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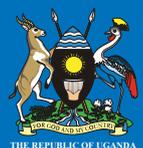
# Strengthening TB and HIV&AIDS Responses in East-Central Uganda (STAR-EC)

**PROGRAM YEAR IV, QUARTER 1 PROGRESS REPORT**  
Achievements, Challenges and Lessons Learned

**October - December 2011**



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# List of Acronyms

|         |  |         |  |
|---------|--|---------|--|
| <       | Less than  | HMIS    | Health Management Information Systems                      |
| >       | Greater than   | HRH     | Human Resources for Health                                 |
| AB      | Abstinence and Being Faithful                              | HSD     | Health Sub-District  |
| ABC     | Abstinence, Being Faithful and Condoms                     | HTC     | HIV Testing and Counseling                                 |
| ACP     | AIDS Control Program                                       | ICF     | Intensified Case Finding                                   |
| AIDS    | Acquired Immunodeficiency Syndrome                         | IEC     | Information, Education and Communication                   |
| ANC     | Antenatal Care   | IGAs    | Income Generating Activities                               |
| ART     | Antiretroviral Therapy                                     | INH     | Isoniazid  |
| BCC     | Behavior Change Communication                              | IP      | Implementation Partners                                    |
| BCCPs   | Behavioral Change Communication Programs                   | IYCF    | Infant and Young Child Feeding                             |
| CBO     | Community Based Organization                               | JCRC    | Joint Clinical Research Centre                             |
| CD4     | Cluster of Differentiation 4                               | JMS     | Joint Medical Store  |
| CDFU    | Communication for Development Foundation Uganda            | JSI     | JSI Research & Training Institute, Inc.                    |
| CDR     | Case Detection Rate  | LG      | Local Government   |
| CM      | Community Mobilization                                     | LMIS    | Logistics Management Information System                    |
| CME     | Continuing Medical Education                               | LQAS    | Lot Quality Assurance Sampling                             |
| CORPs   | Community Owned Resource Persons                           | LTFU    | Lost to follow up  |
| CPHL    | Central Public Health Laboratories                         | m2m     | mothers2mothers  |
| CPT     | Cotrimoxazole Preventive Therapy                           | MARPs   | Most-at-risk populations                                   |
| CPD     | Continuous Professional Development                        | MCPs    | Multiple Concurrent Partnerships                           |
| CSAs    | Community Support Agents                                   | MDR     | Multi-Drug Resistant                                       |
| CSO     | Civil Society Organization                                 | MoH     | Ministry of Health   |
| CSWs    | Commercial Sex Workers                                     | MoU     | Memorandum of Understanding                                |
| DHMT    | District Health Management Team                            | MSH     | Management Sciences for Health                             |
| DHO     | District Health Officer                                    | MUAC    | Mid Upper Arm Circumference                                |
| DLFP    | District Laboratory Focal Person                           | NACWOLA | National Community of Women Living with HIV&AIDS in Uganda |
| DOTS    | Directly observed therapy short-course                     | NSAs    | Network Support Agents                                     |
| DQI     | Data Quality Improvement                                   | NTLP    | National Tuberculosis and Leprosy Program                  |
| EID     | Early Infant Diagnosis                                     | NTRL    | National TB Reference Laboratory                           |
| eMTCT   | Virtual Elimination of Mother-to-Child Transmission of HIV | NUMAT   | Northern Uganda Malaria AIDS and Tuberculosis Program      |
| FLEP    | Family Life Education Program                              | NVP     | Nevirapine   |
| FOC-REV | Friends of Christ Revival Ministries                       | OCA     | Organization Capacity Assessment                           |
| FSG     | Family Support Group                                       | OIs     | Opportunistic Infections                                   |
| GBV     | Gender Based Violence                                      | OP      | Other Prevention   |
| GoU     | Government of Uganda                                       | OVC     | Orphans and Vulnerable Children                            |
| HBC     | Home based care  | PACE    | Program for Accessible Health Communication and Education  |
| HC      | Health Center  | PCR     | Polymerase Chain Reaction                                  |
| HCP     | Health Communication Partnerships                          | PE      | Peer Educator  |
| HCWM    | Health Care Waste Management                               | PEPFAR  | President's Emergency Plan for AIDS Relief                 |
| HIV     | Human Immunodeficiency Virus                               | PITC    | Provider Initiated Testing and Counseling                  |
|         |  | PLHIV   | Persons Living with HIV&AIDS                               |
|         |  | PMTCT   | Prevention of mother-to-child transmission of HIV          |

|          |  |
|----------|--|
| PNC      | Postnatal Care   |
| PP       | Positive Prevention  |
| PrEP     | Pre Exposure Prophylaxis                                       |
| PY       | Program Year   |
| Q        | Quarter  |
| QI       | Quality Improvement  |
| QoC      | Quality of Care  |
| SCHW     | Sub-county health worker                                       |
| SDS      | Strengthening Decentralization for Sustainability              |
| SMC      | Safe Male Circumcision   |
| SPAI     | Service Performance Assessment and Improvement                 |
| SPARS    | Standardized Performance Assessment and Recognition Strategy   |
| STAR-EC  | Strengthening TB and HIV&AIDS Responses in East Central Uganda |
| STIs     | Sexually Transmitted Infections                                |
| SURE     | Securing Uganda's Right to Essential Medicines project         |
| TASO     | The AIDS Support Organization                                  |
| TB       | Tuberculosis   |
| TSR      | Treatment Success Rate   |
| UAC      | Uganda AIDS Commission   |
| URHB     | Uganda Reproductive Health Bureau                              |
| USAID    | United States Agency for International Development             |
| UVRI     | Uganda Virus Research Institute                                |
| UVRI/HRL | UVRI HIV Reference Laboratory                                  |
| VHTs     | Village Health Teams   |
| WHO      | World Health Organization                                      |
| YAU      | Youth Alive Uganda   |

## Executive Summary

This report provides details of activities that were implemented by the Strengthening TB and HIV&AIDS Responses in East Central Uganda (STAR-EC) Program during the period October 2011 – December 2011 of Program Year Four (PY4). The report is being submitted in accordance with the provisions of Cooperative Agreement No. 617-A-00-09-00007-00 between USAID and JSI Research & Training Institute, Inc. the lead partner in the implementation of the STAR-EC program.

The overall goal of the STAR-EC program is to increase access to, coverage of, and utilization of quality comprehensive HIV&AIDS and TB prevention, care and treatment services within district health facilities and their respective communities in nine districts of East Central Uganda.

In this quarter, STAR-EC worked in collaboration the Ministry of Health, the nine STAR-EC supported district local governments, the Strengthening Decentralization for Sustainability (SDS) project and other implementation partners. The program supported implementation of activities at district, community and household levels, delivering quality services to a high number of beneficiaries.

A total of 74,137 individuals (61.9% females and 38.1% males) were counseled, tested and received their HIV results at 108 static and 93 outreach sites. Overall, 3.8% of the 74,247 individuals who were tested were diagnosed HIV positive (1,794 females and 1,018 males). A total of 4,844 couples accessed HTC services of which 124 (2.6%) were discordant, 60 (1.2%) were concordant positive and the rest were concordant negative. The highest seropositivity rate of 6.6% was registered in Namayingo District.

PMTCT services were delivered at 81 sites and a total of 27,834 women (24,147 pregnant and 3,687 post natal care women) were tested for HIV and received their results. Overall, 3.3% of all pregnant women who reported for PMTCT services during ANC, labor and delivery were found HIV positive (this number includes 290 pregnant women with documented HIV positive results). Approximately 606 HIV positive women were enrolled onto a PMTCT prophylactic regimen/HAART. Additionally, 90.3% of 279 babies received Nevirapine syrup refills at six weeks of age.

Over this quarter, a total of 2,163 individuals were reached with HIV prevention interventions and messages focused on Abstinence and/or Be-Faithful and Condom (ABC) with 34% of these clients reached more than once. Due to less CSO activities during this quarter, a total of 829 key populations were reached with other HIV prevention behavioral change promotional messages and condoms among whom 44% were reached more than once.

The program increased the number of health facilities supported to provide SMC services in the region from fifteen to seventeen. STAR-EC provided basic pharmaceutical drugs and other consumables and a total of 11,034 males were received SMC services from 16 health facilities and 187 outreaches. 80% of the SMC clients were served through outreaches.

Over this reporting period, a total of 2,490 Persons Living with HIV&AIDS (PLHIV) were newly enrolled in care and 17,518 clients were active in care. Overall, a total of 219 (8.8%) children aged <15yrs were newly enrolled in chronic care. Antiretroviral therapy (ART) services were provided at 24 static sites and, in total, 950 PLHIV (381 males, 569 females) were started on ART during this quarter. About 8,182 PLHIV were retained as total current on ART. Additionally, 103 (10.8%) children <15yrs were started on ART, bringing the total number of children currently on ART to 669 (8.2%).

Tuberculosis treatment success has progressively improved to 87.3% beyond the national target of 85%. Facilities continue to perform better on TB/HIV indicators across all districts. All districts, except Mayuge (where one TB patient was not tested for HIV), achieved 100% target for TB patients who had an HIV test recorded in the register and cotrimoxazole preventive therapy (CPT) enrolment. Overall 99.8% of 397 TB patients were tested for HIV, 98.6% and 67.8% of TB/HIV co-infected patients were enrolled on CPT and CXT/ART respectively. The regional

HIV prevalence among TB patients was 35.4% and was much lower than the national prevalence of 54%. Despite the progress made, limited access to ART services for TB patients diagnosed from health centre III level and the islands remains one of the major challenges.

Quality of care was enhanced through coaching of a total of 84 facility Quality Improvement teams on the implementation of the quality improvement principles including organizing the activities, implementing the action plans, data collection and utilization at facility level.

Health system strengthening interventions involved training of 89 laboratory staff in logistics management. Owing to the stock out at the NMS, CD4 reagents were provided to the 3 General Hospitals to avert service interruption. In collaboration with SDS and the district structures, patients' blood specimens were transported from peripheral health units to testing hubs in the region. In total, 93,574 CD4 and 791 DNA PCR tests for ART monitoring and EID were performed. Turnaround for early infant diagnosis (EID) results improved from 4 to 2 weeks. Recurrent stock outs of laboratory diagnostics and related supplies was a significant challenge to laboratory services strengthening over this quarter.

During this quarter, STAR-EC worked with the Securing Ugandans' Rights to Essential Medicines (SURE) project in collaboration with Makerere University and trained regional pharmacists to effectively support the Medicines Management Supervisors (MMS) who will come on board during next quarter under the Standardized Performance Assessment and Recognition Strategy (SPARS). Following the national stock out, STAR-EC provided buffer supplies such as kits, anesthetics and sundries for SMC services, CD4 reagents and related accessories.

As part of health systems strengthening, STAR-EC, in partnership with STRIDES, conducted a three-day training for district folks in district health management information systems for all 9 STAR-EC supported districts. A total of 169 district health officials and health workers from 128 health facilities were trained in the quality utilization of the new MoH-HMIS. During the quarter, STAR-EC rolled out a study on the "key populations" entitled "Population Estimation, HIV Knowledge, Attitudes and Practices Study, Hotspots Mapping Among Most-at Risk Populations in the East Central Region of Uganda". The findings will be reported in the second quarter of PY4. With support from USAID, STAR-EC actively participated in sharing information on best practices at international level. A total of twelve abstracts (three oral, seven posters and two CD-Room publications) were accepted and presented for the 16th International Conference on AIDS and STIs in Africa (ICASA) 4-8 December 2011, Addis Ababa, Ethiopia.

Quality of care was enhanced through coaching of a total of 84 facility Quality Improvement teams on implementation of the quality improvement principles including organizing the activities, implementing the action plans, data collection and utilization at facility level.

Additional efforts were placed on creating strong linkages between community service providers and health facilities through training of Village Health Teams (VHTs) on how to conduct referrals and document the referral process. Demand creation for a comprehensive package of services was mainly done through the interactive one-hour radio program; interpersonal communication through peer educators, VHTs and health workers. STAR-EC also collaborated with the MoH and other partners such as Health Communication Partnership (HCP) and the Uganda Health Marketing Group (UHMG) to deliver the communication interventions.

The details of the achievements made and challenges met by the program during this reporting period are provided in the rest of the sections of this report.

**Table 1: Summary of STAR-EC Targets vs. Results for PY4, Quarter One**

| Intervention area  | Key Indicators (Numbers)  | Achievements (Number of Individuals served)  |   |  |   |                   |                           | End of Program Life Target Vs Achievements |   |  |  |
|--|---|--|---|--|---|-------------------|---------------------------|--|---|--|--|
|  |   | PY1* (implementation from July 2009 -Sept 2009)  | PY2 (Oct 2009 - Sept 2010)                  | PY3 (Oct 2010 - Sept 2011)                   | PY4,Q1 (Oct 2011 - Dec 2011)                | End of PY4 target | % of PY4 targets achieved | End of Program Life Target                 | Program Cumulative achievements to date (total PY1*, PY2 and PY3) | % of end of Program Life Target achieved | Comments   |
| HIV Testing and Counselling (HTC)                                | Individuals who received HTC and their results  | 10,376   | 178,303                                     | 330,966                                      | 74,137                                      | 130,000           | 57                        | 600,000                                    | 593,782   | 99                                       | Steady supply of test kits enabled achievement of significant target proportions during the quarter. STAR-EC will continue to provide HTC services with more focus on HIV key populations. IQAS survey results will be used in prioritization of Supervision Areas that have been identified with low HTC uptake |
|  | Individuals trained in HTC  | 64   | 256   | 356  | 0   | 66                | 0                         | 400  | 676   | 169                                      | During this quarter, STAR-EC concentrated on consolidating the quality of service delivery by all past trained HTC service providers through continued support supervision and on job mentorship.  |
|  | Outlets providing T&C services  | 35 service outlets (Only 2 were static)  | 76 static and 280 parishes (outreach sites) | 106 static and 268 parishes (outreach sites) | 108 static and 93 parishes (outreach sites) | 120 static sites  | 90 % of static sites      | 148  | 108 static sites  | 72% of static sites targeted             | Due to some delays in the CSO granting process, the number of outreaches reduced during the quarter. Among CSOs, only FLEP was able to perform some outreach activities.   |
| PMTCT  | Pregnant women with known HIV status (includes tested and received results)   | No Implementation during PY1   | 65,983                                      | 104,689                                      | 27,834                                      | 113,000           | 25                        | 482,600                                    | 198,506   | 41                                       | 22,741 (2.1%) HIV positive received HTC services as part of ANC; 1,116 (2.8%) through labor and delivery; 3,687 (2.4%) through post-natal care and 290 reported with documented HIV positive results.  |
|  | Pregnant women who received ARVs to reduce the risk of mother to child transmission                                     | No Implementation during PY1   | 1,759                                       | 3,418  | 606   | 3,300             | 18                        | 26,230                                     | 5,783   | 22                                       | Routine program data that has been collected over time shows a lower HIV prevalence among pregnant women (<4%) than the national figure (6.5%) used while deriving STAR-EC's program working target and progress to date is in line with this adjusted prevalence rate.  |
|  | Persons trained for PMTCT   | No Implementation during PY1   | 177   | 458  | 0   | 70                | 0                         | 400  | 635   | 159                                      | During this quarter, STAR-EC concentrated on consolidating the quality of service delivery by all past trained PMTCT service providers through continued support supervision and on job mentorship.  |
|  | Service outlets providing PMTCT   | No Implementation during PY1   | 68  | 83   | 81  | 118               | 69                        | 118  | 81  | 769                                      | The program has embarked on scale up to the targeted facilities starting with Quarter 2.   |
| Sexual and Other Behavioral Risk Prevention (General Population) | Targeted population reached with abstinence and/or being faithful messages  | 39,737   | 102,860                                     | 132,586                                      | 2,163                                       | 60,000            | 4                         | 283,000                                    | 277,346   | 98                                       | 34% and 44% of those reached with AB and MARPs messages (respectively) were visited more than once during the quarter. With the exception of FLEP, the absence of CSO activities during this quarter contributed to the slow increment in results.   |
|  | Individuals trained to provide AB services  | 234  | 564   | 298  | 0   | 110               | 0                         | 1,265                                      | 1,096   | 87                                       | In the aftermath of fulfilling a new grantee selection process, CSOs will be brought on board to start/continue with the implementation of sexual and behavioral risk prevention activities starting with Quarter 2. Training of new VHTs will be done in the same quarter.                                      |
|  | MARPs reached with individual or small group level HIV prevention based on evidence and meet minimum required standards | 12,179 were reached through "other prevention" interventions (this result is not part of the overall achievements for MARPs) | 12,763                                      | 19,473                                       | 829   | 26,000            | 3                         | 88,300                                     | 33,065  | 37                                       |  |

| Intervention area  | Key Indicators (Numbers)   | Achievements (Number of Individuals served)     |                            |                            |                              |                   |                           | End of Program Life Target Vs Achievements |  |  |   |
|--|--|---|----------------------------|----------------------------|------------------------------|-------------------|---------------------------|--|--|--|---|
|  |  | PY1* (Implementation from July 2009 -Sept 2009) | PY2 (Oct 2009 - Sept 2010) | PY3 (Oct 2010 - Sept 2011) | PY4 Q1 (Oct 2011 - Dec 2011) | End of PY4 target | % of PY4 targets achieved | End of Program Life Target                 | Program Cumulative achievements to date (total PY1* / PY2 and PY3) | % of end of Program Life Target achieved | Comments  |
| Clinical/Preventive Services- Additional TB/HIV                    | HIV+ patients in HIV care or treatment (pre-ART or ART) who started TB treatment     | 0   | 205                        | 533                        | 111                          | 1,000             | 11                        | 4,900                                      | 849  | 17                                       | The program is increasingly finding less (35%) HIV/TB co-infected patients when compared to the national figure of 54% that was used in targeting for this indicator. At the end of the quarter, 95.7% of 17,518 HIV+ active clients were screened for TB in HIV care and treatment settings  |
|  | TB patients who had an HIV test result recorded in the TB register                   | 13  | 1,802                      | 2,317                      | 397                          | 1,100             | 36                        | 5,500                                      | 4,529  | 82                                       | 99.8% of the patients recorded in the TB register had an HIV test and received their results  |
|  | Individuals trained to provide HIV/ TB related palliative care                       | 64  | 875                        | 250                        | 0                            | 200               | 0                         | 700  | 1,189  | 170                                      | Past trained individuals were strengthened in the performance of their activities through on job support supervision during this quarter. Some trainings of new service providers will begin in Quarter 2   |
| Anti- Retroviral Therapy (ART)                                     | HIV + individuals receiving a minimum of one clinical care service (CXT)             | 283   | 7,041                      | 16,684                     | 17,518                       | 19,000            | 92                        | 26,000                                     | 17,518   | 67                                       | Utilization of Village health teams has helped in increasing access to clinical care through effective referrals and linkages. Among districts, the highest number of clients were found in Kamuli (3,762) and Iganga (3,766) while the lowest were found in Kaliro (776) and Luuka (1,069)   |
|  | Adults and children with advanced HIV infection newly enrolled on ART                | 61  | 1,776                      | 5,083                      | 950                          | 1,650             | 58                        | 8,200                                      | 7,870  | 96                                       | By the end of this quarter 10,644 had ever started on ART. This quarter was also characterized by a scale up to more ART static and outreach sites. Additionally, utilization of village health teams has helped in identifying HIV+ children who are given effective referrals to health facilities.   |
|  | Adults and children with advanced HIV infection receiving ART (CURRENT)              | 372   | 3,119                      | 7,487                      | 8,182                        | 6,423             | 127                       | 9,323                                      | 8,182  | 88                                       |   |
| Safe Male Circumcision (SMC)                                       | Males circumcised  | 0   | 803                        | 14,327                     | 11,034                       | 90,000            | 12                        | 225,000                                    | 26,164   | 12                                       | In October 2011, there were no anesthetic drugs thus the failure to reach quarterly targets. More innovative outreaches are in place to achieve set targets. About 89% of SMC beneficiaries during Q1 were adolescents and adult men. This was an increment from 76% reported during the entire PY3. More outreach services are being extended into the community so as to achieve population level impact. |
|  | SMC surgical sites   | 0   | 7                          | 15                         | 16                           | 18                | 89                        | 18   | 16   | 89                                       |   |
| Strategic information, capacity building and systems strengthening | Local organizations provided with TA for SI activities                               | 4   | 11                         | 11                         | 1                            | 11                | 9                         | 11   | 11   | 100                                      | Only FLEP was able to implement any activities and was thus supported by STAR-EC. The rest of the new/old CSOs will be supported when they get on board during Quarter 2.   |
|  | Individuals trained in SI (including M&E, surveillance and/or HMIS)                  | 122   | 379                        | 170                        | 221                          | 85                | 260                       | 85   | 892  | 1,049                                    | High staff turnover in some districts impedes the execution of work for which such folks are initially trained to undertake   |
|  | Local organizations provided with TA for HIV-related institutional capacity building | 4   | 11                         | 11                         | 1                            | 11                | 9                         | 11   | 11   | 100                                      | Only FLEP was able to implement any activities and was thus supported by STAR-EC. The rest of the new/old CSOs will be supported when they get on board during Quarter 2.   |

\* PY1 (March-September 2009) involved only three months of actual implementation that were mainly on program start-up activities

Source: STAR-EC program records

# 1.0 Introduction

## 1.1 Background

The Strengthening TB and HIV&AIDS Responses in East Central Uganda (STAR-EC) Program is being implemented in nine districts of Uganda which are inhabited by over 3 million people (9 % of the Ugandan population). This region is bordered by the Lakes Victoria and Kyoga in the south and north respectively, a location that allows for both commercial and subsistence fishing. Islands, beaches and landing sites are key features of six of the districts (including Bugiri, Kaliro, Buyende, Namayingo, Kamuli and Mayuge). The East Central mainland is characterized by some densely forested areas, pastoral belts, as well as commercial centers along the northern transport corridor that stretches from the Kenya-Uganda border at Malaba and Busia through Bugiri and Iganga to Kampala.

The Uganda Demographic and Health Survey 2006 showed that the East Central region has one of the highest total fertility rates in the country, averaging 7.5 births per female<sup>1</sup>. Additionally, this region had an estimated HIV prevalence of 6.5%<sup>2</sup>, which translates into approximately 73,000 Persons Living with HIV (PLHIV), the majority of whom did not know their HIV status or had never accessed the treatment and care needed to maintain good health. Other drivers of the HIV epidemic in the East Central region include multiple concurrent and cross-generational sexual relationships due to a high level of polygamy; significant transactional sexual activity especially in those districts situated along the northern transport corridor; a high number of residents involved in the high HIV risk occupation of commercial fishing; migrant plantation workers; and the presence of a large number of uniformed personnel at the armed forces barracks and prisons in the region. This situation was exacerbated by the low HTC service coverage which ranged from 0.5% - 8.8% in the region and ART service coverage that ranged from 2.5 - 10.4%<sup>3</sup>.

According to the Service Provision Assessment Survey 2007, 24% of health facilities in the East Central region offered TB diagnostic services and 83% of these had all components needed to conduct TB sputum tests (microscope, glass slides and ZN reagents). Only 28% of the facilities had TB treatment and follow-up services. District Reports (Oct. – Dec. 2008) to Zonal TB and Leprosy Supervisors indicated a low TB case detection rate within the region (average 35%) and treatment success rate average of 66%. Efforts aimed at providing TB/HIV services in the region are hampered by the general weakness of the primary healthcare and logistics systems. Operational health facilities often have inadequate staffing, equipment and infrastructure necessary to provide a comprehensive range of needed services.

It is against this background that STAR-EC's interventions aim at expanding access to and utilization of the comprehensive package of TB and HIV&AIDS services by building upon existing networks, expanding geographical coverage and populations served through strengthening district specific responses and expanding the role of civil society organizations and communities in planning, implementing and monitoring activities.

## 1.2 Major Objectives of STAR-EC

**STAR-EC has five major objectives that include**

- Increasing access to, coverage of, and utilization of quality comprehensive HIV&AIDS and TB prevention, care and treatment services within district health facilities and their respective communities;
- Strengthening decentralized HIV&AIDS and TB service delivery systems with emphasis on HCs IV and III and community outreach;
- Improving quality and efficiency of HIV&AIDS service delivery within health facilities and civil society organizations;
- Strengthening networks and referral systems to improve access to, coverage of and utilization of HIV&AIDS and TB services; and
- Intensifying demand generation activities for HIV&AIDS and TB prevention, care and treatment services.

## 2.0 Major result areas and progress during the first quarter

### 2.1 *Result 1: Increasing access to, coverage of and utilization of quality comprehensive HIV&AIDS and TB prevention, care and treatment services within district health facilities and their respective communities within the nine supported districts*

#### 2.1.1 Increasing access to and uptake of HIV testing and counseling (HTC) services

##### **Increasing access to and uptake of HIV testing and Counseling (HTC)**



*A health worker conducts a rapid HIV test on Haama Island, Namayingo*

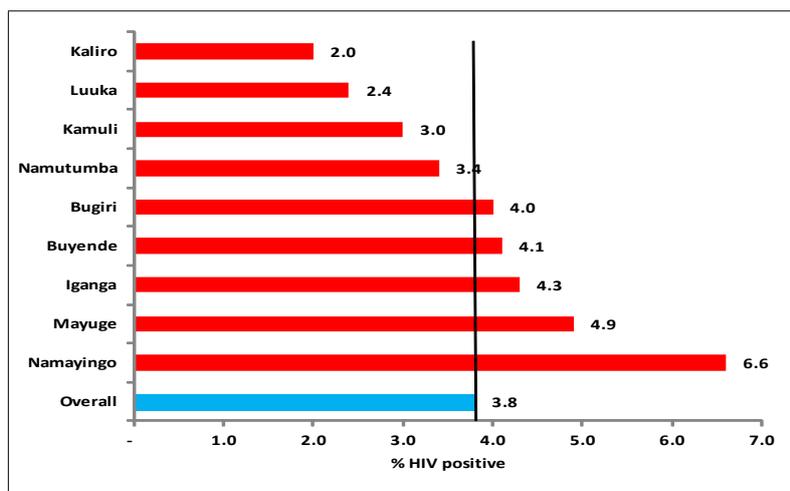
During Quarter 1 of PY4, HTC service delivery to the communities in the nine districts continued mainly through the 108 health facilities. STAR-EC supported both the health facilities to offer HTC services using both static and outreach based approaches. The focus of this support was premised on the prioritization of the key populations like MARPs.

Overall, a total of 74,137 individuals (45,868 females, 28,269 males) were tested for HIV and received results across the nine districts mainly from the public health units. This corresponds to 57% of the overall annual target of 130,000 persons expected to access HTC services during PY4. There was 99% (n = 74,139) acceptance of results for all the clients who were counseled and tested. Overall, a total of 2,812 (1,794 females and 1,018 males) were diagnosed HIV positive resulting in an overall HIV positivity rate of 3.8% (n = 74,247) for the quarter. All the HIV positive

clients were duly referred for further care at sites offering care and ART.

During the quarter, a total of 9,939 individuals (or 4,844 couples) accessed HTC services as couples. A total of 2,951 couples accessed HTC services through the 'Couple Week' HTC approach undertaken by both health facilities and CSOs within the community while 1,161 couples accessed the service through the static HTC services. During the quarter, 25% (n = 19,500) of the PY4 annual couple target was achieved. However the results show that the quarterly couple targets for the facility based and couple week HTC activities were exceeded. Home-to-home HTC yielded few couples due to slow down in activity by the implementers, the CSOs. Among those tested, 124 couples were discordant while 60 were concordant positive. Of the couples accessing the service through outreaches, 66 were discordant while 26 were concordant positive. All concordant positive and discordant couples were linked to health facilities offering chronic care/ART services and occasionally to TASO for appropriate ART evaluation and care.

**Figure 1: HTC prevalence from both static and outreach sites during the quarter, by district**



Source: STAR-EC program records

In all the nine districts supported by STAR-EC, Namayingo had the highest HIV positivity rate of 6.6 % (n=6,379) while the Kaliro District had the lowest prevalence at 2.0% (n=7,469). No integrated island<sup>1</sup> outreaches were undertaken during the quarter hence the apparent reduction of positivity posted by Namayingo from 10.3% at the end of PY3 to the current 6.6% for PY4, Q1.

## Lessons Learned

Without HTC outreaches, there is sub-optimal coverage of the service for the general and key populations which greatly undermines the role of HTC as an entry point to prevention care and treatment services

## Challenges

- Some facilities were faced with stock-outs during the quarter.
- Despite the substantial investment in supporting providers to improve documentation of services provided, the uptake has been slow at some of the facilities resulting in under reporting at some of the service delivery points.

## Way forward

- During the subsequent months of implementation, STAR-EC will continue to support mentorship targeting improvement of documentation and data reporting at facilities in the nine districts.
- The program will continue supporting targeted outreaches to reach key populations as a priority.

## 2.1.2 Prevention of mother-to-child transmission of HIV (PMTCT)

During the reporting period, the program supported the implementation of PMTCT interventions in accordance with the four pronged approach as recommended by WHO and the national policy and implementation guidelines. These include interventions for primary prevention of HIV among women of child bearing age, prevention of unintended pregnancies among HIV positive women, prevention of MTCT, and treatment care and support for HIV positive mothers and their family.

### Prong 1: Primary prevention of HIV among women of child bearing age

Under this prong, the program relied on interventions done within the community setting and alongside HTC service delivery that are aimed at reducing the risk of HIV infection among women of child bearing age. This is

<sup>1</sup> Past program results have shown that island communities do post one of the highest HIV prevalence rates

due to lack of capacity within the facility based PMTCT intervention setting to reach the target population with the interventions.

Overall, a total of 44,301 females were reached with primary prevention. These include 42,064 who received post-test HIV risk reduction counseling; 1,403 females in marriage or cohabiting relationships that were reached with mutual fidelity promotional messages through model couples and peer educators; and 315 females that are part of the fisher folk community that were reached with a comprehensive package for behavioral and sexual risk reduction, STI screening and treatment. A total of 519 youth (10-24) were reached with age appropriate abstinence, be faithful and condom use messages for reduction in risk of HIV acquisition. The details of these interventions are described elsewhere in different sections of this report. The optimal scale will be achieved once the CSOs resume full operations when funding resumes.

## **Prong 2: Preventing unintended pregnancies in women living with HIV**

The program conducted clinical mentorships to assess progress and support the integration of family planning (FP) in HIV services for the benefit of Virtual Elimination of Mother-to-Child Transmission of HIV (eMTCT) among others. Several bottle necks for the integration of FP/HIV services were identified including reliance on the motivation of the client to demand for the service after brief health education talks and the wide spread limitation of logistics and skills for administration of long term FP methods. Providers at 3 hospitals, 12 HCs IV and 1 HC III were mentored on the implementation of provider initiated promotion of contraceptive use for prevention of HIV including targeting of HIV positive women with FP services at ART and post natal clinics and in psychosocial support group meetings like FSGs. During the reporting period 1,857 HIV positive post natal mothers attended family support group meetings at 30 PMTCT sites implementing the m2m peer support model, 13,422 pieces of condoms were distributed and 980 (53%) mothers reported use of other methods of contraception other than condoms (mostly Depo-Provera, the injectable hormonal method).

### **Challenges**

- Lack of recording mechanism for the prong one and prong two interventions/key outputs. Most of the sites do not have the MoH integrated FP registers and for some, prior to the mentorship activity, it was not possible to capture the HIV status of the FP users in the improvised registers.
- Limited access to long term methods through the public health facilities
- The low male involvement in reproductive health activities is a major hindrance to uptake of the service

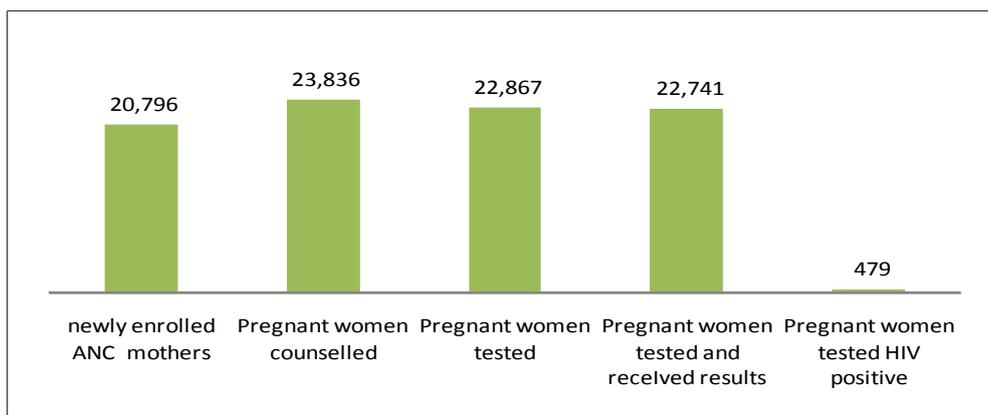
### **Way forward**

- The program will work closely with the MoH Reproductive Health Division and STRIDES for Family Health project to procure integrated Family Planning registers for the PMTCT sites and job aides for FP/HIV integration.
- To mobilize clients in need of long term and/or permanent methods and schedule their appointments with those set by the STRIDES for Family Health program supported CBOs that provide the service on outreach basis.
- Continued community sensitization involving VHTs and peer educators

## **Prong 3: Preventing HIV transmission from women living with HIV to their infants**

During this reporting period, the program supported 85 of the 276 health facilities in the East Central region to offer PMTCT service according to the new national guidelines (Option A). However, only 81 were able to offer services to pregnant women while four were Health Centers II and had no service providers to offer services but referred clients to other health facilities. The support was mainly logistical and in on-going clinical mentorship and technical supervisory visits to the facilities.

**Figure 2: PMTCT testing cascade for mothers attending ANC during Quarter I**

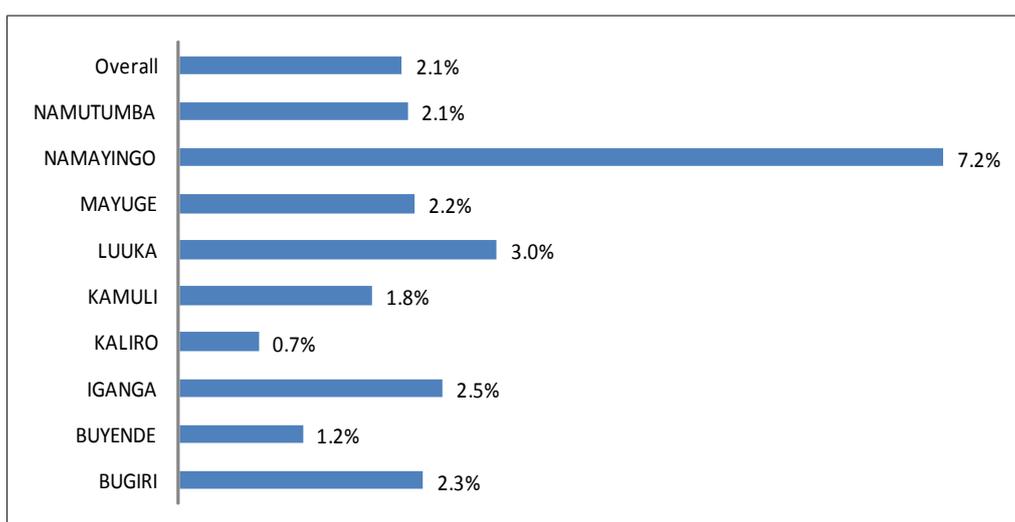


Source: STAR-EC program records

### Provision of essential laboratory tests and use of ARVs for reduction of MTCT risk

During the quarter, HIV positive mothers and their exposed babies accessed CD4 and PCR testing services from their facilities as a result of the collaboration between STAR-EC, SDS, the three district hospitals with CD4 machines in the region and the national EID laboratory at MoH. A total of 27,834 pregnant women were counseled tested and received their results during ANC (22,741 with 2.1% HIV positive), labour and delivery (3,687 with 2.4% HIV positive) as well as post natal care (3,687 with 2.4% HIV positive) and 290 reported with documented HIV positive results. The overall HIV positive rate was 3.2%. As part of the ANC cascade, 20,796 new mothers attended ANC while a total of 23,836 women who attended ANC were counseled. Of these 22,867 (96%) were tested with 22,741 (99%) of those tested receiving their results. Overall, 479 women (2.1%) were diagnosed HIV positive with Namayingo District posting the highest positivity rate (7.2%, n= 572) while Kaliro had the lowest (0.7%, n= 2,268).

**Figure 3: HIV prevalence among ANC mothers by district Q1 of PY4**

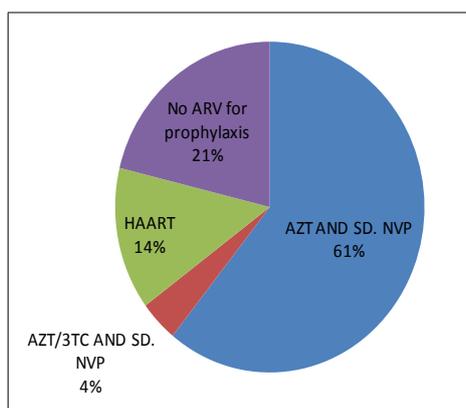


Source: STAR-EC program records

An additional 120 women were diagnosed HIV positive during labor and in the post natal period (31 and 89 respectively) an observation which underscores the need to utilize these opportunities to provide HTC services as an entry point to prevention and treatment. The total number of HIV positive pregnant women who attended the health facilities during the quarter, including the newly diagnosed and those who presented with known HIV status was 769. Out of these, 606 (78.8%) received ARVs for prophylaxis, 569 (74%) were assessed for ART eligibility

using either CD4 or WHO staging and 107 (18.8%) were initiated on HAART. A total of 279 babies were born to HIV positive mothers at health facilities of which 252 received Nevirapine syrup at birth. However, there was a five-fold increase in the number of babies that required Nevirapine syrup refills at six weeks of age highlighting the number of unskilled attended deliveries and the need for more promotional interventions for health facility deliveries.

**Figure 4: ARV prophylaxis accessed by HIV positive mothers attending ANC Q1 of PY4 (n = 769)**



Source: STAR-EC program records

A total of 766 PCR test samples (83% 1st PCR), were sent to the National EID Laboratory during the reporting period. Of these, 549 sample results (71.7%) had been returned by the end of the quarter. Overall, 52 babies (6.8% of the returned results) were HIV positive. A total of 48 of the 52 HIV+ babies (92%) had been enrolled on ART by the end of the quarter. Most of the babies who were diagnosed HIV+ during the quarter had a history of mixed feeding and their mothers not participating in PMTCT services at all. This highlights the need to strengthen the use of the community resource persons in order to mobilize and facilitate completion of referrals for PMTCT interventions. Follow up activities are continuing for the four remaining babies.

STAR-EC program staff also participated in the review of the Uganda National Plan for Elimination of Mother-to-Child Transmission of HIV 2012-2015 during this quarter.

### Enhancing the role of peer support using the mentor mothers'

During the quarter, STAR-EC continued to facilitate peer support through the 'mentor mothers' at the 30 health facilities. A total of 60 'mentor mothers' are currently engaged at the high volume sites. Additionally, 597 new HIV+ women benefited from one-on-one psychosocial support and education. 3,399 HIV+ women and 906 male partners from FSGs were offered group education and counseling and HIV care and support services that included CD4 testing, Dry Blood Spot (DBS) for PCR testing, adherence support and prevention with positives interventions.



A Dry blood spot (DBS) is taken from an exposed infant, on Dolwe Island, Namayingo District

All the 60 'mentor mothers' received client education cards (job aids) for use during one-on-one and group interactions with the PMTCT clients and 21 'mentor mothers' received in service refresher training as part of capacity building and quality assurance for the support services.

In order to enhance adherence and retention of 'mother-baby' pairs in the PMTCT cascade the program is set to adapt active follow up of clients by the 'mentor mothers'. This is aimed at



*Mentor mothers facilitating a Family Support Group meeting at Buyinja HCIV in Namayingo District*

improving phone follow-up and involvement of the 'mentor mothers' in use of phone calls and or physical home visits to identify and communicate with clients who have missed priority PMTCT events and encourage them to return to the facility for continued care and support.

**Strengthening Outcomes by Achieving Results (SOAR): Engaging 'mentor mothers' in using data to assess performance and monitor improvements.**

During the reporting period, the 'mentor mothers' were oriented on an exercise of reviewing progress on outcome indicators from the longitudinal logbooks and identifying gaps for improvement in service delivery. The activity involved sampling clients from the

logbooks for a period of three months and tracking them through the important PMTCT intervention events. The observations from the first sample that was analyzed were as follows: -

- 76% of ANC clients had returned for their 2<sup>nd</sup> ANC visit (n=391)
- 82% had disclosed their HIV positive sero-status (n=652)
- 80% of the clients had done a CD4 test (n=652), of which, 73% received their results
- 93% of the sampled AN clients had received prophylactic ARVs (n=391)
- Facility deliveries for the sampled clients (n=449) was at 66% while 2<sup>nd</sup> post-natal visit was at 76% (n=449)
- 74% of the babies tracked during the review period had received prophylactic ARVs (n=449)
- 81% of the babies had their DBS samples taken for PCR, with 71% of those tested getting back their results

The analysis is used to identify the performance gaps that are further analyzed and then addressed through tailored interventions to improve linkages and adherence to the PMTCT interventions.

**Prong 4: Providing appropriate treatment, care and support to women living with HIV and their families**



*Mentor mothers going through a review of indicators from the longitudinal logbooks*

A total of 267 pregnant women were newly enrolled into chronic care while 32 were newly initiated on ART following confirmation of eligibility for ART. Some of the mothers captured on the PMTCT program are clients with known HIV status and already enrolled in care. However, the challenges to do with completion of the patient monitoring tools and the stock-outs of CD4 reagents could explain the apparent gap in linkage of HIV positive mothers to treatment care and support as well as the assessment of eligibility for ART.

A total of 279 babies were born to HIV + women at the health facility during the quarter and 52 were diagnosed HIV positive during the reporting period. By the end of the quarter, 48 of these had been initiated on ART. More work to track the four remaining children and initiate them on ART remains to be done.

**Lessons learned**

- Strengthening of the inter and intra-facility and community linkages has improved the retention and

- adherence of the HIV exposed mothers and their babies to the new PMTCT policy
- FSGs serve as important follow up points for HIV positive mothers and their infants. There may, however, be need to provide a wider range of support groups to cater for clients graduating from PMTCT. Such groups include pediatric support groups and ART support groups.
  - Three out of every one hundred (3%) mothers newly tested during labor and two out of every 100 (2%) tested during the post-natal period were found to be positive (the latter findings equivalent to those tested during ANC). This highlights the need to emphasize and support HTC during labor and post-natal contact visits to inform interventions.

## Challenges

- Incomplete documentation of patient management information by the providers at selected sites makes it difficult to track linkages and the apparent gaps observed.
- Stock-outs of CD4 reagents significantly affected the assessment of ART eligibility.
- While tracking of the lost mother baby pairs has improved over time, we are still not able to account for all them due to some of them having no fixed addresses and no telephones.

## Way forward

- Ongoing mentorship for providers on complete documentation of patient management information and ART eligibility assessment using WHO staging
- Referral linkages at both facility and community levels will be further strengthened by involving more lay providers and the use of phone follow up in combination with physical home visits

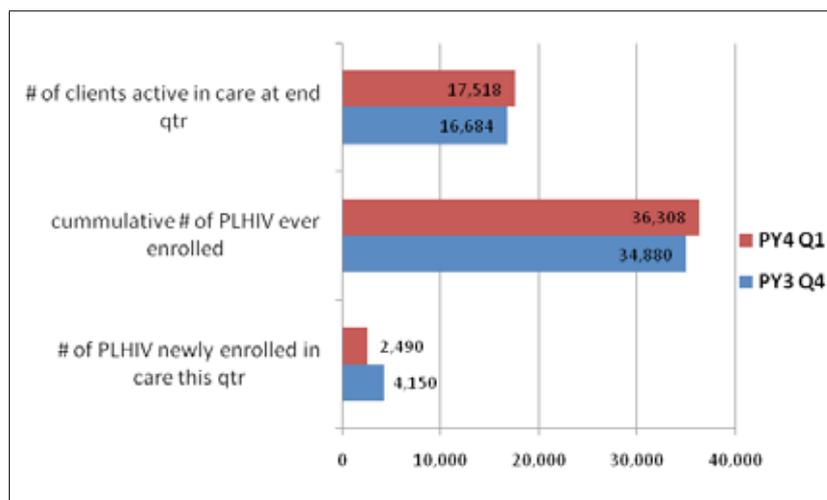
### 2.1.3 Care and support

During the quarter, 131 health facilities (including 33 HCs II located at fishing landing sites) continued to provide a basic package of clinical care for PLHIV that is composed of cotrimoxazole prophylaxis, treatment of opportunistic infections, and laboratory assessment of eligibility for antiretroviral therapy (CD4 test). Note that 35% of all facilities (45 sites) that are mainly large volume sites were supported to provide a more comprehensive package of clinical care that encompasses nutrition support; palliative care – pain and symptom control; management of sexually transmitted infections; prevention with positives; and antiretroviral therapy.

Palliative care, pain and symptom control was provided to 271 clients at four out of thirty two facilities that received technical support from Hospice Africa. The rest of the facilities did not provide this service as there was no oral morphine solution. An additional six facilities received support under the HC I palliative care collaboration, although there are still challenges of accessing appropriate analgesics. As a result of regular technical assistance, there is increased competence of service providers and availability of medicines that enable the facility clinic systems to provide clinical care to huge numbers of PLHIV. About 267 HIV positive pregnant women were linked from PMTCT and newly enrolled in HIV chronic care. All PLHIV are periodically assessed for ART eligibility and so at the end of the quarter, only 122 clients out of those eligible had not yet started ART pending additional adherence preparation counseling sessions.

Nevertheless the cascade of clinical care encountered some critical difficulties during Q1 of PY4 compared to Q4 of PY3. Figure 4 highlights the 60% decline in new enrollment of clients on clinical care and the difficulty to retain significantly more clients as active in care when compared to past quarters. This decline is attributed to prolonged stock-outs of Cotrimoxazole at public facilities. Since active-in-care data excludes 10,644 clients ever started on ART, then probably about 61% of former care clients have progressed to ART and hence the ‘true loss to follow-up’ would be lesser (at 22%).

**Figure 5: The cascade of clinical care – comparison of performance**



Source: STAR-EC program

To-date, 2,974 HIV positive children aged <18 years are registered as ever enrolled in care, while (1,264) are still active in care at 82 health facilities. All children active in care undergo periodic assessments to determine their eligibility for ART, knowing well that early initiation of ART in infants and children greatly reduces infant and childhood mortality. This assessment was mainly by use of the WHO clinical staging criteria due to a prolonged stock out of reagents for CD4 testing. A total of 103 children aged 0-14 years were started on ART during the quarter. Of these, 30 were aged less than 12 months, 42 were 1-4 years while 31 were aged 5-14 years. These were immediately initiated on ART irrespective of their clinical staging or CD4 percentage as per the MoH Pediatric ART 2010 Policy.

The program observed a rise in uptake of pediatric HIV care services during the previous quarter as a result of the August – September 2011 national campaign mobilizing the community for pediatric HIV care/ART services. STAR-EC participated in the above activity by pro-actively engaging the district leaders and facility health workers to participate in the various 10-week long radio programs as well as in the facility-based testing, counseling and providing care to children brought in by caretakers.

### Lesson learned

Decentralization of clinical care to lower level HCs III ensures greater access by PLHIV as evidenced by 40% clients active in care at all HCs III compared to 29% at all HCs IV and 31% at all hospitals.

### Challenge

- The increasing patient load at most sites is affecting the quality of care. Patient waiting time seems to be longer and, if unbearable, may lead to patient loss.
- Stock-outs of commodities including CD4 reagents and cotrimoxazole also contributed to patient attrition.

### Way forward

- Introduce clinical triage at facilities to identify and categorize clients into three namely pharmacy re-fill only visits, nurse visits, and clinician visits to streamline and hasten the client flow.
- Support care teams to better manage staff and patient scheduling on clinic days.
- Establish and facilitate the active client follow up system at high volume facilities.

## Care and support for PLHIV

### Home Based Care

Due to administrative challenges faced by our grantee NACWOLA, the trained volunteers were unable to access facilitation funds to conduct home based care visits to bed-ridden PLHIV clients.

### Way forward

Engage the volunteer PLHIV directly, especially those trained on HBC, and design another mechanism of facilitating them to resume delivering home-based care services including “prevention with positives”. In addition, some health workers will require orientation on HBC so that they take on the role of supervisors of volunteer HBC teams.

The sub-agreement between STAR-EC and NACWOLA has been terminated, however, STAR-EC continues to support all trained village health team members who served under NACWOLA.

### Nutrition support

During this quarter, three hospitals (former NuLife project sites) out of 10 nutrition facilities received Ready-to-Use Therapeutic Foods (RUTF) from RECO industries for nutritional rehabilitation of clients. Subsequently, the STAR-EC program coordinated with the USAID Mission to add seven (7) facilities on the RUTF contract list. The need for RUTF by malnourished PLHIV at these new sites was quantified and shared with USAID. Overall, 10,882 patients received nutritional assessments using weight or MUAC measurements, but only 3% were categorized as malnourished and thus eligible for RUTF support. Of the latter, 63% were HIV positive clients attending clinical care.

**Table 2: Nutritional support to PLHIV during Oct - Dec 2011**

| Facility Name           | Total clients that received nutritional assessments | No. of assessed clients categorized as malnourished | Percentage of malnourished clients that are HIV positive | No. of PLHIV that received RUTF |
|-------------------------|---|---|--|---------------------------------|
| Bugiri Hospital         | 4,344   | 18  | 44%  | 8                               |
| Iganga Hospital         | 2,197   | 66  | 44%  | 29                              |
| Kamuli Mission Hospital | 438   | 8   | 25%  | 2                               |
| Kamuli General Hospital | 671   | 4   | 100%   | 4                               |
| Bumanya HC IV           | 155   | 4   | 100%   | 4                               |
| Kidera HC IV            | 947   | 38  | 95%  | 0                               |
| Kigandalo HC IV         | 320   | 0   | 0%   | 0                               |
| Kiyunga HC IV           | 907   | 73  | 100%   | 0                               |
| Nsinze HC IV            | 216   | 1   | 0%   | 0                               |
| Buyinja HC IV           | 687   | 73  | 100%   | 0                               |
| <b>STAR-EC total</b>    | <b>10,882</b>                                       | <b>285 (3%)</b>                                     | <b>(178) 63%</b>   | <b>48 (27%)</b>                 |

Source: STAR-EC program records

Due to the limited supply of RUTF, nutritional therapy was rationed to only HIV positive clients in severe acute malnutrition (SAM) sub-category. Thus only 48 malnourished PLHIV clients (27% of the eligible 178) were admitted

into the outpatient therapeutic care service and received RUTF support that improved their health. Note that, of the 178 malnourished PLHIV, about 75 were taking ARV medications for their health, hence highlighting the significant need for nutritional support despite receiving ART.

### **Lesson learned**

Very remote new sites such as Kiyunga, Buyinja and Kidera have identified the bulk of malnourished PLHIV. They, however, lack the RUTF to treat them, indicating a need to pro-actively re-distribute the available RUTF to where the neediest sites.

### **Challenge**

The protracted process of accessing RUTF from Reco Industries and/or National Medical Stores has hindered access to effective nutritional intervention.

### **Way forward**

Pro-actively re-distribute RUTF to share with selected new sites having the greatest need, as we await the supply chain to be harmonized by USAID as promised.

# SUCCESS STORY

## Success story: “I almost died of malnutrition!” The significance of nutrition in HIV care



*Wasting features in an AIDS patient: Norah undergoes routine weight and MUAC assessments during nutrition care program*

Namukaya Norah (43 years) from Buwalala village, Kananage Parish, Kamuli District worked as a cashier/sales woman with Nile Breweries Ltd before she was laid off in 2006 due to frequent and prolonged illness. She retired to her village as a full-time housewife. That same year, Norah sought treatment at Jinja Hospital, where she was tested found HIV positive and enrolled into chronic HIV care at the TASO Clinic. Despite years of receiving Cotrimoxazole prophylaxis and other support care, she did not improve and so requested a transfer out to Kamuli General Hospital since it was nearer to her home. She had lost hope of recovering.

On 25th July, 2011 Norah, emaciated with obvious features of HIV wasting syndrome, was enrolled at Kamuli Hospital. Baseline assessments registered a weight of 33 kg and CD4 count of 200 cells/ $\mu$ l. Clinical examination suspected Tuberculosis and this was confirmed by radiology as sputum negative pulmonary Tuberculosis. The final diagnosis was HIV/AIDS Stage 4 with TB co-infection. Norah commenced anti-TB treatment on 2nd August, 2011 and was also initiated on antiretroviral therapy (ART) within 2 weeks. On subsequent review visits, her clinical picture had improved slightly but the weight failed to pick up, despite being adherent on medications.

Norah's mid-upper arm circumference (MUAC) was then 16.7 cm (red zone of MUAC tape), implying Severe Acute Malnutrition and thus making her eligible for nutritional intervention. Nurse Joweriah prescribed ready-to-use therapeutic food (RUTF) and dispensed a few sachets for the appetite test. Norah returned

complaining that RUTAFAs<sup>®</sup> tasted too sweet for her liking and that she had defaulted by not consuming the required daily amounts (8 sachets per day). Nurse Joweriah labored to provide adequate nutrition counseling during 2 targeted home visits and Norah agreed to give RUTF another go. After one week on RUTF, she appeared at the clinic and reported to have consistently consumed adequate amounts of RUTF as per prescription and that she felt much stronger. Her new weight was 44kg (a weight gain of 33%!) and MUAC was 18cm. Norah testifies that “I almost died of malnutrition! I am very grateful to the nurse who sincerely counseled/encouraged me to eat all the RUTAFAs<sup>®</sup>. ... Now I am strong and doing my normal household chores”.

Norah has since exited the nutrition care program as a cured case and is continuing to take ARVs and anti-TB medicines with no complaints. Norah is one of the 48 PLHIV clients that have benefitted from the nutrition interventions of this Program. In essence, nutrition therapy plays a significantly big “life-saving” role in comprehensive care of HIV-TB co-infected patients.

## Psychosocial counseling support

Psychosocial support groups at 26 ART sites continued to meet regularly and provide peer-to-peer support on adherence to medication, coping mechanisms for positive living, and to some extent on income generating activities. Formal counseling was regularly provided during the clinical care visits by the trained expert clients at only 45 out of 131 care facilities.

### Challenge

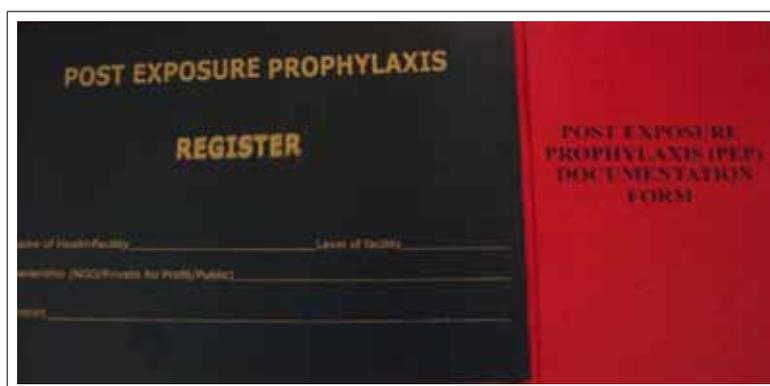
Continued lack of a professional counselor supervisor to mentor and support supervise the service providers especially the volunteer expert clients. Worse still, there is lack of professional counselors in the healthcare staffing structure who would otherwise provide adequate counseling or even support supervises the volunteers.

### Way forward

STAR-EC will provide technical assistance to existing facilities and this will guide scale-up of counseling services covering all care facilities

## Post-exposure prophylaxis against HIV

In a bid to improve documentation and tracking of post-exposure prophylaxis (PEP) services, the STAR-EC program collaborated with MoH and printed 48 copies of the PEP register and the PEP documentation form as shown below.



*Newly designed MoH registers to track PEP services*

The registers have been distributed to 48 facilities that also provide ART services. In addition, these facilities were engaged to hold general staff meetings during which health workers nominated one person per facility that they are comfortable with/confident in as their designated PEP officer. Therefore during subsequent quarters, STAR-EC will facilitate the said PEP officers to strengthen delivery of PEP services to occupational exposure clients as well as rape/defilement survivors. During this reporting period, there were no clients registered for PEP. The program will provide ongoing support for community sensitization about the availability of the service as part of other outreach activities, delivery and documentation of the outputs.

### 2.1.4 Treatment – Antiretroviral Services

During the reporting period, static ART service outlets increased from 26 to 45 following support for accreditation by MoH. The additional 19 HCs level III were formerly ART outreach sites that would be visited on a monthly basis by providers from accredited sites to provide ART. This increase of ART accredited sites is expected to have multiple effects on service delivery including:

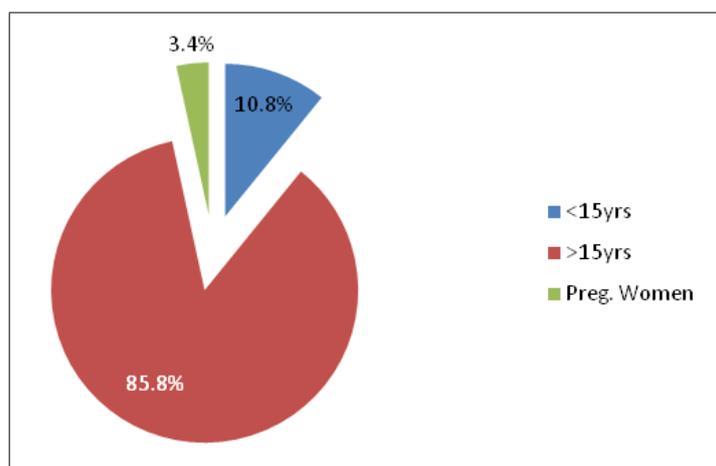
- Improving coverage and access to ART;
- Improving retention in care and adherence to treatment; and
- Decongestion of existing sites thus improving general quality of care.

By the end of this quarter, 10,644 had ever started on ART and 8,182 were still active on ART. A total of 950 new clients were enrolled on to ART compared to 850 for the same period during PY3 (which translates to a 12% increment). However, when compared with the previous quarter (PY3, Q4), there was a decline from the 1,704 clients who were newly enrolled. The sharp decline could be attributed to the slowdown in activities that affected ART centered activities like CD4 enumeration for clients in care.

Strategies, which include outreaches to lower level health units located along lake shores and islands, have been a mainstay in recruitment of key populations into the ART programme. As a result, quarterly outreaches to the island sites of Lolwe HCII and Singila HCII were prioritized.

The categorization of the newly enrolled clients is shown in Figure 8. The proportion of children enrolled on ART has improved to 10% from 8% in the previous quarters but is still below the national target of 15%. With the continued use of the Know Your Child's Status strategy in all STAR EC supported sites, the ART enrollment will, however, continue on the upward trend

**Figure 6: Categorization of newly enrolled clients on ART**



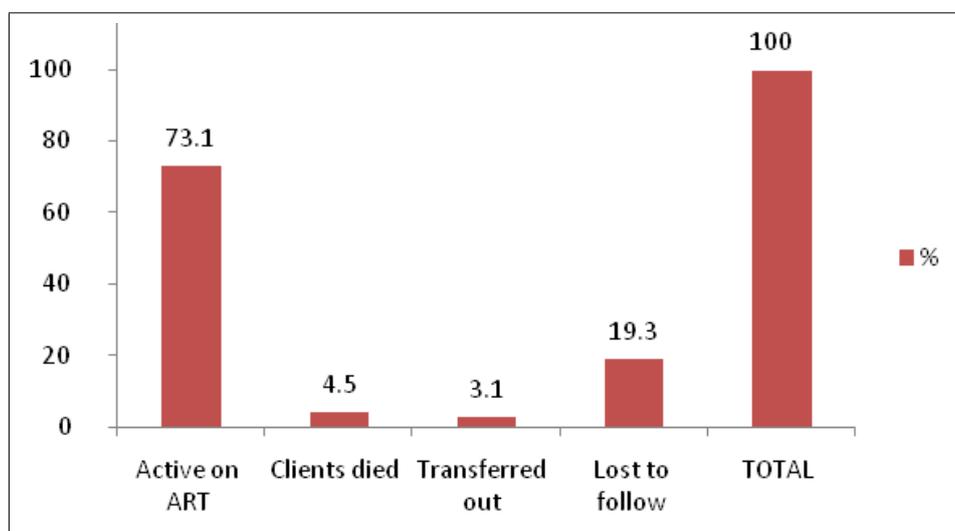
As part of the retention strategy, STAR EC, in collaboration with Clinton Health Access Initiative (CHAI) and MoH, are piloting an appointment and data management system which includes but is not limited to e-health, use of VHTs and tracer cards in 7 selected ART sites in the region. This arises from the premise that the lost to follow up rates have stagnated at 20% and are the drivers of loss of clients on ART. Lack of appointment books was a common feature in poorly performing sites.

We will focus on sites that have low rates of retention and use the experiences to roll out to all ART sites. Preliminary site visits were carried out and intervention areas identified at the pilot sites. The areas include:

- Lack of uniform system for appointment of clients on ART;
- Lack of uniform tracer system to track clients across different health units; and
- Lack of cost effective follow up mechanism for clients who have missed appointments.

The identified interventions, like mobile telephony follow up and use of standardized appointment book will be used to address the challenges encountered in addressing loss to follow up.

**Figure 7: A 12 month ART cohort analysis for clients who started treatment during the period October – December 2011**



### Lessons learned

Appointment system for ART is a useful tool in client retention.

### Challenges and Way forward

Logistical challenges in delivery of CD4 reagents and cotrimoxazole by NMS affected client care in the ART programme. We do hope NMS will rectify the challenges in future.

## 2.1.5 Clinical /Additional TB/HIV

### Capacity building

During the reporting period, STAR-EC and district officials conducted joint mentorship visits for health care providers in Namutumba, Bugiri and Kamuli districts. The activity focused mainly on Multi-Drug Resistant TB (MDR), Isoniazid (INH) prophylaxis and follow up sputum examination. This activity is aimed at supporting providers to identify MDR suspects and to adhere to safety requirements for sample delivery. There is limited awareness about this intervention that is compounded by lack of INH supplies at the facilities through the National TB and Leprosy Program (NTLP). As a result, this component of TB/HIV collaborative interventions has stalled. Through advocacy, STAR-EC will support facilities to requisition supplies from NTLP and continue to build capacity through mentorship and coaching across the nine districts. Also during this quarter, the program provided financial and technical support for the South–East national TB zone quarterly meeting that focused on data quality and validation. All the nine STAR-EC program districts are part of this zone.

### TB/HIV collaboration at facilities

Facilities continue to perform better on TB/HIV indicators across all districts. All districts except Mayuge (where one TB patient was not tested for HIV) achieved 100% target for TB patients who had an HIV test recorded in the register and cotrimoxazole preventive therapy (CPT) enrollment. Overall 99.8% of 397 TB patients were tested for HIV, 98.6% and 67.8% of TB/HIV co-infected patients were enrolled on CPT and CXT/ART respectively. The regional HIV prevalence among TB patients is 35.4% and is much lower than the national prevalence of 54%.

**Table 3: Achievements on select TB indicators for Q1 of PY4**

| Indicator | New patients recorded in TB register | New patients recorded in TB register who had an HIV test done | New TB patients tested HIV positive | TB/HIV co-infected patients started on CTX (cotrimoxazole) | TB/HIV co-infected patients started on CTX and ART |
|-----------|--------------------------------------|---|-------------------------------------|--|--|
| Iganga    | 140                                  | 140   | 53                                  | 53   | 47   |
| Bugiri    | 72                                   | 72  | 21                                  | 21   | 9  |
| Kamuli    | 41                                   | 41  | 12                                  | 12   | 11   |
| Namutumba | 22                                   | 22  | 7                                   | 6  | 6  |
| Kaliro    | 16                                   | 16  | 6                                   | 6  | 3  |
| Mayuge    | 50                                   | 49  | 21                                  | 20   | 8  |
| Buyende   | 16                                   | 16  | 5                                   | 5  | 3  |
| Namayingo | 28                                   | 28  | 13                                  | 13   | 7  |
| Luuka     | 12                                   | 12  | 2                                   | 2  | 1  |
| Overall   | 397                                  | 396 (99.8%)   | 140 (35.4%)                         | 138 (98.6%)  | 95 (67.8%)   |

Source: STAR-EC Program Records

Routine screening for TB has been rolled out in 82 facilities providing HIV chronic care services. The aim is to cover all 131 health facilities that provide chronic care services.

**Table 4: TB status in HIV chronic care services (Care & ART) for Q1 of PY4**

| Indicator | No. of current HIV+ clients seen during the quarter | No. of HIV+ clients screened for TB | % HIV+ screened for TB | No. of suspects investigated for TB | No. of clients treated for TB |
|-----------|---|-------------------------------------|------------------------|-------------------------------------|-------------------------------|
| Iganga    | 3,766   | 3,685                               | 97.8                   | 67                                  | 48                            |
| Kamuli    | 3,762   | 3,704                               | 84.5                   | 37                                  | 12                            |
| Bugiri    | 2,456   | 2,455                               | 100                    | 19                                  | 22                            |
| Namutumba | 1,377   | 1,091                               | 79.2                   | 39                                  | 7                             |
| Kaliro    | 776   | 656                                 | 97.8                   | 39                                  | 7                             |
| Mayuge    | 1,592   | 1,555                               | 97.7                   | 14                                  | 3                             |
| Buyende   | 1,267   | 1,181                               | 93.2                   | 14                                  | 2                             |
| Luuka     | 1,069   | 1,052                               | 98.4                   | 7                                   | 5                             |
| Namayingo | 1,453   | 1,382                               | 95.1                   | 23                                  | 3                             |
| Overall   | 17,518  | 16,761                              | 95.7                   | 259                                 | 111                           |

Source: STAR-EC Program Records

A total of 17,518 patients were reviewed during the quarter out of these 16,761 (95.7 %) were screened for TB

## TB Control Activities

### Case detection rate

In a bid to improve the TB case detection rate, the program supported 80 HCs II in Namutumba, Kaliro, Mayuge and Bugiri districts to prepare and deliver slides to higher level diagnostic facilities. Through this referral process, a total of 230 slides were examined out of which 10 smear positive TB cases were identified. However, the general observation is that the number of new TB cases detected continues to decline despite the innovative efforts supported in the districts. During the subsequent quarters STAR-EC will continue to mobilize the communities through *TB week* campaigns, engage private stakeholders such as drug shop attendants, clinics and traditional healers on intensified TB case finding and other TB control activities.

**Table 5: CDR progress during the quarter**

|           | Expected No. of cases | No. identified | CDR         |
|-----------|-----------------------|----------------|-------------|
| Iganga    | 164                   | 71             | 43.3        |
| Bugiri    | 133                   | 45             | 33.8        |
| Mayuge    | 151                   | 35             | 23.2        |
| Kamuli    | 160                   | 25             | 15.6        |
| Namutumba | 72                    | 15             | 20.8        |
| Kaliro    | 71                    | 13             | 18.3        |
| Buyende   | 84                    | 15             | 17.9        |
| Luuka     | 84                    | 8              | 9.5         |
| Namayingo | 74                    | 20             | 27          |
|           | <b>993</b>            | <b>247</b>     | <b>24.9</b> |

Source: STAR-EC Program Records

### TB DOTS and Treatment Success

Treatment success has progressively improved beyond the national target of 85% to 87.3%. TSR of 85.9% was achieved for patients enrolled in the first quarter of PY4. A total of 4 districts achieved the national target of 85% and 2 districts were slightly below the national target. The new districts of Namayingo, Buyende and Luuka



A session during one of the SCHWs review meetings in Kamuli District

have had their past reporting on TSR executed as part of their original mother districts of Bugiri, Kamuli and Iganga respectively. They will start reporting disaggregated data on this indicator during Jan-March quarter of 2012 as recommended by NTL. Although significant improvements have been observed in the cure rate that now stands at 42%, it is still below the national target of at least 50%. The default rate stands at 3.6%, a significant improvement from a baseline of 20%. This activity was not facilitated for the districts of Buyende and Namayingo due to the slowdown of activities, hence the observed decline in TB DOTS coverage. STAR-EC supported SCHW performance review meetings, during which registers are up-dated and patient transfer and defaulting is shared.

**Table 6: Progress of TSR and TB DOTS coverage for the districts**

| District  | TBDOTS coverage% | Treatment success rate % |
|-----------|------------------|--------------------------|
| Iganga    | 60.3             | 90.4                     |
| Luuka     | 91.7             | *                        |
| Kamuli    | 82.9             | 85.7                     |
| Buyende   | 56.0             | *                        |
| Kaliro    | 100              | 87.0                     |
| Namutumba | 68.0             | 89.2                     |
| Bugiri    | 80.5             | 83.3                     |
| Namayingo | 46.0             | *                        |
| Mayuge    | 76.0             | 85.5                     |
| Overall   | 73.5             | 87.3.                    |

Source: NTL annual and district quarterly reports

\*Newly formed districts' data (Namayingo, Luuka and Buyende) on TB treatment success rate is reported under Bugiri, Iganga and Kamuli respectively

## Multi Drug Resistant (MDR)

A total of 31 samples from MDR suspects were delivered to NTRL and out of these, the results of 16 had been returned by the end of the quarter with one MDR TB confirmed case in Iganga district. The patient and the family members have been sensitized on TB infection control.

### Challenges and way forward

- The uncertainty of the TB burden in the region and the practice of self-referral of clients make it difficult to appropriately monitor the performance of the sites based on the case detection rate. The program will support regular client tracking activities with the major service providers in the region.
- TB/HIV co-infected patients' reluctance to take both TB drugs and ART continue to affect ART enrollment. The program will continue to support health workers to educate patients on the importance of early initiation of treatment.
- Lack of packaging equipment for sputum and transport facilitation for sample referral. STAR-EC will continue to support procurement of the required items in collaboration with NTLP and make provision for transportation of the samples.

### Lessons learned

Building the capacity of district mentors through joint mentorship visits is feasible and likely to be a cost effective and sustainable strategy for capacity building for TB care activities.

## 2.1.6. Promotion of HIV Prevention through Sexual and Behavioral Risk Reduction

### Promotion of 'combination' HIV prevention in the general population

During PY4 Quarter 1 (Q1), STAR-EC supported the implementation of the new National 'Combination' HIV Prevention Strategy to promote behavioral, structural and biomedical interventions. The behavioral risk reduction interventions focused on delay of sexual debut through supporting activities that aimed at life skills development, counseling on the risk of multiple concurrent sexual partnerships and promotion of correct and consistent condom use as well as condom distribution. Structural HIV prevention targeted negative socio-cultural practices that predispose individuals, especially women and girls, to the risk of HIV acquisition such as gender based violence, early marriages, permissiveness, male dominance and widow inheritance. The community was called upon to change and adopt positive attitudes toward women and girls.

Biomedical HIV prevention was promoted mainly through information dissemination on the different services that are available and proven to prevent HIV infection such as SMC, PMTCT, HTC and ART. The approaches used include peer-to-peer dialogue sessions, small group discussions and behavioral change programs (BCPs) to promote HIV prevention messages. Close collaboration and linkages with health facilities was promoted by CSOs (peer educators referred individuals) especially for other biomedical services like HTC and SMC. Additionally, efforts were made to ensure that peer educators utilize relevant information, education and communication materials including talking points and other job aides to facilitate their community peer education and behavioral change programs.

The activities to enhance sexual and behavioral risk reduction are predominantly implemented by CSOs. Over this reporting period, CSOs funding had ended and they were undergoing a process of applying for new funding for PY4. The results highlighted in this section of the report were mainly obtained from activities that continued to be directly/centrally funded by STAR-EC. These are the 'Knowledge room'<sup>2</sup> based activities at Lugala and Naluwerere and the community structures of peer educators who are volunteers in the community.

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2 *A place within a community where people get health information and education, health service and recreation*

## 2.1.6.1 Promotion of age-appropriate Abstinence, Being faithful and Condom use (ABC)

### Interventions among youth

Youth aged 10-24 years were reached with activities that promote delay of sexual debut and skills building on life skills focusing on goal setting, assertiveness, negotiation, and building self esteem and self worth. These activities included games and sports, holding small group dialogue and one-to-one sessions to promote HIV prevention messages. Additionally, the youth were reached with information on avoiding early marriages, dangers of teenage pregnancies and providing age appropriate information on HIV including basic facts on HIV, how to prevent its transmission, including abstinence, reduction of multiple sexual partners and for those who are sexually active condom promotion education and distribution was conducted. A total of 1,000 youth (519 females; 481 males) were reached with HIV prevention interventions during PY4, Q1.

## 2.1.6.2 Promotion of mutual fidelity and sexual partner reduction among couples

For married couples; religious leaders and model couples engaged couples in the community to promote HIV prevention activities. The model couples used small group dialogue sessions and home-to-home, one-to-one sessions, fidelity talks and community dialogues to promote mutual fidelity and multiple partner reduction counseling. Model couples continue to use 'families that prosper' model to promote couple communication and mutual fidelity counseling. The married couples were also reached with HTC; males that needed SMC were referred for such services to nearby health facilities. Condom education on correct and consistent use was promoted for dual protection for couples living in discordant relationships.

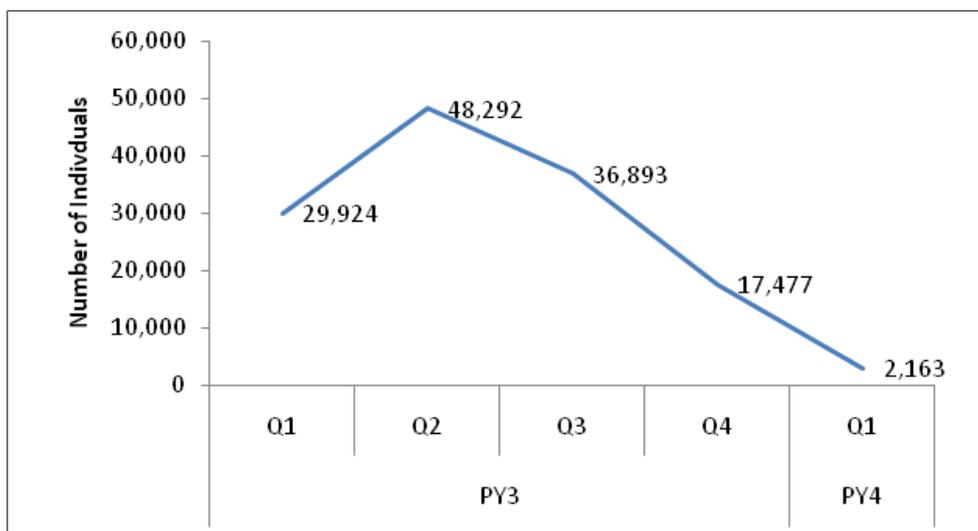


*A peer educator demonstrates condom use to a couple*

For structural prevention, 'Men and HIV' model was used by peer educators during community dialogues to discuss issues that make women and girls become vulnerable to HIV infections such as gender base violence, forcing girls into early marriages for economic gains, male dominance and permissiveness among women. The community was challenged to discourage and called upon to desist from such practices.

During this reporting period, a total of 2,163 (1,056 females and 1,107 males) were reached with AB interventions to promote HIV risk reduction and mutual fidelity programs. 25% of these were reached more than once. Starting with Quarter 3 of PY3, there was more focus on quality through reaching out to individuals more than once with the same prevention messages. This therefore contributed to the decline in numbers of persons reached. Additionally, there was only one CSO (FLEP) that was able to implement any activities. The rest of the CSOs will be on board after fulfilling the CSO request for proposal process in Q2.

**Figure 8: Number of individuals reached with appropriate HIV risk reduction interventions by quarter**



Source: STAR-EC program records

### Lessons learned

- Engaging different community support structures of peer educators (model couples, youth peer educators, religious leaders) to promote ‘combination’ HIV prevention is feasible and only requires systematic ways of delivering prevention packages.
- Active referral is needed for promotion of effective ‘combination’ HIV prevention especially for biomedical services like SMC where the peer educators identify the individuals and make appropriate referrals.

### Challenges and way forward

- Among CSOs, only FLEP was able to provide any results during this quarter. This affected the results of PY4, Q1. We hope to achieve better results in Q2 as funding for CSOs resumes.
- Poor health seeking behaviors for couples and youth as some of them present with some reproductive health challenges like lack of family planning especially for couples and signs of STIs which are reported among youths. On-going counseling is being provided to enable them adopt positive health seeking habits.

### 2.1.6.3 Promoting HIV risk reduction strategies among key populations

Through the ‘Knowledge Room’ based interventions, community structures of the BMU and peer educators only one category of key populations (fisher folk) was reached during Q1. The peer educators implemented condom promotion, education on correct and consistent use of condoms and their distribution, and risk reduction counseling to the fisher folk. The approaches used included peer-to-peer talk, small group discussions and community dialogues. Since the CSOs’ funding had stopped, STAR-EC ensured that the knowledge rooms, BMU and peer educators got supplies of condoms to avoid stock-out, especially at the landing sites among the fisher folks where the consumption is high. Individuals who needed biomedical prevention services beyond condoms such as HTC, STI screening and management, family planning, ART and SMC were provided through either referrals or outreaches to the community by health facilities. The structural prevention promoted among MARPs included dialogues on transactional sex, male dominance



A peer educator distributing condoms to fisher folk at Wakawaka landing site

and permissiveness by women and girls that make them vulnerable to acquisition of HIV infection and cross generational sex.

A total of 829 fisher folk (315 females, 514 males) was reached (31% more than once) during the reporting period. The other populations that are emerging as key populations like plantation workers, boda-boda riders; bar, lodge and video hall attendants; and the business community were reached with HIV prevention interventions (Table 7). A total of 20,515 condoms were distributed to the key population through 59 condom outlets in the community.

**Table 7: Number of other categories ‘the emerging’ key populations reached with HIV risk reduction interventions during PY4 Q1**

| Category of key populations | Numbers reached |
|-----------------------------|-----------------|
| Plantation workers          | 63              |
| Boda-boda riders            | 47              |
| Business community          | 308             |
| Bar and Lodges attendants   | 72              |
| Video hall attendants       | 56              |
| Youth reached by peers      | 37              |
| Couple reached by peers     | 14              |
| Others                      | 58              |
| Total                       | 655             |

*Source: STAR-EC program records*

### Challenge and way forward

Sustainability of peer support activities is still a very big challenge as some of the peer educators become inactive in the absence of a CSO on ground. This was experienced during this reporting period where most CSOs had not yet received new funding. There is need to design a sustainability plan through initiating income generation projects to allow groups continue with their activities and attract other resources.

### Lesson learned

Using the existing community structures such as the BMU and the knowledge rooms can be avenue through which logistics and supplies for MARPs can be used to improve on the supply of condoms and other materials to the hard-to reach communities of the fisher folk.

#### 2.1.6.4 Promotion of HIV Prevention through Prevention with Positives (PwP) programs

Through the existing PLHIV support systems of community support agents (CSAs), the following PwP packages were provided to PLHIV in the community - condom promotion education and distribution counseling on positive living; disclosure counseling; ART adherence counseling; skills building on safer sex practices; family planning; STIs; positive health seeking behaviors; stigma and discrimination; partner care and support; and counseling for couples who desire to have babies.

The CSAs utilized home to home, small peer support group sessions, community dialogue and interpersonal communication and counseling to support fellow PLHIV in the community to deliver PwP interventions.

In one of the home visits conducted for Rose and John; the couple has a story to share ... John and Rose have

# SUCCESS STORY

## A testimony from a discordant couple

seven children and are living in a discordant relationship, each time Rose was pregnant she visited a health facility for her ANC and each time she was tested for HIV, 'all my test results were negative; my husband John had never tested for HIV says Rose. It was during one of the community HTC outreaches that John took an HIV test, unfortunately his HIV result turned out positive. It took the couple some time to accept the HIV status, through peer support, John and Rose have accepted to live together, 'since am now HIV positive I will always use a condom to protect my wife from contracting HIV so that she can look after our children in case I die' says John.



*Left: John receives condoms from a peer educator*



*Right: the couple in a session with a peer educator*

During the reporting period, a total of 1,969 (1,158 females, 811 males) were reached with minimum PwP package. Of these 1,075(55%) were old clients and 894 (45%) were new. As part of the package for PwP, a total of 13,354 condoms (101 female; 13,253 male) were distributed through 25 condom outlets in the community.

### Challenges and way forward

There was slowdown in community PwP interventions because NACWOLA, the key implementing partner, was not active during the reporting period. The program has a strategy to re-organize the available PLHIV in the community to continue running PwP activities.

### Lesson learned

With minimal facilitation, some of the CSAs are in position to continue carrying out peer support and counseling for other PLHIV in the community.

### 2.1.6.5 Promotion of Biomedical Prevention through Safe Male Circumcision (SMC)

During the quarter, the program increased the number of health facilities supported to scale up SMC services in the region from fifteen to seventeen. As part of the scale up plan nine service providers (three teams) were trained in collaboration with Makerere University Walter Reed Project (MUWRP). Out of these seventeen sites, STAR-EC supported 13 facilities to conduct both static and outreach services while the four that had just started delivering the service utilized static clinics only.

Over this reporting period, STAR-EC partnered with STRIDES for Family Health to integrate SMC service delivery during Safe Motherhood Day commemoration across the region and several teams were dispatched to deliver

services to provide post circumcision instructions, assess any adverse events, reinforce abstinence messages during the healing period, and educate spouses and other family members on providing support to the circumcised persons.

### Lessons Learned

- Stock-outs, especially of anesthetics have far reaching effects including demoralizing the providers, the mobilized communities and increases the cost of mobilization at resumption of service delivery
- Receiving SMC disposable kits from USAID has greatly increased the efficiency of the limited number of teams in the region and therefore enhanced the achievement of results
- Acceptance of HIV testing and counseling has been over 97% and this has greatly contributed to the HTC results thereby increasing uptake of HIV&AIDS services amongst men. SMC serves as an effective way of reaching men with other services including HTC and linkage to care.

### Challenges and way forward

- Stock-outs of anesthetics during October 2011 affected achievement of higher results. We hope this will be addressed through bulk purchase of anesthetics by USAID and their delivery through JMS commences.
- During Q1, STAR-EC did not support any circumcision camp due to difficulty in mobilizing service providers and drug supplies were erratic. The program hopes to execute a circumcision camp in February 2012 while prioritizing high prevalence areas.
- During the subsequent quarters, the program will support circumcision campaign weeks to be conducted concurrently with the couple week and in collaboration with HCP.

## **2.2 Result Area 2: Strengthening decentralized HIV&AIDS and TB service delivery systems with emphasis on Health Centers III and IV as well as community outreaches**

### 2.2.1 Improving leadership and governance at district and lower levels

In order for local governments to take advantage of the paradigm shift that is making local resource mobilization a new source of long term financing, local governments have to develop a mechanism of generating local resources so as to cover costs that provide new long term financing to the local government service delivery in the health sector especially HIV/AIDS service delivery. It is against this background that STAR-EC organized a resource mobilization follow up meeting for District HIV&AIDS Committees (DACs) and District HIV&AIDS Task forces (DATs). The purpose of this meeting was to support the districts to come up with a resource mobilization team which will spearhead the task of developing a District HIV strategic plan and resource mobilization strategy. A total of 20 participants were drawn from each district sector including technocrats who had participated in the earlier resource mobilization training. The meeting also attracted CSO representatives and PLHIV forum coordinators. By the end of the meeting a resource mobilization task force had been constituted and their roles clearly stipulated. STAR-EC will conduct support supervision to ensure that the task force comes up with a strategy for mobilizing resources.

### 2.2.2 Support to strategic information collection and dissemination

#### **Program performance review**

During quarter 1, STAR-EC conducted an in-house annual program performance review (at institutional level) for all staff responsible for providing technical assistance to local government (LG) structures and CSOs. This review was enriched by the 2011 LQAS results that had been conducted in July. All program interventions were reviewed against program, national targets and standards. Overall, STAR-EC had realized most program and national targets.

This was attributed to capacity built among supported partners and improved coordination of implementation of program activities at district and community level. Key issues that emerged during the reviews included; the need to strengthen follow up of supported CBOs especially the new that will come on board during PY4; need to enhance integration and more focus on evidence-based programming to target sub-counties and parishes whose HIV&AIDS prevalence is still high. The district and lower level program performance reviews will be conducted in the second quarter of PY4.

### **District Health management information systems (HMIS) strengthening**

As part of health systems strengthening, STAR-EC in partnership with STRIDES conducted 3-day training for district folks in district health management information systems for all 9 STAR-EC supported districts. The training attracted Clinical officers, Medical officers, Midwives, Nurses, Nursing Assistants and Medical Records Assistants, District HIV&AIDS focal persons, Health Management Information (HMIS) Officers and Laboratory technicians among others. A total of 169 people from 128 health facilities attended the training as follows;

**Table 8: Number of district folks trained in the MOH revised HMIS tools**

| Name of district | Number of health facilities | Number of participants |
|------------------|-----------------------------|------------------------|
| Bugiri           | 16                          | 20                     |
| Buyende          | 6                           | 11                     |
| Iganga           | 26                          | 34                     |
| Kaliro           | 10                          | 12                     |
| Kamuli           | 25                          | 30                     |
| Luuka            | 9                           | 14                     |
| Mayuge           | 14                          | 18                     |
| Namayingo        | 12                          | 16                     |
| Namutumba        | 10                          | 14                     |
| <b>Total</b>     | <b>128</b>                  | <b>169</b>             |

*Source: STAR-EC Program Records*

The participants were oriented on the reviewed HMIS tools which included, PMTCT, ART, Care, HCT and TB among others. The trainings were led by district level facilitators who had initially been trained as trainers by the MoH staff and STAR-EC prior to the training. According to the pre-and post training assessment exercise, participants gained better knowledge in understanding and interpreting the district HMIS indicators. This will go a long way in improving data collection and utilization at lower levels.

### **Geographical Information Systems (GIS) training**

During this quarter, five Strategic Information staff were trained in the use of GIS software. This training will enable STAR-EC strengthen evidence-based programming through presentation of information on maps.

### **Operational research and other special studies**

#### (i) Special studies

During the quarter, STAR-EC rolled out a study on the “key populations” entitled “Population Estimation, HIV Knowledge, Attitudes and Practices Study, Hotspots Mapping Among Most-at Risk Populations in the East Central Region of Uganda”. This study had initially been approved by USAID, the Institutional Review Board (IRB) as well as the Uganda National Council of Science and Technology (UNCST). The main objectives of the study were to obtain baseline data on the estimates of key populations size and types and to obtain data on the knowledge,

attitudes and practices of such key populations. Initial findings will be reported in the second quarter of PY4.

### (ii) Operational Research

During the quarter, STAR-EC, through its program and LQAS data, identified eight preliminary operational research topics, some of these will be prioritized for action. They include:

- Comparison of PMTCT performance in m2m and non-m2m sites at health facility levels
- Factors that contribute to the decreasing TB CDR in East Central Region
- The role of contact tracing approach in TB case detection in East Central region of Uganda
- Reasons why knowledge among people in communities who believe in ART treatment is stagnating despite ART interventions in place
- Underlying reasons why women with a known HIV positive status continue to become pregnant
- Early warning signs. ART study to mitigate delays in initiating ART clients on second line treatment
- The gender perspective of ART cohort analysis to determine survival factors of clients on ART

It is anticipated that information obtained from the above studies will further enhance TB and HIV&AIDS programming both in East Central Region as well as at national level.

### **Meetings and workshops**

During quarter 1, STAR-EC attended several strategic information workshops and meetings at district and national levels, and included the Technical Working Group (TWG) meeting on the upcoming LQAS international conference. MSH, together with other partners, is organizing the above meeting where STAR-EC was nominated to play an active role. STAR-EC is participating in developing conference objectives, themes and structure and designing call for papers. It will also participate in the review conference papers / presentations as well as sharing her experiences in LQAS application in East Central Uganda.



*Dr Kazibwe presenting an oral paper during ICASA 2011, Addis Ababa*

### **Information sharing on best and promising practices**

With Support from USAID, STAR-EC actively participated in sharing information on best practices at international level. A total of twelve abstracts (3 oral, 7 posters and 2 CD-Room publications) were accepted and presented for the 16th International Conference on AIDS and STIs in Africa (ICASA) 4th – 8th December, 2011, Addis Ababa, Ethiopia. Four members of staff Kazibwe F., Ndifuna M., Odong T. and Mashate S. represented STAR-EC.

### **Papers presented at the conference include:**

#### **Oral Presentations**

1. Use of improved tracking of exposed infants during early infant diagnosis (EID) to reinforce PMTCT outcomes in a low resource setting. Lessons from East Central Uganda.
2. Utilizing an innovative M&E System to improve community based referral mechanisms for HIV&AIDS and TB services: Lessons from East Central Uganda.
3. Strengthening Laboratory TB diagnostic capacity of peripheral laboratories in East Central Uganda - A key contributing factor to increasing TB Case Detection Rate.

## Poster presentations



*Martin Ndifuna discussing a poster presentation during ICASA 2011, Addis Ababa*

1. Scaling-up Integrated HIV&AIDS Services to Most-at-Risk Populations: The case of Sigulu Islands of Lake Victoria, Uganda.
2. Involvement of lay providers to improve TB service delivery: A case study from Iganga district.
3. Using Quality of Care (QoC) teams to improve the quality of HIV/AIDS and TB services in the East Central Uganda
4. Increasing the uptake of HIV Testing and Counseling Services among Couples
5. Taking Safe Male Circumcision services to a fishing village in East Central Uganda.
6. Increasing access to CD4+ testing services using a specimen referral network for rural settings: A Model from

East Central Uganda.

7. Referrals and Networking increases access and utilization of HIV&AIDS and TB services: Experiences from East Central Uganda.

### For publication on the conference website and abstract CD-ROM)

- Accelerating access to Pediatric antiretroviral therapy services in East Central Uganda.
- Overcoming barriers to PMTCT services Access: Experiences from Family Support Groups in East Central Uganda.

### Strengthening Human Resources for Health: Strategic information success story

During the quarter, a total of seven interns successfully completed their internship with JSI Research & Training Institute Inc. for the Strengthening TB and HIV & AIDS Responses in East Central Uganda (STAR-EC) Program. These interns assisted the project realize some achievements. They also fulfilled their learning objectives for which they were placed at JSI. The skills they obtained will contribute to shaping their career after the internship. Below is a success story from one of the interns.

# SUCCESS STORY

## Andrew Gidudu, the Strategic Information Intern speaks out on benefits of his internship

The JSI Strengthening Tuberculosis and HIV/AIDS Response East Central (STAR-EC) hired an intern from March 2011 to November 2011. His major objectives for Internship were: to assist the team in ensuring that technical staff and stake holders such as the civil society organizations (CSOs) are provided with timely, accurate, and reliable information generated from the programs monitoring and evaluation (M&E) System; work hand in hand with the SI team to ensure that all required technical assistance and support supervision is provided to grantees and the local governments; and to assist in ensuring that quality reports from all output, outcome and other program or relevant data are written and submitted in a timely manner and assist in data entry and checks. He was expected to support integration and use of knowledge and skills in a practical monitoring and evaluation setting and become better acquainted with the types of work settings in which monitoring and evaluation can be applied for his career in this area. Having participated in all SI activities, he was able to acquire multiple skills and competencies in; M&E leadership skills; M&E mentorships; Knowledge in monitoring program activities against targets; designing data capturing tools; data-base management including

effective communication and report writing skills.

On completion of his internship, he got employment with another reputable project. He strongly believes that this success was a result of his internship with STAR-EC. In his words he said "On the whole, the internship period has been very successful. During his departure, he went further and remarked "It has been great interacting and knowing each one of you and I will always cherish my time with the program. I have gained a lot and will use the experience very wisely where ever am going. I am more than grateful particularly to the Program leadership for exposing me to whatever I have gone through. Strategic Information directorate (SI); you have been "Super great". One lesson learned during this internship points to the fact that setting objectives for an intern before placement, mentoring of the intern, teamwork and hands-on experience are powerful tools to focus, motivate and transform interns into professionals. STAR-EC appreciates and celebrates his achievements and success in obtaining professional employment. Additionally, this success story is a contribution to strengthening human resources for health.

### 2.2.3 Improving Human Resources for Health

#### Training of Human Resources for Health (HRH)

STAR-EC continues to collaborate with the different stakeholders in improving the numbers and quality of the existing HRH in the region. During the reporting period, the program mostly utilized clinical mentorship and supportive supervision approaches for building the capacity of providers to provide quality TB and HIV&AIDS services. A total of 184 health workers from 32 health centers were mentored during joint support supervision visits. Additionally, 51 laboratory personnel received lab specific mentorship from MoH officials during this reporting period. This approach helped in building clinical skills of 26 health workers as well as mentoring skills of the district

clinical mentors that worked alongside the STAR-EC technical teams. These clinical mentors were trained during PY3 using the MoH clinical mentoring guide. The health workers appreciated the mentorship and they expressed the following remarks.

"We thank you very much for visiting us, we have learnt a lot and now that you have come, the staff have been more attentive and keen to learn" said Sr. Rose (In charge, Nakalama HC III)

"It has been a good but short experience; we would have liked to spend more time with mentors to learn more. I wish this activity could be done more frequently....." said the In-charge, Nawandala HCIII.



*A clinical mentor discussing with a nurse on how to fill in a circumcision register at Kityerera HCIV*

In collaboration with the STRIDES for Family Health, STAR-EC supported MoH to roll out the revised health information management system (HMIS) to all the HCs III in all the supported districts. Plans are underway to cascade the training to HCs II using district based trainers. Furthermore, in response to the need to improve skills for the management of laboratory logistics, the program provided support for the training of laboratory staff in logistics management. The numbers and personnel trained during this quarter are presented under each sub-technical area.

STAR-EC will continue collaborating with the central, regional MoH and district clinical mentors to provide regular support supervision and mentorship to enhance skill development among the health workers.

### **Challenge**

High staff attrition in several health facilities affected the effectiveness of the clinical teams built over the past three years.

### **Way forward**

STAR-EC will advocate for maintenance of clinical teams and consideration of service delivery capacity during the transfers by the district administration. The program will continue to support clinical mentorships and supportive supervision activities for capacity building.

## **2.2.4. Injection Safety and Waste Disposal Interventions**

Following the provision of health care supplies and equipment and training of providers in HCWM during PY3, the program continued to provide tailored support to enhance infection control practices during joint mentorship visits.

STAR-EC participated in the 7th Annual National Stakeholders' Conference on Health Care Waste Management (HCWM) and the information shared has been crucial in guiding the district local governments to budget for HCWM activities since this was not the case before.

### **Challenge**

Non-compliance with waste segregation guidelines remains a challenge in some facilities.

### **Way forward**

To continue collaborating with MoH to support CPD sessions and on-site support to build a culture of health care waste management according to the recommended standards

## **2.2.5 Post Exposure Prophylaxis**

The program facilitated the orientation of health workers on post exposure prophylaxis (PEP), sensitization of the local police forces and councilors about the availability of PEP services at the 28 ART sites for referral. The program supported the printing of the PEP documentation form and registers designed by MOH for piloting within the STAR-EC supported health facilities. As a result, six clients received ARVs for PEP during Q3 of whom one was non-occupation exposures (rape and defilement cases).

### **Challenge**

- The demand for PEP services is low because the majority of community people are not yet aware of this intervention to prevent HIV transmission

### **Way forward**

- The program will re-produce IEC materials for PEP and facilitate health workers to conduct community sensitization/dissemination meetings. There is, also, an opportunity to liaise with STRIDES for Family Health to integrate PEP with emergency contraception services

## 2.2.6 Human Resources for Health (HRH) planning

### Supporting laboratory services, health infrastructure and equipment needs

In collaboration with MoH through the Central Public Health Laboratories (CPHL), National TB Reference Laboratory (NTRL), Uganda Virus Research Institute/HIV Reference Laboratory (UVRI/HRL), National Medical Stores (NMS), Jinja Regional Referral Hospital and other implementing partners, the program continued to support the implementation of interventions to enhance provision of laboratory services at 86 facilities in the region. The characteristics of the health facilities supported and the nature of support provided are illustrated in Tables 9 and 10, respectively. The overall aim of the interventions was to increase community access to essential tests geared at contributing to the national response to prevention, care and treatment TB, HIV, malaria and related clinical conditions.

**Table 9: Number of Health Facility Laboratories supported in Q1 PY4**

| Authority/Ownership    | Levels of Health Facilities |           |                   | Total            |
|------------------------|-----------------------------|-----------|-------------------|------------------|
|                        | HC III                      | HC IV     | General Hospitals |                  |
| Government             | 60                          | 12        | 3                 | 75 (87%)         |
| Private Not For Profit | 9                           | 0         | 2                 | 11 (13%)         |
| <b>Total</b>           | <b>69</b>                   | <b>12</b> | <b>5</b>          | <b>86 (100%)</b> |

Source: STAR-EC Program Records

**Table 10: Laboratory support provided during the period October-December 2011**

| Type of support provided   | Outputs  |
|--|--|
| Mentorship of laboratory staff   | Sixty (60) laboratory staff from the supported HCs were mentored to consolidate good laboratory practices<br>Reviewed conformities and adherence to laboratory information management, documents and records; organization and personnel, equipment inventory, logistics and supplies management, process control, internal and external quality assessment including facility safety at 51 HCs<br>Laboratory performance data for 17 different tests for Q1 PY4 from the 86 HCs was collected and correlated to enhance its utilization for targeted programming. Disease burden for different ailments was estimated |
| Supplementary diagnostic supplies, equipment maintenance and repair                                | Due to stock out at the NMS, selected essential supplies were provided to HCs (3 General Hospitals received CD4 reagents to avert service interruption)<br>Equipment servicing & repair supported at 3 Health facilities (1 CD4 machine and 3 microscopes)<br>89 laboratory staff trained in laboratory logistics to improve on supplies management<br>80 laboratory staff provided with laboratory coats by the program to enhance safety practices; Other supplies, namely microscope immersion oil and lens cleaning tissues provided during the visits   |
| Strengthening Laboratory Management Towards Accreditation (SLMTA)                                  | Technical support provided to 3 General Hospital Laboratories that have been enrolled in the WHO/AFRO Step by Step approach to accreditation. Laboratory organization, re-arrangement and document review for the 3 laboratories (Kamuli, Iganga and Bugiri) was conducted. As a result, working space and workflow attained improved  |
| Blood specimen referral for CD4 testing for ART monitoring and Early Infant Diagnosis of HIV (EID) | In collaboration with CPHL, SDS and the district structures, patients' blood specimens were transported from peripheral HCs to testing hubs in the region. As a result, 93,574 CD4 and 791 DNA PCR tests for ART monitoring and EID performed. Turn-around for EID results improved from 4 to 2 weeks<br>Provided specimen referral books to all supported HCs including NTRL referral books for sputum for MDR testing  |

| Type of support provided   | Outputs   |
|--|---|
| National External Quality Assessment Scheme (NEQAS) implementation | Supported the all HC laboratories to engage in quality assurance processes for TB, HIV and malaria testing. Performance for Q1 PY will be reported in Q2 PY4<br>10 HC received tailored mentorship following their suboptimal results of their TB proficiency panel testing by MOH/NTRL during the previous NEQAS   |
| Advocacy for laboratory support AND                                | Presented 4 scientific papers at national and international conferences. 2 at the 16th International Conference on STIs and AIDS in Africa-ICASA and 2 at the 29th Uganda Medical Laboratory Technology Association Conference<br>Contributed in various technical working meetings convened by MoH/CPHL<br>Conducted a planning meeting with the district implementers from 80 HCs to augment specimen referral networks from peripheral health facilities to the regional and national laboratories for CD4 and early infant diagnosis. |

Source: STAR-EC Program Records

### Performance of Health Facility Laboratories in PY4, Q1 (Oct-Dec 2011)

Data collected from the health information management system (HIMS 055b) at the supported health facilities indicated that:



A STAR-EC staff member servicing a CD4 machine at the Bugiri General Hospital Laboratory

- The support provided by the program contributed to service delivery beyond TB and HIV&AIDS as shown in Table 11. A total of 226,624 laboratory tests were performed
- HIV and TB testing were among the top 4 most requested and performed laboratory tests with blood slide examination for malaria (n=96,085) being the most reported test carried out (Table 12). 41% (n=93,574) of all the laboratory tests performed were HIV antibody screening
- The data showed that HIV antibodies and DNA PCR tests performed revealed prevalence of 3.5% (n=93,574) and 4.7% (n=791), respectively. It further revealed that malaria and intestinal parasite infestation had the highest prevalence of 34.0%

(n=96,085) and 23.9% (n=2,320), respectively.

- There was a significant decline in the number CD4 tests for ART/immunological monitoring during this reporting period (Q1 PY4) due to prolonged stock out of the CD4 reagents at NMS (Figure XX). To a lesser extent, the transition processes of handing over the specimen referral funding to the districts through to SDS under Category A grant coupled with allowing the districts take full control of coordinating this activity as opposed to previously when STAR-EC was in control could have affected the process.
- The Q1, PY4 laboratory data reported by the facilities also revealed that, based on the tests performed, there is an apparent decline in the prevalence of TB, HIV (both for HIV antibody tests and HIV DNA PCR) .

**Table 11: Number of laboratory tests performed in PY4, Q1 by the supported health facilities**

| No. | Type of laboratory test performed                    | Number of tests performed (reported) |                     |
|-----|--|--------------------------------------|---------------------|
|     |  | Total tests                          | Number positive (%) |
| 1.  | Blood slide examination for haemoparasites (Malaria) | 96,085                               | 32,710 (34.0%)      |
| 2.  | HIV (antibodies screening)                           | 93,574                               | 3,247 (3.5%)        |
| 3   | Hb estimation  | 5,764                                |                     |

| No. | Type of laboratory test performed         | Number of tests performed (reported) |                       |
|-----|---|--------------------------------------|-----------------------|
|     |   | Total tests                          | Number positive (%)   |
| 4.  | Syphilis (antibodies screening)           | 5,319                                | 342 (6.3%)            |
| 5.  | Sputum ZN microscopy for TB               | 5,142                                | 331 (6.4%)            |
| 6.  | Blood grouping                            | 3,947                                |                       |
| 7.  | Urine protein                             | 3,908                                | 730 (18.7%)           |
| 8.  | Urine Glucose                             | 3,820                                | 229 (6.0%)            |
| 9.  | CD4 cells count enumeration               | 2,484                                | 673 (CD4 cells<350µl) |
| 10. | Stool microscopy for intestinal parasites | 2,384                                | 568 (23.9%)           |
| 11. | Pregnancy (urine HCG)                     | 2,009                                | 698 (35.0%)           |
| 12. | Blood Glucose                             | 867                                  |                       |
| 13. | HIV DNA PCR                               | 791                                  | 37 (4.7%)             |
| 14. | White blood cell counts                   | 253                                  |                       |
| 15. | Liver Function Tests (LFTs)               | 103                                  |                       |
| 16. | Viral Load                                | 16                                   |                       |
| 17. | Renal Function Tests (RFTs)               | 158                                  |                       |
|     | <b>Total number of tests</b>              | <b>226,624</b>                       |                       |

Source: STAR-EC Program Records

## Challenges and the way forward

- Recurrent stock outs of laboratory diagnostics and related supplies (CD4 reagents, HIV tests kit from the national supply system significantly hampered service delivery and the efforts to improve the management of laboratory logistics. The program will continue to provide support to address the provider dependent gaps
- Under-staffing compounded by a high turnover of laboratory staff especially in the new districts has created new challenges of dealing with the high demand created for TB and HIV related tests; The program will continue to advocate for recruitment of additional staff by the local governments
- Under-utilization of the automated laboratory equipment (Clinical Chemistry and Hematology Analyzers) placed at the three hubs in the region for ART monitoring and other clinical conditions. This may be due to inattention by the providers and heavy workload that perhaps impedes consideration of these additional monitoring tests. Mentorship to improve caseload management is planned

## 2.2.7 Ensuring Equitable Access to Medical Products

### Improving supply chain management

#### Capacity Building for Supply Chain Management

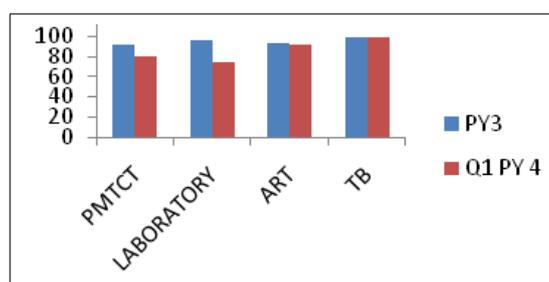
During the reporting period, the program supported training of 89 laboratory staff (71 males and 18 females) using the newly updated laboratory logistics curriculum. This followed observation of sub-optimal quality of reports earlier on during implementation. Following the training, improvements have been observed in the quality of reporting including accurate presentation of the units of measure and completeness of the reports. Post-training follow up is planned for the new quarter to ascertain the level of improvement of other components of supply chain management such as stock management.

During this quarter, the Medical Logistics Specialist participated in a training organized by the Securing Uganda's Rights to Essential Medicines (SURE) in collaboration with Makerere University. The training was aimed at equipping regional pharmacists with skills to effectively support the Medicines Management Supervisors (MMS) who will come on board next quarter under the Standardized Performance Assessment and Recognition Strategy (SPARS).

## Improving Logistics Management Information Systems

The program also supported the process of ordering for health commodities from both National and Joint Medical Stores (NMS, JMS). Every health facility is expected to report at the end of every two months. The reporting rate dropped significantly for Kaliro District in the areas of PMTCT and laboratory, which in turn impacted on the reporting rate for the region as shown in figure 12 below. This was attributed to lack of coordination as a result of the protracted change process in district leadership and transfer of health workers that STAR-EC had already trained.

**Figure 10: Comparison of Reporting Rate PY4, Q1 versus Average PY 3**



Source: STAR-EC Program Records

The program supported the distribution of PMTCT commodities from NMS to nine health centers that had been trained in the previous quarter. These included ARVs, test kits and related accessories as well as data tools including PMTCT order books and dispensing logs. Mentorship was also provided on how to complete the tools. Support was also further provided by the district PMTCT coordinators. From these sites, reporting rate of 80% was achieved.

“Thank you for bringing us these supplies. Now that we have medicine, I hope the mothers will be encouraged to deliver from here” said a midwife at Mutumba HC III.

**Table 12: Provision of Buffer Supplies**

| Item Description  | Purpose  | Quantity | No. of Facilities   | Remarks  |
|---|--|----------|---|--|
| SMC Kits, anaesthetics and sundries   | SMC  | 5,075    | 15 SMC sites, 880 vials of lignocaine, 271 vials of bupivacaine |  |
| Partec CD4 Easy count kits<br>Partec CD4% Easy count kits and related accessories | HIV chronic care- initiation of ART and monitoring of immune response to treatment | 84<br>8  | 3 hospitals   | Buffer stock procurement due to national stock out |

Source: STAR-EC Program Records

## Challenges

- Changes in staffing are significantly affecting coordination, reporting timeliness and consequently the uninterrupted supply of commodities in Kaliro District.
- Stock-out of essential commodities for HIV chronic care, including cotrimoxazole and CD4 reagents, at national level
- Availability of products for CSOs is constantly interrupted as they are no longer receiving regular supply from STAR-EC but are instead relying on district stocks.

## Way forward

- Continue technical support to Kaliro District health workers in collaboration with the newly appointed DHO and the district health team

- Support CSOs to report consumption rates and required quantities to the districts for inclusion in their bi-monthly orders
- Train MMS in preparation for the roll out of SPARS strategy

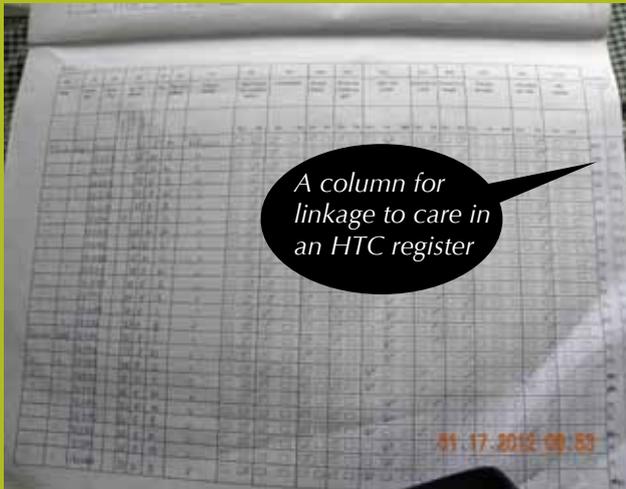
## ***2.3 Result Area 3: Improving quality and efficiency of HIV&AIDS and TB service delivery within health facilities and civil society organisations***

### **2.3.1 Health Care Improvement**

During the reporting period, the program supported the implementation and integration of quality improvement approaches across the nine districts. A total of 84 facility quality improvement (QI) teams were coached on operationalization of the quality improvement principles including organizing activities, implementing action plans, data collection and utilization at facility level. This coaching which was jointly conducted by the district and regional quality improvement teams also enabled the transfer of knowledge and enhancement of coaching skills for the district QI team members. The various DHOs were sensitized on this exercise and received reports on the same increasing awareness and support for QI in the districts. Emphasis was placed on building the capacity of health workers to collect and utilize data for decision making and to identify gaps for improvement at the facility level. As a result of this exercise, 50 health facilities actively implemented quality improvement activities compared to 46 of the previous quarter. Utilization of data has greatly improved at the facility level as indicated by the number of facilities that have it displayed on their walls and can refer to it in their monthly meetings to review their performance.

# SUCCESS STORY

## Iganga Islamic Medical Centre establishes a chronic HIV care clinic.



Iganga Islamic Medical Centre a private not for profit health facility had no established HIV clinic. Clients were always referred to Iganga hospital but with no proper documentation or follow up on whether or not referred clients received care at the intended

destination. The facility could therefore not account for any of the clients that tested HIV positive. Following training in quality improvement, the facility QI team identified this gap and agreed to start up a clinic with support from the Iganga General Hospital HCIV care team and to ensure that all clients tested are enrolled into that clinic and subsequently followed up. They also addressed the documentation gap by conducting on-job mentorship for all clinical staff by the Records Officer. They also provided registers and created additional columns in the HTC register to indicate linkage to care against every positive client. In addition, the team included 'linkage of positive clients to care' on the list of their priority indicators to monitor. As a result of these changes, the facility now has a chronic HIV care clinic which has grown from 17 to 62 clients per month. In addition, the team can now account for all clients testing HIV positive at the facility.

## On the road to achieving optimal adherence to ART

Adherence to ART was an enormous problem to many clients in Kamuli General Hospital. Most of the clients averaged at 90% adherence which was below the acceptable level of 95%. To address this challenge the QI team identified 20 clients whose adherence was below 90% (some were as low as 74%) and whose main reason for non-adherence was inability to recall the time for their pills. Each client was issued a clock after proper counseling and their adherence was monitored and charted on each of their subsequent clinical visits. Over a period of five months, all clients provided with clocks improved their adherence by at least 17%, 14 of them achieved above 95% adherence level and of the 6 that did not achieve the target, four had recurrent problems with resetting the clock while two failed to have their dry cells replaced. Overall the average adherence of these clients increased from 79% to 93%.

Among those who achieved the desirable adherence, Ibanda Brian testified on the benefits of the clock "This small clock has helped me take all the medicines, it fits in my pocket so I move with it everywhere I go so that if it rings, I quickly take my medicine. I have not missed even a single tablet since I started using it. Taking my pills on time has improved my life, I have gained five kilograms and my skin has now cleared"

In order to respond to the skills gaps that often stifle sustained performance improvement, the program supported a joint clinical mentorship exercise that was conducted by STAR-EC technical staff and district based clinical mentors.

A variety of health workers in 32 health facilities had their skills built in the areas of HTC, PMTCT, ART, Laboratory services, TB care, quality improvement, logistics management, records management and other areas. This approach not only enabled the transfer of skills to facility health workers but to district mentors as well. It is anticipated that the built skills will continuously contribute to better performance results in Q2 and thereafter. The mentorship visits were also used to deliver buffer supplies and tools and to address other performance and resource gaps.

**Figure 11: Average Adherence among clients who received adherence clocks**



Source: STAR-EC Program Records

## Lessons learned

Joint clinical mentorships between STAR-EC and district staff enable the transfer of skills to district based mentors as they work alongside STAR-EC technical staff. They also serve as avenues to assess the quality of support provided by the districts and follow up on utilization of resources given to the facilities.

## Challenges

- The staff changes and transfers that occurred in a number of facilities affected the composition of quality improvement teams and implementation of QI activities.
- The work load coupled with limited human resource constrained the transfer of skills in some of the facilities as mentor-health worker interaction was heavily interrupted by big lines of clients
- Shortage of supplies like test kits, ARVs and CD4 reagents also affected the performance of a number of sites



A health worker at Kamuli General Hospital instructs Mr. Ibanda on how to correctly use an adherence clock

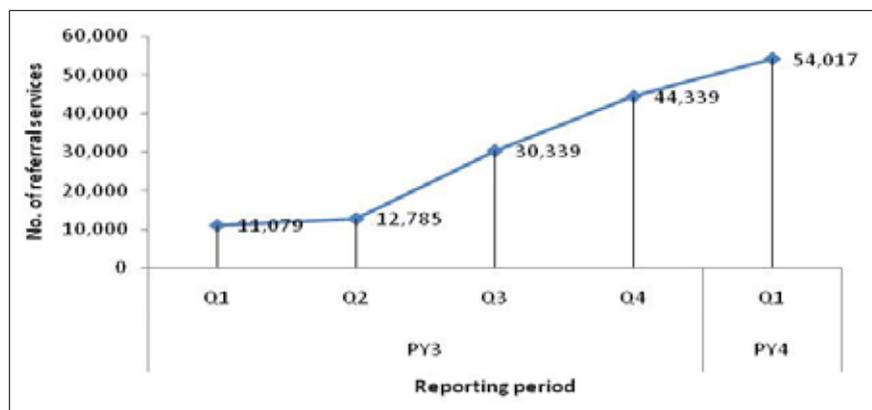
## Way forward

- Joint clinical mentorships will continue through PY4 to further build the capacity of districts to eventually carry on with this exercise
- Active follow up on implementation of quality improvement will continue through quarterly joint coaching visits
- During Q2, the program will support district-based learning sessions which will be coordinated by regional coaches in order to increase district participation in, as well as ownership of, quality improvement activities. This exercise will also motivate the various teams as they will continuously look forward to sharing their efforts with the district management

## **2.4 Result 4: Strengthening networks and referrals systems to improve access to, coverage of and utilization of HIV&TB services**

In a bid to increase access to and coverage of, and utilization of HIV&AIDS and TB services in the region, STAR-EC has continued to promote effective referrals and networking between and among the different levels of health facilities as well as among the different CSOs and other service providers of HIV&AIDS and TB services. Through supporting integrated activities implemented by health facilities, CSOs and centrally by STAR-EC and ensuring documentation and follow up of all referred cases to the different service centers, the results to date, about referrals and networks indicate some marked improvement in access, coverage and utilization of health services.

**Figure 12: Service utilization as a result of referrals**



Source: STAR-EC program data

The graph above shows a 79% improvement of services utilizations through referrals from Q1 PY3 to Q1 PY4. This is attributed to proper linkages between community service providers and health facilities effort through STAR-EC's integrated services.

### 2.4.1. Strengthening the capacity of Village Health Teams (VHT)

During PY4, Q1 STAR-EC oriented 590 (120 Buyende and 470 Kamuli) VHTs on how to conduct referrals and documentation of the referral process. A total of 555 VHTs in Bugiri were also supported to conduct a quarterly review meeting where achievements like mapping of households and registering of household members, conducting of home visits and door to sensitizations, participating in national campaigns (TB, immunizations, etc.), and promotion of community hygiene and lessons learned were shared. This improved their capacity in conducting proper referrals from the community hence contributing to high numbers of attendance at supported health centers.

In addition, STAR-EC supported the printing of more 300 copies of VHT registers and 500 copies of referral forms which were distributed to the VHTs to improve documentation and reporting of the referral process. Referral data collection tools and PwP tools were revised and disseminated to the VHTs and CSOs which has greatly improved the quality of referrals conducted and PwP reports. As a result of this effort, 25,919 clients were referred for different services and 21,349 (82%) reported to have received the services following referrals.

### 2.4.2. Improving Community – Facility Referral Linkages

In order to complete the linkage between community and health centers, 72 health workers across the region were mobilized and oriented on the essential elements of the referral system, intra and inter facility referral systems and their roles in improving the referral system. The net effect of this has been realized on the increase of clients receiving services with about 20% following referral as is indicated in the results below.

**Table 13: TB and HIV&AIDS services for which individuals were referred Vs received services for the period October 2011- December2011**

| TB and HIV&AIDS related services  | Services for which individuals were referred |      |               | Services received |      |             | %ge         |
|---|--|------|---------------|-------------------|------|-------------|-------------|
|   | Female                                       | Male | Total         | Female            | Male | Total       |             |
| HTC   | 8352   | 5468 | <b>13,820</b> | 6303              | 4161 | <b>8042</b> | <b>58.2</b> |
| Care and support  | 1558   | 875  | <b>2,433</b>  | 1116              | 575  | <b>1513</b> | <b>62.2</b> |
| ANC services  | 1994   | 9    | <b>2,003</b>  | 1269              | 28   | <b>1103</b> | <b>55.1</b> |
| PMTCT (Counseling, testing, ARV Prophylaxis, infant feeding counselling)                              | 2573   | 130  | <b>2,703</b>  | 1734              | 119  | <b>1457</b> | <b>53.9</b> |
| HAAT Services (ART, ART Adherence, CD4,)  | 2546   | 1543 | <b>4,089</b>  | 1720              | 961  | <b>2364</b> | <b>57.8</b> |
| TB Screening / Treatment  | 1731   | 1111 | <b>2,842</b>  | 1134              | 688  | <b>1526</b> | <b>53.7</b> |
| Treatment for other Medical Conditions  | 4088   | 2759 | <b>6,847</b>  | 3004              | 2113 | <b>3547</b> | <b>51.8</b> |
| STI services  | 15667  | 928  | <b>2,495</b>  | 993               | 516  | <b>1366</b> | <b>54.7</b> |
| Psychosocial support (PLHIV group services, Youth groups, discordant couple services, post test club) | 3030   | 2073 | <b>5,103</b>  | 2206              | 1520 | <b>3124</b> | <b>61.2</b> |
| Safe Medical Circumcision   | 0  | 2806 | <b>2,806</b>  | 0                 | 1402 | <b>1402</b> | <b>50.0</b> |
| Family Planing  | 1672   | 285  | <b>1,957</b>  | 1149              | 266  | <b>1170</b> | <b>59.8</b> |
| Homebased care  | 1622   | 867  | <b>2,489</b>  | 926               | 329  | <b>1197</b> | <b>48.1</b> |
| Wrap around services, Material support, Education support, legal support, Micro finance, IGAs)        | 2548   | 1726 | <b>4,274</b>  | 1668              | 1096 | <b>2342</b> | <b>54.8</b> |
| 14. Other Specify   | 81   | 75   | <b>156</b>    | 41                | 32   | <b>66</b>   | <b>42.3</b> |

Source: STAR-EC Program Records

As in the previous years, most clients were referred for HTC services 13,820 (8,352 female and 5,468 male). Other services like treatment for other medical conditions (6,847), psychosocial support (5,103) and HAART services (4,089) also attracted high referrals. In addition, in Q1 a number of clients were also referred for food and nutrition, materials support, education support, legal support and IGAs (wrap around services) to a total of 4,274 services an indication that service providers are building strong networks from time to time.

### Challenges and way forward

- Inadequate referral forms and VHT registers to facilitate the referral process and enable all VHTs keep track of all the clients in their respective villages. STAR-EC will continue to print and distribute referral materials to all the CSOs and VHTs and keep good track of their reports
- Most data was reported by VHTs and only two CSOs (FLEP and NACWOLA) and this in one way or the other compromised on the number of referrals for the quarter. STAR-EC will provide support to other CSOs so that by next quarter they are able to contribute to program reporting
- Long distance to service provider points which hinder a number of clients from reaching referral points. STAR-EC will continue to support the districts to scale up service delivery to lower level facilities

## 2.5 Result 5: Increasing demand for comprehensive HIV&AIDS and TB prevention, care and treatment services

During the quarter, STAR-EC continued to reach targeted audiences with relevant messages through: Information Education and Communication (IEC) materials and job aides; interactive one-hour radio program and interpersonal communication through peer educators, VHTs and health workers. The program also collaborated with the MoH and other partners such as HCP and UHMG to deliver the communication interventions.

### i. Intensifying demand through Information Education and Communication (IEC) materials and Job Aides

#### STAR-EC disseminated the following IEC materials during this reporting period

- 2,000 Paediatric ART guidelines and dosing charts received from the MoH
- 5,000 brochures (3,000 SMC Luganda and 2,000 English) on facts about safe male circumcision
- 2,000 copies of couple HTC Luganda and 1,000 Lusoga leaflets received from HCP
- 17 SMC signposts were placed at SMC service centres in the East Central region
- 2,700 Couple HTC certificates



A health worker gives out couple HTC leaflets to couples during an outreach in Namayingo District

The job aides are disseminated to health workers during the mentorship visits to make sure they understand their purposes and how they are utilized. The client materials such as the brochures are distributed at OPD, antenatal clinics and during outreaches. They occupy the clients as they wait for services and thereafter taken home for more information about health services.

A health worker from Ivukula said, “Having these ART guideline displayed on the wall reminds me on how to deal with clients and the dosing chart guides me or the nurse seeing clients on who gets what to avoid mistakes. The Ministry of Health should have guidelines for all health services printed and displayed on the walls.”

### ii. Creating demand for services through the interactive One-Hour Radio program

During the quarter, STAR-EC continued to support the one-hour interactive radio program on NBS Kodh'eyo 89.4 to reinforce messages on various aspects of TB and HIV&AIDS prevention, care and treatment delivered through other channels. Local leaders, health professionals, VHT members, beneficiaries of health services such as SMC were among the guest speakers. A total of thirteen interactive radio talk shows were aired during this period and the topics covered included:

- Role of VHTs and health workers in referrals for TB and HIV&AIDS services
- Role of local leaders in TB and HIV&AIDS prevention, care and treatment
- Safe Male Circumcision
- Couple HIV Testing and Counseling

During the interactive radio talk show listeners are given chance to express their views and ask questions. The commonly asked questions included:

- Do VHTs work for a specified period say 3 years and retire?
- Do VHTs treat minor illnesses?
- What can be done to reduce health worker rudeness to clients?
- Is true that after SMC, the first sexual encounter has to be with a woman outside marriage?
- Is true that circumcision reduces chances of cervical cancer in women?

- Why do some sub-counties have VHTs and some do not?

Moses Lusiba from Iganga called to thank the presenter and health workers (guest speakers) on the radio program saying that after listening to the SMC radio program, he learned that it is a simple procedure whereby a person does not need to be admitted and that he recovers within 6 weeks. "After listening to the radio program, I learned that it is a simple procedure and would heal (resume sexual activities) within six weeks. All along I thought I would be admitted but I walked into Bugono HCIV, got the service and rode my bicycle back home. I am glad that this radio program cleared my worries."- said Moses Lusiba.

In October 2011, STAR-EC continued airing two radio spots produced by the MoH, twice a day, on two regional radio stations (Victoria FM and NBS 89.4 FM). The spots encourage couples to test together and also direct them to health centres with a couple HTC sign post. The second spot encourages mothers to attend antenatal clinics to avoid transmission of HIV from the mother to the child.

Sister Egulwa Harriet (District Nursing Officer) from Kamuli District says, "I have interacted with mothers at the hospital (Kamuli) who said they were encouraged to attend antenatal clinics by a radio spot on NBS radio as it spells out reducing chances of transmitting HIV from the mother to the child. We should continue disseminating messages through multiple channels so that people get the same message from the different sources. – said Egulwa Harriet.

### iii. Commemoration of the World AIDS Day

STAR-EC directly supported three districts (Buyende, Luuka and Namayingo) and in collaboration with the SDS program, the other six districts including Bugiri, Iganga, Kaliro, Kamuli, Mayuge and Namutumba were also supported to commemorate World AIDS Day. District leaders including LCV chairpersons, Chief Administrative Officers and Resident District Commissioners presided over the functions. A wide range of services were provided during the commemoration including health promotion through drama and testimonies by PLHIV, HTC services, SMC, TB and reproductive health serves. A total of 1,816 people (1,001 female and 815 male) received HTC services in the nine districts. 29 female, 15 male were HIV positive and they were all linked to HIV care services. A total of 352 men received SMC services during the commemorations.



*Clients receiving SMC, TB screening and HTC services during AIDS commemoration in Namutumba District*

150 T-shirts, 150 caps, 18 banners and a newspaper supplement in the New Vision newspaper were produced as promotional items for the commemoration.

### iv. Working with other partners to provide integrated services

In a bid to respond to the malnutrition problem that hit Namutumba district in 2011 where children were at increased risk of death and the community suspected witchcraft, UHMG organized an integrated services outreach at Magada HCIII. Different partners including the MoH, DFCU Bank, Centenary Rural Development Bank, Kampala Pharmaceutical Industries, Quality Chemicals, Abacus Pharmaceuticals Limited, Baylor College of Medicine, Gittoes Pharmaceuticals, NTV and Uganda Baati Limited joined hands to provide a wide range of services including health education, nutritional guidance, immunization and treatment of minor illness in children and the entire community.

STAR-EC supported provision of HTC services and TB screening during the outreach. One hundred three community members tested for HIV and six people tested HIV positive. The positives were linked into HIV care services at Magada HCIII. Thirty six community members had their sputum screened for TB and none was found positive.



*Community members waiting for health services at Magada HCIII during the integrated outreach*

### Lesson Learned

Working with other partners in health services delivery provides an opportunity to ride on each partner's strength in order to provide an integrated package of services to the community.

### Challenges

- Some communication print materials placed on the walls of health facilities are often removed when they are still relevant
- Some health workers do not utilize the opportunity they have with clients to talk to them about a wide range of health services they could receive. For example mothers who bring young children for malaria treatment also need information and services on family planning and HTC.

### Way Forward

- Putting up posters with glue and at a level where it is hard for clients to pull them off for other reasons
- Continued mentorship to health workers so that they utilize all opportunities to give information about services provided at the health facility and referring for services that are provided elsewhere

### 3.0 Grants and Sub-Awards

The four prequalified grantees namely FLEP, URHB, Youth Alive Uganda and NACWOLA have been playing pivotal roles in the implementation of the STAR-EC program activities through the provision of various services as summarized in Table 14

**Table 14: Pre-qualified CSOs’ coverage of the districts by technical intervention areas**

| Name of CSOs   | Intervention areas  | Districts of operation | No. of Sub counties covered |
|--|---------------------|------------------------|-----------------------------|
| Family Life Education Program (FLEP)                       | HTC, AB, OP, CM     | Kamuli                 | 2                           |
|  |                     | Luuka                  | 3                           |
|  |                     | Mayuge                 | 6                           |
| Uganda Reproductive Health Bureau (URHB)                   | HTC, TB/HIV, AB, OP | Bugiri                 | 6                           |
|  |                     |                        |                             |
|  |                     | Namayingo              | 1                           |
| Youth Alive Uganda (YAU)                                   | CM, AB, CP, HTC     | Kamuli                 | 7                           |
|  |                     | Namutumba              | 4                           |
|  |                     | Kaliro                 | 2                           |
|  |                     | Iganga                 | 7                           |
|  |                     | Luuka                  | 4                           |
|  |                     | Buyende                | 4                           |
| National Community of Women Living with HIV/AIDS (NACWOLA) | PP, REF, CM         | All                    | All the S/counties          |

Source: STAR-EC program records

However, during this first quarter, some of the prequalified CSOs did not implement activities as planned. Out of the four CSO’s, FLEP and NACWOLA did partial implementation and reported some results. Youth Alive Uganda and URHB did not actively implement. This was because the PY4 work plans had not yet been approved hence funds could not be disbursed to the prequalified CSOs during this period. The CSOs are in the process of revising their work plans and budgets to incorporate review comments made by USAID and these will be re-submitted to USAID for approval upon completion.

Despite STAR-EC’s efforts to provide support to NACWOLA, it continues to have serious leadership and management problems.. Consequently, after a careful review, STAR-EC had no further options but to terminate the Grant agreement with NACWOLA on 30 November 2011. STAR-EC is now using alternative mechanisms through strengthening NACWOLA’s previous achievements and grassroots structures in service delivery thus filling the implementation and results gap created by this termination.

#### Sub Partners

STAR-EC continued to work with four sub-partners namely Bantwana Initiative, Communication for Development Foundation Uganda (CDFU), mothers to mothers (m2m) and Uganda Cares in implementation of program activities. m2m provided support through in-service training of mentor mothers, their placement within health facilities, and training on utilization of IEC materials. They also trained other STAR-EC staff on aspects of active client follow ups. Uganda Cares provided technical support to laboratory technicians in twenty STAR-EC laboratory facilities in the districts. CDFU’s plans to provide technical assistance to CSOs and district health teams were not carried out during this quarter because the implementing partners had not yet received funds from STAR-EC, pending approval of their PY4 work plans. Bantwana Initiative facilitated orientation of the newly trained VHT members in all the districts on referrals and effective networking systems and provided technical support to the VHTs and CSOs in the area of

## **Conclusion**

This quarter witnessed vast contributions from STAR-EC consortium members, district and a few CSO partners as well as the Ministry of Health. As a result of this concerted effort, the approaches used in delivering services were not only dynamic and client focused, but also evidence informed. The strategies adopted by STAR-EC during this reporting period are the sum total of field experiences, findings of LQAS, program operational data and, to some extent, insights garnered from national surveys and studies on the current trends and drivers of the HIV epidemic. This explains the emphasis that was placed onto interventions focusing on key populations at higher risk in various hot spots located in the nine districts. The program has also continued to tap into the synergies of the public and private sectors and further harness the potential of families, communities and PLHIV to find solutions to local issues in its approach towards delivering quality and comprehensive TB and HIV&AIDS services in East Central Uganda.

STAR-EC is grateful for the information and experience sharing meetings that took place at national level among United States funded programs. These forums not only created a platform for leveraging resources and information sharing on key strategies, but also helped in addressing issues of common interest. We look forward to consolidating the achievements so far attained as the program strives to further improve the lives of the people in East Central Uganda.





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