lobbied to ensure that education funds are allocated in areas of need, managed well to the benefit of the children, and that community is drawn closer to partake in the education system of their areas.

2.4 Quarterly seminar for parish development committees will be held for them to critically integrate education issues in development planning since they spearhead the planning processes at parish and village levels and also actively participate at the sub county levels.

2.5 Participating in world education day at centers gazetted by the district, as a sign of solidarity with other actors.

Theme 3 Organisational Positioning

Organizationally, NSMCCA is a member organization. Members pay membership fee on entry and annual subscription fees to renew their membership. The management of the Association is vested in a General Assembly that meet once a year to make policies. The technical arm is managed by elected leadership headed by an executive committee composed of the Chairperson and the Vice, Secretary and the Vice, Treasurer and the Vice, and a Field officer who also head the community facilitators for child sponsorship programme. The executive committee is assisted by sub committees for Revolving fund, Disciplinary, Construction, and Procurement, each with a Chairperson, Treasurer and two other members. These committees meet monthly to plan and review their plans and to report on their progresses. The only limitation is that there is no inter committee progress update let alone the time lag the general assembly has to know and respond to operational challenges.

Over time, the Association has been able to increase its membership from 8 to more than 30 people. Various skills have been acquired e.g., counseling skills (by 10 people), facilitation skills (all members), making nutrition supplement – FIGROMA (from fish, g-nuts, and fermented maize flour), project writing, savings and credit, and basic facts about HIV/AIDS. Members have the pride and identity of belonging to the Association. Few critical assets have also been acquired (e.g., video sets, office furniture, bicycles, and cooking utensils). Equally, its public image, legitimacy and acceptability in Okoro county has increased. A cordial working relationship has been built with Nyapea Hospital, Action Aid, and Nebbi district local governments. At present, the Association is engaged in expanding and strengthening Nyapea hospital outreach activities in Okoro health sub district.

However, the association has hit a snag in its savings and credit scheme that was formed with members' own savings worth Ushs 500,000 to help members access, use unrestricted, low interest rate (5% per period) loan for a 3 month period. Although a committee was set for this, and it approved the first batch of loans, many people who even placed security for their borrowing have upto 1.2 years failed to repay the loan. The established management lacks the knowledge and skills

to operate the scheme. Besides, members also lack skills for income generation management and end up getting loans that they invest in non profitable ventures.

4.1 SWOT analysis

Table 2 SWOT analysis of NSMCCA

Strength	**Weaknesses**
• PLWA are active partners in HIV prevention and mitigation • Recognized by local government • Have some human resources that are skilled in their work • Creating markets for itself • Known and accepted by the community • Has a long term partnership with AAN	• Inadequate capacity to coordinate (logistic, funds, skills) • A mobile office without a secretariat • High expectations of PLWA • Limited opportunity to share experiences • Ad hoc operations without plan and guidelines • Time conflict with hospital work for the majority of members • Over-dependence on one donor support • Members have limited selflessness to contribute to the group • Inadequate management skills • Lack of operational guidelines to guide control, checks, and procedures of financial, planning, asset, human, and administrative management.
Opportunity	**Threats**
• Global political and donor will and support • High HIV/AIDS infection rates • Increasing community interest in fighting HIV/AIDS and low education level in the county	• High income poverty level • Political uncertainty • Exploitation by some organization • High illiteracy rate

Practical Objective

The above alluded to challenges, records set, and external environmental constraints and opportunities provide NSMCCA a need to position itself strategically. The association has to become a learning organization that is adaptable to meeting the changing environment in Okoro. To do this the association should be able to achieve the following results:

Expected results

- Become vibrant in its thematic areas of operation.
- Operate within an agreed upon guideline and the constitution.
- Have competent members capable of handling the thematic focuses with quality outcomes.

Objective 1: Strengthened capacity of NSMCCA's to function optimally

Realization of the above set objectives is dependent on the functionality of NSMCCA. This, thus, reflect the concern that the association has in ensuring that its members knowledge, skills, and attitudes, are better fitted within the operations of the various stated objectives. To achieve this the below objective and activities will be pursued:

Activities

1.1 Establishing a functional secretariat. NSMCCA will employ a full time project person who will coordinate all its activities as planned. This person will be appraised in a participatory manner basing on her/his performance in view of the plan execution. The hired staff will be housed in a NSMCCA office that will, in the first year, be rented as the 'own' office block is completed.

1.2 Establishing operational guidelines. To ensure that the existing organizational structure operates effectively, better functional systems will be put in place. This will include guidelines for planning, financial control, asset management, human resource management and administration. This will be developed in the first year by a hired consultant and will be discussed by the executives before approval by the general assembly. The consultant will also be required to hold a one-day feedback to members to avoid abuse, messing, and wrong interpretation of the guidelines in its use.

1.3 Regular (feedback) meetings: As per the constitutional requirements, NSMCCA executives will need to meet quarterly to review progress and plan for the next quarter. In this meeting, reports from the various committees are discussed. A quarterly general assembly will also be held to keep members abreast of what is going on in the association so that all reports are discussed.

1.4 Training of NSMCCA members. Basing on the operational challenges discussed and core training needs agreed upon for members, it was pointed that NSMCCA will conduct training in the following areas a) Management skills training (Financial management; Human resource management (teamwork and conflict management); Communication skills and report writing; Fund raising strategies; Participatory planning, M+E ; and Advocacy and lobbying); and b) Technical skills training (in Succession planning and legal rights; IGA selection, planning and management; Savings and credit management; Proposal writing; and Life skills education).

4.0 FINANCIAL IMPLICATIONS

The implementation of the strategic plan over the 3-year period cost Ushs 351.2 million of which 8% will be raised locally and 92% will be solicited from external agencies. The funds will be spent as follows: 43% on HIV/AID component, 31% on primary education component, and 13% on child sponsorship as a separate fundraising strategy and lastly19% on general management. The funds will be spent in a declining time-ratio of 42% in year 1, 31% in year 2 and 28% in the final year.

Table 3 Summary of budget estimate

	Core components	Total	Local	Others
1	HIV/AIDS	150,487,200	9,790,000	140,697,200
2	Primary education	88,425,000	7,810,000	80,615,000
3	Child Sponsorship	47,181,000	1,875,000	45,306,000
4	Organizational	65,072,600	9,406,600	55,666,000
	Total	351,165,800	28,881,600	322,284,200

Fund raising strategy will be widened. Child sponsorship will be the largest funding raising strategy. NSMCCA is also actively involved in child sponsorship programme only in Nyapea sub county. Under this programme, potential children (age 4-9 years), in schools, are identified, registered, their case histories collected, photographs taken and are linked by Action Aid Uganda (AAU) to potential sponsors in the UK. When a child has got a sponsor, regular messages are collected from the child and mailed by AAU to UK where there is cordial exchange of messages between the child and the sponsor. The child's growth – physical and educational- is monitored. The difference between this programme with those run by other organizations such as World Vision and Plan International is that instead of directly supporting the sponsored child, any support derived from the child's sponsor is used to benefit the entire community.[5]

To date, there are 527 children in the scheme and 7 have already dropped out due to permanent relocation (three each in Abeju and Oyeyo and one in Abira parish). Six facilitators have been introduced to the programme operationalisation and they are equipped with bicycles. St. Mystica Nursery School have already benefited in the form of scholastic materials for the nursery education of children in the school.

The Experience

While the programme has started well, it has not yet sunk down well in the community. The programme has prioritized 'software' aspects like education promotion without 'hardware' component that the community can visibly see and can attach to the sponsorship. This in part contributes to a hazy situation where community members are saying, 'NSMCCA is taking and selling pictures of their children to Europeans for selfish motives'. Such articulation indicates that the community is not fully aware of the programme principles. On the other hand, it signal that such secured benefit from the 70% allocation to NSMCCA should be planned on cautiously to facilitate both the groups' activities and to fund physical community projects. Such projects can be solicited from the parish development committees and parish action plans. In this way, there will be physical accountability to the people. Caution need be taken that this should not the overriding aim of such co-support to community project but an entry point for reinforcing advocacy work through partnership building and 'talking from examples'.

Further, the sentiments of parents that they need direct child support as opposed to community support presents either the inability of the programme to explain to the communities. It may also be that the programme was hurried in the community before people understood the programme entirety.

The facilitators are also faced with problems related to tracing up missing children especially those who have temporarily moved to far off distances. Besides, in the process of registration and message collection, the geographical barriers such as heavy rain, impassable rivers, and high hills affect coverage. Weighed against the rate of remuneration, the task proves not to receive its equivalent worth.

Thus, there is need to entrench the programme, within the plan period, in Nyapea sub county so that people know and appreciate its benefit to the community. This will be done by:

1.1 Community sensitization talks on child sponsorship held at village levels to explain to the parents about the programme, how it works, the processes involved in its operations and above all the merits of collective community benefits over child-based benefits.

[5] This strategy evolved from a number of years of experience by AAU in child sponsorship. First, direct child sponsorship create 'sponsor queens/kings' that discriminate against even children in the same home. Secondly, AAU work for the benefits of the entire community and not an individual. Thus the community benefit sponsorship strategy befit the mission of AAU and social discrimination that it is fighting.

1.2 Increasing the registration of children. A total of 2000 children should be registered and adopted by the end of the plan period.

1.3 Training of 6 more community facilitators. This training will require the inclusion of child handling as part of component.

1.4 Equipping the new facilitators with means of transport and together with the old one providing them with raincoats, gum boats, umbrella, and backpacks.

1.5 Improving the remuneration of facilitators from Ushs 30,000 to about Ushs 50,000 per task accomplishment.

1.6 Replacement of permanently transferred children.

1.7 Allocating funds for bicycle maintenance.

1.8 Supporting community based projects that have improved well being bearing such as water source, supply of desks to schools, and supplying improved seeds to parents.

Further, project proposals will submitted to AIM programme, Northern Uganda Social Action Fund, CARITAS-Nebbi, Action Aid Uganda, AFARD, TASO, and AIDS Information Centre.

Linkages will be built with Nyapea Hospital and the Sub County Local Governments in the five sub counties where the plan implementation will be centred so that their support is solicited right from participating in their annual planning processes through the inclusion of the Association workplan and budget in these organisations' annual budget framework paper.

5.0 IMPLEMENTATION PLAN

Below is the implementation schedule of the proposed activities. The project manager will be directly charged with the day-to-day activity implementation. The organisational structure will be revisited to allow for the dissolution of all committees. There will be the position of an annual general meeting, patron, the executives, and a secretariat composed of the project manager, field officers and child facilitators. The establishment of any committee will thus be short term and their action will primarily be like a task force to help the secretariat meet its objective.

The association will take a direct charge in the operation of school and home based counselling aides and peer educators to ensure that activities are implemented with the guaranteed quality. Support supervision will be provided as part and parcel of the field based activities.

Table 4: Activity Plan

	Component/Activity	**2004/2005**	**2005/2006**	**2006/2007**
	HIV/AIDS			
1.0	*Behaviour change communication*			
1.1	Training of Peer educators	√		
1.2	Training of Traditional Healers		√	
1.3	Training of Teachers	√		
1.4	School visits	√	√	√
1.5	Community education meetings	√	√	√
1.6	Radio talk shows	√	√	√
1.7	Radio spots	√	√	√

1.8	Mother-child relation meeting	√	√	√
1.9	Life skills Training	√	√	
1.10	Drama shows	√	√	√
1.11	Video shows	√	√	√
2.0	*Community counselling*			
2.1	Training counselling aides	√	√	√
2.2	Training counsellors	√		
2.3	Training teachers as counselling aides	√	√	√
2.4	VCT promotion seminar	√	√	√
2.5	Home based visits	√	√	√
2.5	PTC formation and support	√	√	√
3.0	*Condom Promotion*	√	√	√
4.0	*Community based care and support*			
4.1	Awareness talks on community based care and support	√	√	√
4.2	Home based care visits	√	√	√
4.3	Provision of material support	√	√	√
4.4	Memory book and will writing training	√	√	√
4.5	Training PLWA caretakers	√	√	√
5.0	*Advocacy and lobbying*			
5.1	Advocacy and lobbying workshops	√	√	√
5.2	Dialogue meetings	√	√	√
5.3	Training of community leaders	√	√	√
5.3	Participating in world AIDS day	√	√	√
	Education			
1.0	Community sensitisation			
1.1.1	Education talk - parents	√	√	√
1.1.2	Education talk - out of school children	√	√	√
1.1.3	Education talk - community leaders	√		
1.2	Drama shows	√	√	√
1.3	Video shows	√	√	√
1.4	Radio talk shows	√	√	√
1.5	Education bye law follow up	√		
1.6	School visits	√	√	√
1.7	Education talk - Teachers	√	√	√
1.8	Training SMC and PTA executives	√	√	√
2.0	*Advocacy and lobbying*			
2.1	Missing out mapping	√	√	√
2.2	Advocacy and lobbying workshops	√	√	√
2.3	Dialogue meetings	√	√	√
2.4	SMC/PTA dialogue meetings	√	√	√
2.5	Participating in world AIDS day	√	√	√
	Child sponsorship			
1.1	Awareness talk with parents	√	√	
1.2	Child registration	√	√	√
1.3	Training 6 facilitators	√		
1.4	Equipping facilitators	√		
1.5	Facilitators reward	√	√	√
1.6	Replacing children	√	√	√
1.7	Bicycle repair	√	√	√

1.8	Community project support	√	√	√
	Management support			
1.1	Setting a functional secretariat	√	√	√
1.2	Operational guidelines	√		
1.3.1	Executive meetings	√	√	√
1.3.2	Committee meetings	√	√	√
1.3.3	General Meeting	√	√	√
1.4.1	Financial management	√	√	√
1.4.2	Human resource management		√	
1.4.3	Communication skills	√		
1.4.4	Fund raising strategies	√		
1.4.5	Participatory impact monitoring	√		
1.4.6	Advocacy and lobbying	√		
1.4.7	Succession planning		√	
1.4.8	IGA - SPM		√	
1.4.9	Savings and credit	√		
1.4.10	Proposal writing	√		
1.4.11	Life skills education	√		
1.5	Project management	√	√	√
	Periodic review	√	√	√
	Documentation of best practices	√	√	√
	Annual planning	√	√	√
	Annual audit	√	√	√

6.0 MONITORING AND EVALUATION

Tracking progress will be one aspect of the plan implementation. NSMCCA need to know whether it is realising its intended results besides achieving the outputs so targeted. Monitoring of progress will, thus, be done at both community (beneficiary assessment) and the association levels. Any remedial actions so desired will also need to be based on a clear diagnostic study. The following will constitute the monitoring activities:

6.1 *Periodic review meetings*: Quarterly implementation reviews will be held at the general assembly level. The project manager will be expected to compile a cumulative performance report for presentation to and discussion by the members. This meeting will be fed by clear activity reports for every component. Reports from these meeting will be circulated to various stakeholders to inform and/or consult on progress and other related decisions. This will requires having a clear annual workplan and budget; and simple but comprehensive format for activity, progress and annual reporting.

6.2 *Annual planning meetings:* Annual rolling action plan will be formulated from a planning meeting that will be attended by all stakeholders to review progress and chart a new direction. This will also be a basis for annual reviews and evaluation and reporting.

6.3 *Reporting*: The following reports will be submitted to the general assembly: Quarterly, Mid-year and Annual activity and financial reports; and annual audit reports. Copies of these documents will also be sent to other stakeholders.

6.4 *Accountability to the population*: The beneficiaries of the project will be involved in planning meetings and annual review /feedback meetings in addition to regular discussions during the

course of the project. These are sessions where lessons are learned and avenues explored to ensure maximum beneficiary satisfaction within the constraints faced by the project. Involving other key stakeholder such as Local Government in these sessions will provide a wider networking and acceptance opportunity for the association.

6.5 *Annual audit*: While NSMCCA will delve into participatory impact monitoring methodology, a firm will be hired to conduct annual audit that will merge both financial, physical and community views – for use in the annual planning process.

ANNEX 1: MONITORING FRAMEWORK

Activities	Output	Effects	Verifiable Indicators	Tools
Theme 1: HIV/AIDS *Objective 1: Increased positive sexual behaviour change in the community*				
• Training of Peer educators • Training of Traditional Healers • Training of Teachers • School visits • Community education meetings • Radio talk shows • Radio spots • Mother-child relation meeting • Life skills Training • Drama shows • Video shows	• 72 peer educators trained • 70 traditional healers trained • 130 teachers sensitised • 120school visits made • 26 meetings held • 12 radio talk shows held • 18 radio spots aired • 780 mothers sensitised • 180 boys and girls trained • 12 drama shows staged • 30 shows staged	• Girls and boys are willfully able to say Yes/No to sex. • Free public discussion on HIV/AIDS without any shyness. • Free interaction with and acceptance of PLWA. • Increase in VCT (especially pre-marriage, pre-delivery, and pre-sex cases). • Flexibility of religious leaders on sex education and condom use. • Improved mother -to-girl child relationship. • Increased response to peaceful positive living by PLWAs. • Reduction of school dropouts due to teenage pregnancies.	• # of sexual partners per young adult • # using VCT services • Public opinion on condoms • # of PLWA participating in PTC • % of local government funds allocated to HIV/AIDS	• Review meetings with beneficiaries • Opinion survey • Okoro Health sub district report
Objective 2: Improved community counselling services	• 72 aides trained • 10 counsellors trained • 40 teachers • 30 VCT promotion held • 5 PTCs established and 156 meetings held			
• Training counselling aides • Training counsellors • Training teachers as counselling aides • VCT promotion seminar • Home based visits • PTC formation and support				
Objective 3: Increased condom use among both elders and the youths.				
• Condom education	• 18,000 people educated			
Objective 4: Strengthened community based care and support for PLWA				

Activities	Output	Effects	Verifiable Indicators	Tools
• Awareness talks on CBCS • Home based care visits • Provision of material support • Memory book and will writing training • Training PLWA caretakers	• 780 people sensitised • 560 visits made • 360 people reached • 600 people supported • 150 PLWA trained • 100 caretakers trained			
Objective 5: HIV/AIDS friendly policies lobbied and advocated for.				
• Advocacy and lobbying workshops • Dialogue meetings • Training of community leaders • Participating in world AIDS day	• 150 government staff lobbied • 125 community leaders lobbied • 150 community leaders trained • 3 WADs attended			
Theme 2: Primary education *Objective 1: Increased equitable access to, retention in, and progression within the education system for boys and girls*				
• Education talk - parents • Education talk - out of school children • Education talk - community leaders • Drama shows • Video shows • Radio talk shows • Education bye law follow up • School visits • Education talk - Teachers • Training SMC and PTA executives	• 2700 parents reached • 360 children out of school reached • 150 community leaders reached • 6 drama shows staged • 30 video shows staged • 12 radio talk shows held • 2 byelaws followed • 21 visits made • 360 teachers reached • 100 SMC/PTA trained	• Increased equitable enrolment of boys and girls in schools. • Reduced drop out of especially girls from school. • Cultural acceptance of girl child education. • Improved school infrastructure. • Improved children – parent – teacher relations.	• General and net enrolment rate by gender • Cohort survival rate • Education budget allocation by sub county • Frequency of school-community dialogue	• Education report • Education infrastructure survey • Opinion survey
Objective 2: Sub county lobbied to support primary education				
• Missing out mapping • Advocacy and lobbying workshops • Dialogue meetings • SMC/PTA dialogue meetings • Participating in world AIDS day	• 5 sessions held • 150 politicians lobbied • 105 SMC/PTA lobbied • 105 PDCs lobbied • 3 WED attended			

Activities	Output	Effects	Verifiable Indicators	Tools
Child sponsorship				
• Awareness talk with parents • Child registration • Training 6 facilitators • Equipping facilitators • Facilitators reward • Replacing children • Bicycle repair • Community project support	• 2590 parents reached • 1000 children registered • 6 facilitators trained and equipped • 4 community projects co-supported	• Increased child enrolment and retention in schools. • Community is happy and knowledgeable about the programme. • Expanded community project support.	• # of children in sponsorship • # of projects supported	• Annual report • Sub county development plan
Theme 3: Organisational Positioning *Objective 1: Strengthened capacity of NSCCA to function optimally*				
• Setting a functional secretariat • Operational guidelines • Executive meetings • Committee meetings • General Meeting • Training in various management and technical skills • Periodic review • Documentation of best practices • Annual planning • Annual audit	• I operational manual produced • Office space hired; office equipped; an administrative assistant hired • 30 members trained in various skills • 12 executive meetings, 60 sub committee and 12 general meetings held • 12 reviews conducted • 3 best practices documented • 3 annual planning sessions held • 3 annual audit conducted	• Quality services delivered to their clients. • Improved public image and acceptance of NSMCCA • Vibrant in its thematic areas of operation. • Operate within an agreed upon guideline and the constitution. • Have competent members capable of handling the thematic focuses with quality outcomes.	• Availability, quality, approval and adherence to annual plan and budget • Beneficiary satisfaction • Regularity of meetings • Thematic areas Vs skills competency • Funding strategy stabled	• Reviews of plans, budgets, and reports • Opinion survey • Minutes of meetings • Humans resource inventory