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

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

**January – March, 2012**



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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
SOAR	Strengthening Outcomes by Achieving Results
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 represents achievements made by the Strengthening TB and HIV&AIDS Responses in East Central Uganda (STAR-EC) program during the reporting period January – March 2012. This submission is in accordance with the provisions of the cooperative agreement No. 617-A-00-09-00007-00 between USAID and JSI Research & Training Institute, Inc..

During this quarter, STAR-EC supported the delivery of services through providing financial and technical support to three CSOs and 131 health facilities working in close collaboration with the Ministry of Health (MoH), nine district local governments, Strengthening Decentralization for Sustainability (SDS) and other partners to ensure delivery of quality services to the target population.

HCT services were delivered using a combination of static and outreach approaches. A total of 93,017 individuals (56,490 females and 36,527 males) were counseled, tested and received their HIV results at 108 static and 106 outreach sites at parish level. Overall, a total of 3,612 people (2,225 females, and 1,387 male) were diagnosed HIV positive translating into a positivity rate of 3.9%. A total of 5,822 couples (11,975 individuals) accessed HTC services during the quarter with 81.3% of them accessing the service through outreach HTC services. Of these, 2.2% (126) couples were discordant while 16.8% (86) were concordant HIV positive and were linked to care and services.

During the same period, the program supported PMTCT services at 81 health facilities mainly focusing on provision of option A. Overall, a total of 34,337 women were served as part of the PMTCT HIV testing package that includes ANC (28,244), pregnant women who turn up with a known and documented HIV positive status (324), labor and delivery (1,398) as well as PNC (4,371). During ANC, 1.8% were diagnosed HIV positive, while 1.6% and 1.4% were found HIV positive during labor and delivery and postnatal care respectively. Of the 825 HIV positive pregnant women attending ANC, 75.9% were assessed for ART eligibility using both CD4 and WHO staging while 80.7% did receive ARVs for PMTCT prophylaxis. In addition, 282 HIV exposed babies were born during the quarter and 93.6% of them received Nevirapine syrup at birth. Over 1400 mothers and their spouses were offered a combined package of services including counseling, CD4 & PCR testing, ARV prophylaxis, TB screening among others during monthly support group meetings.

SMC was scaled up to 18 facilities up from 16 during the last quarter. Both static and outreach modes of delivery were utilized and in total 22,499 clients received SMC services which contributed to the national HIV prevention effort by averting 1,184 new HIV infections (calculation based upon a UNAIDS and PEPFAR collection <http://www.ploscollections.org/VMMC2011>). STAR-EC procured anesthetic drugs and adjustable couches and received 5,000 pre-packed SMC disposable kits from USAID which helped to increase efficiency and outputs especially during outreaches.

Further to these efforts, STAR-EC supported the provision of clinical care at 130 facilities. A total of 19,534 (12,998 female; 6,536 male) received CTX and 3,846 children received counseling and testing during the 'know your child's HIV status' campaigns which yielded a positivity of 1.5% (56 children).

Delivery of TB services was supported through strengthening support supervision at all levels in the nine districts and involvement of the private health facilities as well as traditional healers. In total, 539 TB patients were recorded in the register, 99.1% of whom were tested for HIV and 176(33%) were positive. Of those with both HIV and TB, (97.2%) were started on CXT, and 129 (73%) patients were started on both CTX and ART. TB treatment success (of 86.3%) has substantially remained above the national target of 85%.

Provision of ART services was supported at 45 sites 19 of which were newly accredited in December 2011 by the MoH to offer ART. Overall, 981 new PLHIV were initiated on ART bringing the total number of clients currently on ART to 9,233 (6,008 female & 3,225 male). Of these, 748 were children <15 years up from 669. The cumulative total ever started on ART stands at 11,650

During the quarter, a total of 3,485 (1,839 male; 1,646 female) individuals were reached with risk reduction counseling and combination HIV prevention interventions. Additionally, STAR-EC supported the new National 'HIV Combination Prevention Strategy mainly targeting the key populations<sup>1</sup>. About 1,473 key population were reached, of whom, 1,391 (94%) were fisher folk, 4% were sex workers and 2% were truckers. Fifty five (55%) were reached more than once.

Lastly, systems strengthening and capacity building interventions continued in all nine districts. The program supported the training, mentorship and support supervision of health workers in delivery of quality services; and also provided buffer supplies like CD4 reagents, SMC anesthetics and sundries, test kits and Septrin to health facilities to mitigate interruption of service delivery. During this quarter, the program was able to obtain useful strategic information that was generated through the MARPs study conducted by STAR-EC in nine East Central Uganda region districts. This information is now being used in focusing on impact and prioritization of the different estimated key populations and in designing strategies that are in response to the epidemic drivers.

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

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 (Oct 2011 - Sept 2012)			End of PY4 target	% of PY4 targets achieved	End of Program Life target	Program Cumulative achievements to date (total PY1*, PY2, PY3 and PY4 (Q1&Q2))	% of end of Program Life target achieved	Comments
					PY4,Q1 (Oct 2011 - Dec 2011)	PY4,Q2 (Jan 2012 - Mar 2012)	Program Cumulative achievements (Q1&Q2)						
HIV Testing and Counselling (HTC)	Individuals who received HTC and their results	10,376	178,303	330,966	74,137	93,017	167,154	130,000	129	600,000	686,799	114	Increased integration of SMC and HTC services as well as the steady supply of test kits helped to increase numbers. STAR-EC will continue to provide HTC services with more focus on HIV key populations. LQAS survey results will be used in prioritization of Supervision Areas that have been identified with low HTC uptake
	Individuals trained in HTC	64	256	353	0	32	32	66	48	400	705	176	STAR-EC is concentrating 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)	108 static and 106 parishes (outreach sites)	108 static and 106 parishes (outreach sites)	120 static sites	108 % of static sites	148	108 static sites	73% of static sites targeted	Due to some delays in the CSO granting process, the number of outreaches reduced during the quarter. However two CSOs (FLEP and YA) managed to give results
PMTCT	Pregnant women with known HIV status (includes tested and received results)	No Implementation during PY1	65,983	104,689	24,147	29,952	54,099	113,000	48	482,600	224,771	47	Overall, a total of 34,337 women were served as part of the PMTCT HIV testing package that includes ANC (28,244), pregnant women who turn up with a known and documented HIV positive status (324), labor and delivery (1,398) as well as PNC (4,371).

1 The term 'key populations' refers to Most at Risk Populations (MARPs)

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 (Oct 2011 - Sept 2012)			End of PY4 target	% of PY4 targets achieved	End of Program Life Target	Program Cumulative achievements to date (total PY1, PY2, PY3 and PY4 (Q1&Q2))	% of end of Program Life target achieved	Comments
					PY4,Q1 (Oct 2011 - Dec 2011)	PY4,Q2 (Jan 2012 - Mar 2012)	Program Cumulative achievements (Q1&Q2)						
PMTCT	Pregnant women who received ARVs to reduce the risk of mother to child transmission	No Implementation during PY1	1,759	3,418	606	666	1,272	3,300	39	26,230	6,449	25	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. Progress to date is in line with this prevalence rate until a time of approval for new and realistic targets.
	Persons trained for PMTCT	No Implementation during PY1	177	458	0	84	84	70	120	400	719	180	22 were trained from 18 landing site based facilities, 54 from 27 mainland facilities and 8 from 8 island facilities
	Service outlets providing PMTCT	No Implementation during PY1	68	83	81	81	81	118	69	118	81	69	The program has embarked on scale up to targeted facilities especially among key populations in response to eMTCT
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	3,485	5,648	60,000	9	283,000	280,831	99	19% and 36% of those reached with AB and MARPs messages (respectively) were visited more than once during the quarter. With the exception of FLEP, YA and URHB the absence of CSO activities during this quarter contributed to the slow increment in results. 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 3. Training of new VHTs will be done in the same quarter.
	Individuals trained to provide AB services	234	564	298	0	10	10	110	9	1,265	1,106	87	
	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	12,763	19,473	829	1,473	2,302	26,000	9	88,300	34,538	39	
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	115	226	1,000	11	4,900	849	17	The program is increasingly finding less (33%) 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, 97.3% of 19,534 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	534	931	1,100	36	5,500	4,529	82	
	Individuals trained to provide HIV/ TB related palliative care	64	875	250	0	0	0	200	0	700	1,189	170	

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 (Oct 2011 - Sept 2012)			End of PY4 target	% of PY4 targets achieved	End of Program Life Target	Program Cumulative achievements to date (total PY1*, PY2, PY3 and PY4 (Q1&Q2))	% of end of Program Life target achieved	Comments
					PY4,Q1 (Oct 2011 - Dec 2011)	PY4,Q2 (Jan 2012 - Mar 2012)	Program Cumulative achievements (Q1&Q2)						
Anti- Retroviral Therapy (ART)	HIV + individuals receiving a minimum of one clinical care service (CXT)	283	7,041	16,684	17,518	19,534	19,534	19,000	92	26,000	19,534	75	Utilization of village health teams has helped in increasing access to clinical care through effective referrals and linkages.
	Adults and children with advanced HIV infection newly enrolled on ART	61	1,776	5,083	950	981	1,931	1,650	58	8,200	8,851	108	By the end of this quarter 11,650 had ever started on ART. 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	9,233	9,233	6,423	127	9,323	9,233	99	
Safe Male Circumcision (SMC)	Males circumcised	0	803	14,327	11,034	22,499	33,533	90,000	37	225,000	48,663	22	More innovative outreaches are in place to achieve set targets. Contributed to the national HIV prevention effort by averting 1,184 new HIV infections during this quarter (calculation based upon a UNAIDS and PEPFAR collection)
	SMC surgical sites	0	7	15	16	18	18	18	89	18	18	100	
Strategic Information, capacity building and systems strengthening	Local organizations provided with TA for SI activities	4	11	11	1	3	3	11	9	11	11	100	Only FLEP, YA and URHB were able to implement any activities and were thus supported by STAR-EC. The rest of the new/old CSOs will be supported when they get on board during the rest of PY4.
	Individuals trained in SI (including M&E, surveillance and/or HMIS)	122	379	170	221	0	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	3	3	11	9	11	11	100	Only FLEP, YA and URHB were able to implement any activities and were thus supported by STAR-EC. The rest of the new/old CSOs will be supported when they get on board during the rest of PY4.

\* 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 about 2.7 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++. Additionally, this region had an estimated HIV prevalence of 6.5%, 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%.

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 Quarter 2 of PY4

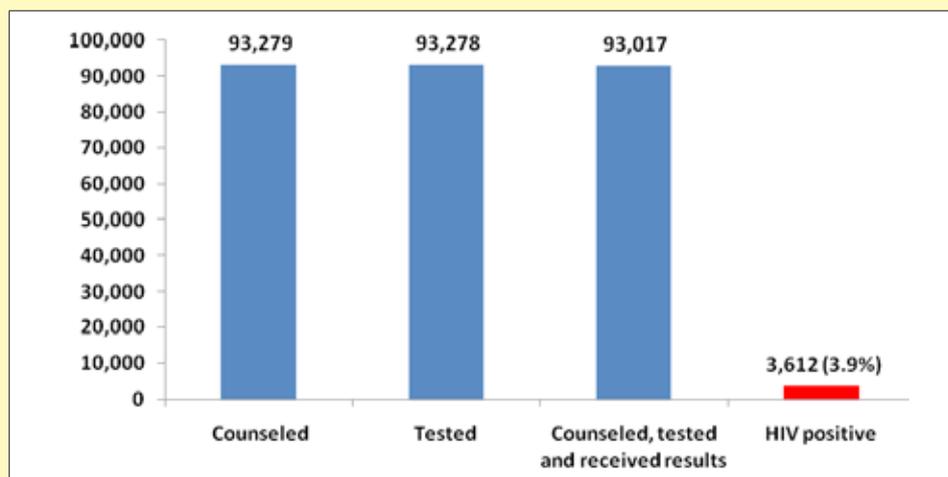


*A health worker offering HTC services during an outreach in the community*

During Quarter 2 of PY4, HTC service delivery was undertaken at 108 facilities using both static and outreach based approaches that prioritized key populations such as fisher folk, commercial sex workers and truckers both on the mainland and the islands. During this quarter STAR-EC supported three CSOs (FLEP, Youth Alive and URHB) to offer HTC services as an entry point into combination prevention, care and treatment.

The program also conducted monthly outreaches targeting MARPs on the islands of Dolwe and Sigulu main in Namayingo District; and Jaguzi and Sagitu in Mayuge District. A total of 2,780 people (1,369 females and 1,411 males) received HTC services on these islands and of these 13.2% were found to be HIV positive but with differences among women (13.7%, n=1,369 and men 12.7%, n=1,411).

**Figure 1: HIV Counseling, testing and received results cascade**



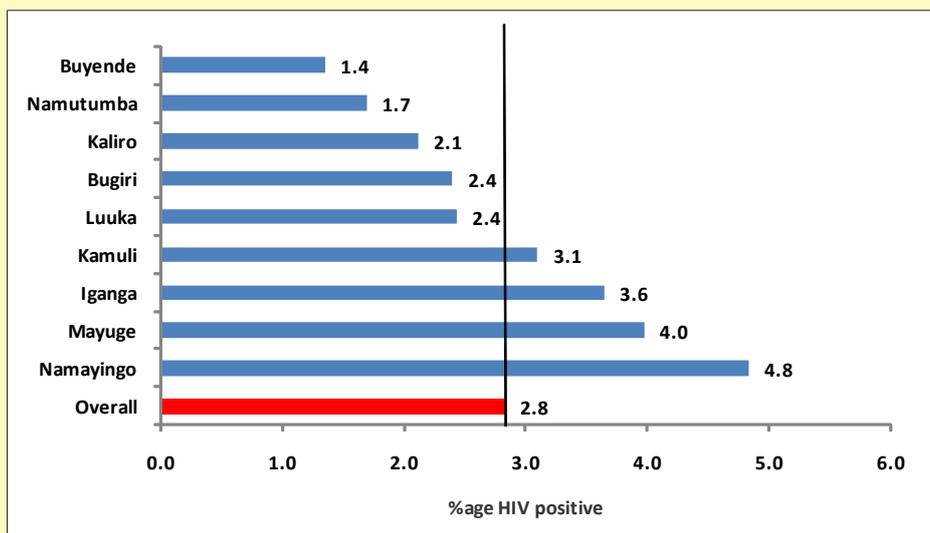
Source: STAR-EC Program Records

Through these outreaches, a total of 21 couples (42 individuals) accessed HTC, three (14.3%) of whom were discordant and two (9.5%) of whom were found concordant HIV positive. All HIV positive persons were duly linked to care through the integrated service delivery outreaches.

Overall, in all nine districts, a total of 93,278 people (56,615 females and 36,663 males) were tested for HIV and a total of 93,017 (56,490 females and 36,527 males) received their results from both public health units and CSOs.

As a result of HTC undertaken during PY4 (quarter1 and quarter 2), a total of 167,154 individuals were counseled, tested and received results – a 129% achievement of the PY4 annual target of 130,000. This situation therefore calls for the program to focus for impact with high prioritization of HTC services among key populations and parishes that have been underserved or those known to be of high prevalence over the subsequent quarters.

**Figure 2: HIV prevalence amongst pregnant women during ANC and Labour and Delivery**



Source: STAR-EC Program Records

Overall, a total of 3,612 individuals (2,225 females, and 1,387 males) were diagnosed HIV positive translating into a positivity rate of 3.9% for the quarter.

A review of positivity by district shows that while the overall was 3.9%, districts such as Mayuge and Namayingo posted the highest positivity rates of 7.5% and 9.0% respectively, while Luuka and Kaliro posted the lowest positivity rates of 2.6% and 1.8% respectively in the East Central region.

During Quarter 2, outreaches accounted for 44% of all HTC service delivery while static sites accounted for the remaining 56%. The “Know Your Child Status” campaign targets HIV-exposed children. During this quarter, the campaign targeted all children of HIV positive mothers on ART across the 9 districts. Table 2 below illustrates in detail results of the various HCT approaches including couple HTC outcomes.

**Table 2: HTC cascade detailing HTC outcomes both at facility and outreaches**

HTC approach	Total counseled	Total tested	Total received results	HIV positive	Positivity (%)
<b>Outreach HTC</b>					
Couple HTC	10,872	10,871	10,870	247	2.3
Free standing HTC	25,150	25,150	25,079	765	3.0
Home to home HTC	1,328	1,328	1,328	61	4.6
Know your child status	3,855	3,855	3,846	56	1.5
Sub total	41,205	41,204	41,123	1,129	2.7
<b>Static HTC</b>					
Static/facility based HTC	52,074	52,074	51,894	2,483	4.8
<b>Overall</b>	<b>93,279</b>	<b>93,278</b>	<b>93,017</b>	<b>3,612</b>	<b>3.9</b>

Source: STAR-EC Program Records

individuals who received HTC services. Additionally, 81.3% of all couples accessed the service through outreaches. Furthermore, couple HTC accounted for 61.5% of all the couples who accessed HTC during the quarter. Of these, 126 couples were found to be discordant while 86 were concordant HIV positive. Table 3 illustrates the details;

**Table 3: Couples accessing HTC services**

HTC approach	Counseled tested and received results	Discordant couples	Concordant couples
Couple HTC	3,580	54	40
Free standing HTC	1,054	9	7
Home to home HTC	101	2	0
Static/facility based HTC	1,087	61	39
<b>Overall</b>	<b>5,822</b>	<b>126</b>	<b>86</b>

Source: STAR-EC Program Records

### Lesson learned

- Facility based HTC identifies more HIV positive persons than HTC outreaches.

### Challenges

- Island communities are still underserved by HTC services despite posting the highest positivity rates in the region.
- The demand for HTC services is growing day by day, yet the available resources are not able to meet this requirement. In this regard, STAR-EC is refocusing its HTC service provision to target key populations.

### Way forward

- Refocus HTC services provision to target key populations (fisher folk, truckers and Commercial sex workers) and couples in the islands, along the lakeshores and mainland hotspots (such as Naluwerere town), so as to improve access of these underserved key populations (that are currently driving the HIV epidemic in the region) to combination prevention, care and treatment services.



An MoH official mentoring Nsinze HC IV health workers and community volunteers (mentor mothers and community support agents) on how to use PMTCT-EID records



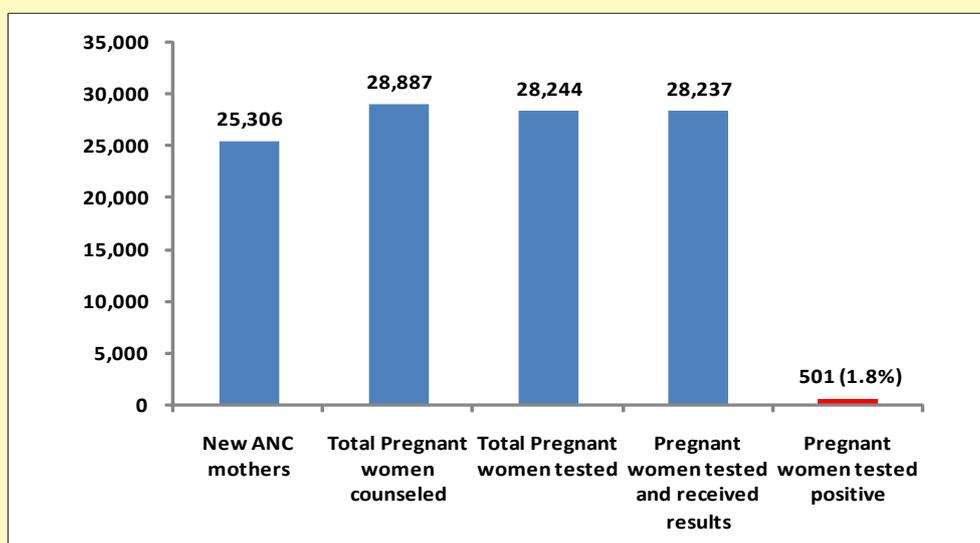
A health worker & mentor mother at Bugiri Hospital show a new mother how to breast feed

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

During the period January – March 2012, STAR-EC supported 81 health facilities (four hospitals, 12 HCs IV, 59 HCs III and six HCs II) in the nine districts of East Central Uganda to implement PMTCT services according to the revised guidelines (Option <sup>2</sup>). During the same period a total of 84 health workers (22 trained from 18 landing site based facilities, 8 from 8 island facilities and 54 from 27 mainland facilities) underwent training using the Integrated Management of adult Illnesses (IMAI)/Integrated Management of Pregnancy and Childbirth (IMPAC) as part of the phased scale up to areas with large numbers of key populations. STAR-EC also supported an integrated MOH and district team to conduct PMTCT-EID mentorships in 45 health facilities (four Hospitals, 12 HCs II and 29 HCs III).

As a result of this support, a total of 34,337 women were served as part of the PMTCT HIV testing

**Figure 3: PMTCT Counselling and testing cascade**



Source: STAR-EC Program Records

package that includes ANC (28,244), pregnant women who turn up with a known and documented HIV positive status (324), labor & delivery (1,398) as well as PNC (4,371). During ANC, 1.8% were diagnosed HIV positive, while 1.6% and 1.4% were found HIV positive during labor & delivery and postnatal care respectively.

A review of the positivity of new mothers from ANC, labor and delivery across the region shows that while the overall positivity was 2.8%, Namayingo (4.8%), Mayuge (4.0%), Iganga (3.6%) and Kamuli (3.1%) districts posted the highest positivity while Buyende (1.4%) and Namutumba (1.7%) districts had the least positivity rates.

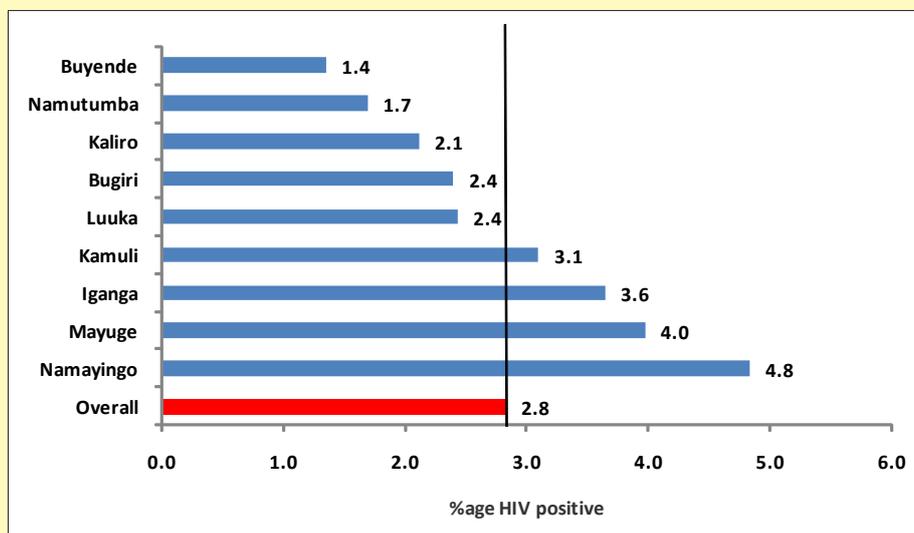
Of the 825 HIV positive pregnant women attending ANC, 75.9% were assessed for ART eligibility using both CD4 and WHO staging while 80.7% did receive ARVs for PMTCT prophylaxis.

<sup>2</sup> Option A: Refers the use of AZT tabs for the pregnant mother commencing at 14 weeks of pregnancy up to labour where the mother is switched to combivir (AZT and 3TC) and single dose nevirapine for a duration of 1 week after delivery. The baby on delivery is started on Nevirapine syrup daily up to 1 week after weaning/cessation of breastfeeding (policy advocates for a breast feeding period of up to 12 months to ensure that the baby benefits from prolonged breast feeding)

Option B: Mother is started on HAART from 14 weeks of pregnancy all through delivery until one week after the baby ceases breast feeding. The baby is covered with Syrup nevirapine for a period of 6 weeks only.

Option B+: Mother is started on HAART for life from 14 weeks of pregnancy, the baby meanwhile is covered with nevirapine syrup for 6 weeks only.

**Figure 4: HIV prevalence amongst pregnant women during ANC and Labour and Delivery**



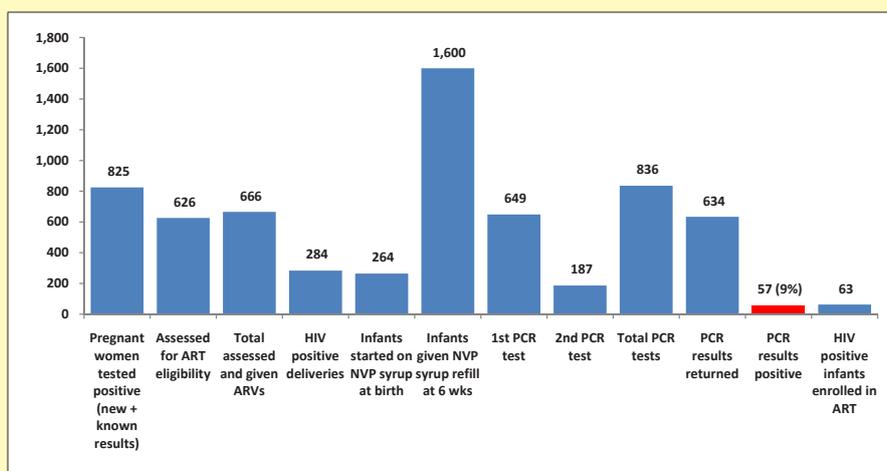
Source: STAR-EC Program Records

Of those mothers who received ARVs for prophylaxis, 16% were on HAART compared to the recommended 30 – 40%, 2.5% were on AZT, 3TC and SdNVP while 62.2% were on AZT and single dose Nevirapine. Additionally, a total of 8,023 deliveries were registered in the 81 health facilities from which 282 were children born to HIV positive pregnant women. Of the 282 HIV exposed babies born, 93.6% received Nevirapine syrup at birth. During the same period, a total of 836 PCR tests (1<sup>st</sup> PCR – 649 and 2<sup>nd</sup> PCR – 187) were conducted and 75.8% of the results were available. Overall 57 (9%) of the available 634 PCR results were HIV positive.

### Enhancing the role of peer support using the ‘mothers2mothers’ model

STAR-EC during the quarter supported capacity building activities to boost the performance of 60 mentor

**Figure 5: PMTCT cascade for HIV positive pregnant women and their exposed babies**



Source: STAR-EC Program Records

Mothers currently implementing the m2m model in 28 high volume health facilities; enhancing PMTCT service uptake through provision of HIV pre-test education, linking mothers to essential PMTCT services and supporting follow up of lost mothers. A total of 12 mentor mothers benefited from pre-service training on a range of HIV related

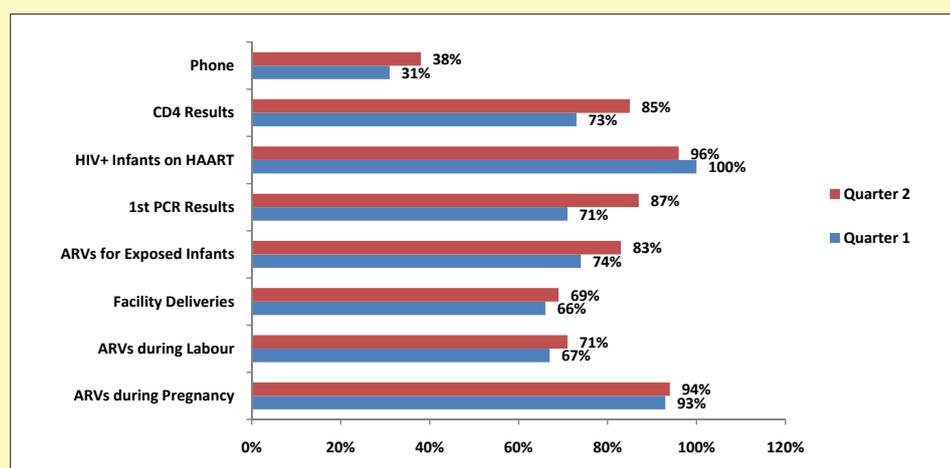
topics before placement in 6 health facilities. All mentor mothers attended training in ‘Client Active Follow up’ for mother-baby pairs, and a wellness debrief session by TASO Uganda. The trainings are partly meant to ensure quality assurance for the support services. The group debrief sessions in particular strengthen the capacity of mentor mothers to cope emotionally with the challenges they face as HIV positive clients and while providing support to fellow HIV positive mothers.

Peer support efforts by mentor mothers reached over 600 new HIV+ women (Antenatal 453, Postnatal 174) through one-on-one psychosocial support and education. A total of 1,042 HIV+ women and 250 male partners were supported in PMTCT family support groups from where 155 women got a CD4 test, Dry Blood Spots collected for 111 infants, 153 PCR results declared to care takers, 130 women accessed family planning services, 108 supported to disclose their HIV status, and 25 partners tested for HIV during group meeting days. In reference to the chart above; mentor mothers supported 94% of the 483 women who were attending antenatal clinic for the first time. The ‘Active Client Follow-up’ initiative was rolled out in 28 health facilities in March 2012. The initiative aims at enhancing adherence and retention of mother-baby pairs in the PMTCT cascade. Follow-up was done through phone services, home visits and referrals to community support agents. The initiative will continue to be supported and monitored in the next quarter for learning purposes and improvement.

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

A total of 514 antenatal and postnatal women were sampled from longitudinal registers completed by mentor mothers. The data revealed that 94% of 352 antenatal women received ARVs during pregnancy, 69% of 327 postnatal women had delivered at a health facility, 71% of positive women swallowed ARVs during child labor and 83% of 257 women who had tested their babies received PCR test results. A total of 24 infants tested HIV positive and 96% of them were initiated on HAART. Out of a total sample of 514 women, 85% had valid CD4 results, and 38% access to a mobile phone. Below is a comparison of quarter one and two SOAR results.

**Figure 6: PMTCT Service Uptake among Clients enrolled in the m2m Program**



Note: The sampled clients were enrolled into the program between April and September 2011. The data is updated continuously until the mother-baby pair graduates at 18-24 months.

Source: STAR-EC Program Records

Strengthening Outcomes by Achieving Results (SOAR) is a quality improvement initiative that highlights areas requiring attention. Therefore in the next quarter, one-on-one and couple education sessions as well as follow up activities will focus more on uptake of PMTCT ARVs during labor, facility deliveries and ARVs for exposed babies.

Preliminary results of the 2010/2011 Uganda Cohort Outcome Data Analysis disseminated during the reporting period; revealed access to CD4 testing services for HIV+ women enrolled into the m2m program at 80% (n = 744), first PCR testing at 82% (n = 651), and facility deliveries at 68% (n = 324). 49% of Antenatal clients had first attended antenatal clinic at/or after 28 weeks of pregnancy. These findings were in agreement with those of Let's SOAR i.e. good performance in provision of CD4 and PCR testing services, and the need to improve facility based deliveries.

### Lessons Learned

PMTCT-EID services provision is possible, though it requires the availability of PMTCT-EID logistics, correct, complete and timely recording and a vigilant health worker/community volunteer network to seek out and link new and lost mother-baby pairs to the service.

### Challenges

- Constantly changing PMTCT-EID policy guidelines have in effect meant that our training, mentorship/coaching and register/reporting tool printing budgets have to be adjusted to meet this challenge
- Some health facilities receive HIV+ mothers during PNC and when their babies are tested, their HIV results turn out to be positive. This tends to contribute to a higher HIV+ prevalence among these babies when their PCR results are received

### Way forward

- STAR-EC in collaboration with the Ministry of health is preparing to embrace PMTCT services provision using Option B+ guidelines. In the meantime all sites are being supported to strengthen the existing Option A services in preparation for the transition to new guidelines.
- Additionally, more targeted efforts will be put in place to reduce on the proportion of mothers who turn up for first time HIV testing during PNC by ensuring that the same heed to PMTCT and HIV testing during ANC.

## 2.1.3 Care and support

### 2.1.3.1 Care

During January-March 2012, STAR-EC provided technical support to 27 facilities implementing palliative care, pain & symptom control. Regional Palliative Care Officers mentored 35 trainee health professionals while disseminating the palliative care documentation case book and forms. About 182 clients received pain medication (codeine and liquid oral morphine). On the other hand, all 130 supported facilities continued to provide clinical care to PLHIV including Cotrimoxazole prophylaxis and/or treatment of opportunistic infections (OIs). However only 92 of the 130 facilities submitted reports as the rest lacked pre-ART registers to document work done. In total, 19,534 PLHIV received a minimum of one clinical care service. This is a rise from the previous quarter which was 17,518 and the increase is attributed to the big number (2,972) of clients newly enrolled in care during this reporting period. The 19,534 excludes those who transitioned to ART, those who died and those who missed appointment.

### Challenges

- Liquid oral morphine is still not easily accessed by all implementing facilities due to a restricted prescriber policy of MoH
- Prolonged national and facility stock out of Cotrimoxazole 960mg for >2 months, implies that more PLHIV clients risk developing OIs and hence will rapidly progress to AIDS and/or death.

### Way forward

- A comprehensive list of Palliative Care Officers including the recent grandaunts from the Palliative Care Association of Uganda – Health Care Improvement collaboration, will be sent to National Medical Stores to aid in fast tracking requisitions for oral morphine
- Procure a buffer stock of Cotrimoxazole, following USAID approval.

### 2.1.3.2 Psycho-social support and nutrition

The program's community level support care includes home-based care and positive health dignity and prevention (PHDP). MoH officials provided support supervision to nine volunteer home-based care teams in the community. A couple of workshops on Positive Living were organized by Health Communication Partnership (HCP) during which they disseminated tools for health workers, IEC materials, and mass media materials for use in further disseminating the PHDP concept to parish level PLHIV networks.

At facility level, care and support included nutrition therapy and adherence counseling. The 10 nutrition facilities provided ready-to-use-therapeutic foods to 68 HIV positive clients and improvements in anthropometric measures were recorded. The Uganda Cares' Counselors mentored 46 facility-based volunteer expert clients on adherence counseling while disseminating copies of the Uganda National Antiretroviral Therapy Adherence Strategy.

#### Way forward

The program will in the next reporting period engage the existing PLHIV groups/ networks at parish level to scale up the PHDP program.

### 2.1.3.3 Clinical/Preventive Care – Additional Pediatric Care

In January 2012, STAR-EC facilitated 23 facilities to conduct the "Know Your Child's HIV Status" testing campaign (KYCHS) targeting children born to HIV +ve parents enrolled in HIV/ART clinics, and children that are in custody of other guardians. The majority of such children were found HIV negative except for 57 children who were found HIV positive (1.5% sero-positivity rate) and linked to/enrolled at respective HIV care/ART clinics.

**Table 4: Outputs for Know Your Child's HIV status campaign**

Know Your Child's HIV Status campaign -- Age	<5 yrs	5-14 yrs	15-17 yrs	TOTAL
# of children who received HIV testing, results	1,264	2,137	435	3,846
# of children found HIV positive	29	18	9	56

Source: STAR-EC Program Records

Besides evidence of MTCT among the <5 years, there is low pediatric HIV infection rates, and this may explain why the performance of the East Central region regarding pediatric ART targets is still low compared to the national target as highlighted below:

- Proportion of currently enrolled PLHIV that are children aged <14 years = 6.8% (national target = 15%) i.e.: 1,329 are children <14yrs out of 19,534 current enrolled PLHIV all ages
- Proportion of ART clients that are children aged <14 years = 8.1% (national target = 15%) i.e.: 739 children on ART out of 9,180 current ART clients all ages
- Proportion of enrolled HIV +ve children aged <14 years that are on ART = 55.9% (national target = 50%) i.e.: 748 children are current on ART out of 1,337 children <14 years current enrolled in care.

#### Way forward

A second KYCHS campaign will run in April/May to enable comparison of trends and in-depth analysis of implications.

### 2.1.3.4 Post Exposure Prophylaxis

During the quarter, 46 facilities (ART accredited) were supported to offer post exposure prophylaxis (PEP) services by providing technical assistance in addition to ARVs from USAID. Unfortunately, only five sites (Bugiri and Iganga

hospitals; Magada HC III, Nsinze and Bugono HCs IV) had documented providing PEP to a total of 29 clients (12 males and 10 females) of whom 12 clients (females) were exposed to HIV after incidents of rape/sexual assault and 14 were occupational exposures amongst health workers.

### Challenge

- Most facilities did not document and report their PEP services, although we are aware of 2 sites that actually provided PEP but did not document by the time the data capture team moved round
- The higher incidence of rape/defilement cases means more girl children are being exposed to HIV. Because the health system is unable to stop this bad practice, we need input from the civil and legal sectors.

### Way forward

- Assign a designated PEP Officer to be responsible for prescribing PEP ARVs, and documenting in the MoH PEP register/ case documentation form
- Facility PEP Officers will disseminate to various villages the IEC posters we acquired from the Center for Domestic Violence Prevention (CEDOVIP). These poster messages include: "Seek help after rape or defilement"; "Has anyone you know been raped?"; "Funa okuyambibwa luvanyuma ly'okukakibwa okwegatta mu by'omukwano oba okusobezebwaako!" and "Omanyiyo omuntu eyakakiddwa okwegatta mu by'omukwano?".

## 2.1.4 Treatment – Antiretroviral Therapy

In quarter two (January – March 2012), MoH accredited about 19 STAR-EC supported HCs III to deliver ART bringing the total ART service outlets to 45. Two (2) of the new sites are private-not-for-profit (PNFP) namely Nawanyago Catholic HC III and Iganga Islamic HC III, making a total of 3 PNFP sites providing ART (1 hospital, 2 HCs III). Among the newly accredited sites is Sigulu Island HC III that serves the fisher folk in the Islands (21% HIV sero-positivity rate). STAR-EC in collaboration with ACP, trained 62 health workers and 18 Expert Clients on comprehensive HIV/ART treatment including pediatric ART and PMTCT courses as a combo. Trainees were drawn from 22 new facilities including 8 PNFP and 2 private-for-profit (PFP) clinics namely Fastline Medical Centre – Bugiri, and Doctors' Plaza Iganga clinic; in tandem with the USAID paradigm shift to support the private sector to provide ART services.

In Namayingo District (with the highest HIV prevalence), there are now 3 ART sites which treated 703 active ART clients of whom 109 were newly started on ART during this quarter. In order to significantly reduce the infectiousness of key populations in Namayingo (fisher folks, commercial sex workers, etc.), there is need to increase utilization of ART to cover >40% of the estimated PLHIV at population level (22,835). Otherwise the current 703 clients accessing ART is mere 3% coverage and of no impact on the HIV transmission ('treatment as prevention' concept) especially in Sigulu Islands.

Overall in the region, the program initiated on ART 981 new PLHIV and treated 9,233 PLHIV as current on ART. The cumulative total ever started on ART stands at 11,650 meaning that about 2,417 ART clients were either transferred out to other regions, were lost-to-follow-up or died.

### Challenges

- Utilization of ART in Sigulu Islands is still low despite facilitating 4 ART outreaches monthly
- A sustained high loss to follow-up (LTFU) rate of 18.7% in a sample 12 months ART cohort (see table 5). Although there was a drop from last quarter (LTFU 19.3%) this was not a significant drop.

**Table 5: ART cohort analysis and outcomes for the last two quarters**

Cohort analysis indicators	Oct - Dec 2011 (Q1)		Jan - Mar 2012 (Q2)	
	#	%	#	%
ART clients started ART 12 months ago	906		1,185	
ART clients still alive on ART after 12 months	662	73.1%	821	69.3%
ART clients dead within 12 months	41	4.5%	50	4.2%
ART clients transferred out within 12 months	28	3.1%	93	7.8%
ART clients lost to follow up within 12 months	175	19.3%	221	18.7%

Source: STAR-EC Program Records

### Way forward

- In order to address the gap in utilization of ART (delayed initiation of ART), a review meeting with ART outreach teams (Clinicians and Nurses) will be held to understand the processes. Then clinical teams will apply quality improvement approaches to mitigate delayed initiation e.g.: routinely measure performance against targets, and serially test changes in the process of ART initiation
- The program will engage Clinton Health Access Initiative (CHAI) to pilot an intervention of patient management and tracing lost clients. This will tackle process gaps in the filing system, appointment system, and follow-up/tracing system, and is set to roll by May2012 at 7 sites that have the highest LTFU rate.

## 2.1.5 Clinical /Additional TB/HIV

### Capacity building



*STAR-EC staff examines a TB suspect child during a mentorship session*

During the reporting period, STAR-EC and District officials conducted mentorship for health care providers in Iganga, Kaliro, Luuka, Mayuge, Buyende and Namayingo districts. The mentorship 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, adhere to safety requirements for sample delivery and indications of INH prophylaxis. Additionally health workers from 20 high volume sites were mentored on Pediatric TB case management. The program also provided financial and technical support for the South –East zone quarterly meeting focused entirely on data validation.

#### 2.1.5.1 TB/HIV collaboration at facilities

In an effort to promote TB/HIV collaboration, STAR-EC supported a joint TB/HIV support supervision to 27 facilities; the findings reveal continued improvements in TB/HIV indicators across all nine districts. Overall 99.1% TB patients had an HIV test, 97.2% and 73.3% were enrolled on CPT and ART respectively. The regional HIV prevalence among TB patients is 32.7%, much lower than the national prevalence of 54%.

**Table 6: Achievements on select TB indicators for Quarter 2 of PY4**

Districts	New patients recorded in TB register			New patients recorded in TB register who had an HIV test			New TB patients tested HIV positive			TB/HIV co-infected patients given CTX			TB/HIV co-infected patients given CTX and ART		
	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T
Buyende**	9	15	24	9	15	24	2	3	5	2	3	5	2	3	5
Iganga	80	78	158	78	78	156	34	24	58	33	24	57	22	15	37
Kaliro	11	12	23	11	12	23	2	6	8	2	6	8	2	6	8
Kamuli	25	31	56	25	31	56	8	8	16	8	7	15	7	8	15
Luuka**	5	18	23	5	18	23	2	4	6	2	3	5	1	3	4
Mayuge	41	56	97	41	55	96	10	10	20	8	10	18	5	3	8
Namayingo**	17	28	45	17	28	45	14	12	26	14	12	26	10	11	21
Namutumba	13	20	33	13	20	33	2	8	10	2	8	10	2	8	10
<b>Grand Total</b>	<b>240</b>	<b>299</b>	<b>539</b>	<b>236</b>	<b>298</b>	<b>534 (99.1%)</b>	<b>84</b>	<b>92</b>	<b>176 (33%)</b>	<b>81</b>	<b>90</b>	<b>171 (97.2%)</b>	<b>57</b>	<b>72</b>	<b>129 (73.3%)</b>

\*\* Newly formed districts

Source: STAR-EC Program Records

Routine screening for TB has been rolled out in 82 facilities providing HIV chronic care services.

**Table 7: TB status in HIV chronic care services (Care & ART) for Quarter 2 of PY4**

District	Clients newly enrolled in care during the quarter	Clients seen during the quarter (Active)	Clients Screened for TB	Clients started on TB treatment	Number of TB suspects	Number received TB / ART treatment
Bugiri	369	2,556	2,476	5	24	6
Buyende**	200	1,641	1,595	13	62	11
Iganga	634	4,104	3,935	52	83	72
Kaliro	157	768	628	7	42	2
Kamuli	523	3,611	3,553	20	63	15
Luuka**	254	1,311	1,297	13	14	6
Mayuge	233	1,888	1,883	2	11	2
Namayingo**	415	2,096	2,095	2	11	3
Namutumba	187	1,559	1,553	1	25	2
<b>Grand Total</b>	<b>2,972</b>	<b>19,534</b>	<b>19,015</b>	<b>115</b>	<b>335</b>	<b>119</b>

\*\* Newly formed districts

Source: STAR-EC Program Records

A total of 19,534 patients were reviewed during the quarter and out of these 19,015 (97.3 %) were screened for TB compared to Q1 achievement of 95.7%.



*DHE of Mayuge, during orientation of traditional healers in Mayuge district*

### 2.1.5.2 TB Control Activities

#### Case detection rate (CDR)

In a bid to improve TB case detection, 80 Health Centers level II in the districts of Namutumba, Kaliro, Mayuge and Bugiri were supported to prepare and deliver slides to higher level diagnostic facilities. Through this referral process, 9 smear positive TB cases were identified. In order to promote public- private partnership and also strengthen the referral networks in the communities, a total of 470 drug shop attendants and 300 traditional healers were oriented on intensified TB case finding and referrals. TB campaigns were also supported in all the districts and a total of 81 smear positive TB cases were identified. Following the mentioned innovations CDR increased from 24.9 for Q1 to 36.4% during Q2 though

still lower than PY3 achievement of 42.8% and the national target of 70%.STAR-EC will continue to support these initiatives during the subsequent quarters

**Table 8: CDR progress during the quarter**

District	Expected No. of cases	No. identified	CDR
Iganga	170	90	52.9
Bugiri	145	46	31.7
Mayuge	157	84	53.5
Kamuli	170	44	25.9
Namutumba	74	22	29.7
Kaliro	74	16	21.6
Buyende	84	20	23.8
Luuka	89	22	24.7
Namayingo	79	35	44.3
<b>Overall</b>	<b>1,042</b>	<b>379</b>	<b>36.4</b>

Source: STAR-EC progressive quarterly reports

#### TB DOTS and Treatment Success

Treatment success rate continues to improve above the national target of 85%. A total of 466 smear positive TB cases were evaluated during January- March quarter of 2012 and out of these 402 (86 %) succeeded. A total of 6 districts achieved the national target of 85%. The cure rate stands at 46.1% compared to first quarter achievement of 41% and the default rate stands at 4.7% above the national target of 5%, a significant improvement from a baseline of 20%. During this reporting period, STAR-EC also supported Sub-county health workers' performance review meetings, during which registers are updated and patients' transfers and defaulters are shared and discussed. CB-DOTS implementation continued although Iganga District registered a low coverage because the Strengthening Decentralization Systems for Sustainability Project (SDS) did not facilitate this activity during the quarter.

**Table 9: Progress of TSR and TB DOTS coverage for the districts**

District	TBDOTS coverage (%)	Treatment success rate (%)
Iganga	32.3	91.7
Luuka	100	70
Kamuli	91.5	86.2
Buyende	62.5	81.5

Kaliro	78	81.8
Namutumba	97	86.8
Bugiri	72.5	85.7
Namayingo	93.3	89.2
Mayuge	66	86.1
<b>Overall</b>	<b>82.2%</b>	<b>86.3%</b>

Source: NTLP annual & district quarterly reports

### Multi -Drug Resistance (MDR)

During the quarter, 26 samples from MDR suspects were delivered to National TB reference laboratory (NTRL )out of which 4 were identified with MDR-TB in Iganga, Namayingo, Namutumba and Buyende districts. The patients' family members have been sensitized on TB infection control.

### Advocacy Communication and Social Mobilization

During World TB Day 2012 (WTD) the national emphasis was placed on childhood TB. STAR-EC conducted mentorship on management of childhood TB in 20 high-volume facilities;conducted sensitizations and sputum outreaches in schools, and a total of five children and two adults, a cook in one of the schools in Namayingo and a visitor in one of the schools in Iganga District were identified. The patients were duly initiated on treatment.

### Challenges and way forward

- Implementation of INH prophylaxis remains a challenge because of unavailability of INH drugs. Facilities have been supported to submit requisitions for INH
- Though performance on ART enrollment increased from 68% for Q1 to 73%, Stock outs of Efavirenz affected early initiation of ART for TB/HIV co-infected in some districts
- Until recently Luuka District has been experiencing low lab coverage due to inadequate lab staff and faulty microscopes in Ikumbya HC111, therefore patients were diagnosed late with advanced TB. During this quarter, the district registered high mortality for TB patients , explaining the low TSR. Additionally, other districts have their unique challenges that include migratory islanders in Mayuge as well as those in the forested areas of Bugiri, Buyende and Namayingo districts

### Lessons learned

Integrated meetings between the private and public sectors are very key in enabling the private sector appreciate their role in TB control.

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

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

During Quarter 2 of PY4, STAR-EC supported the implementing partner CSOs to develop a new scope of work and helped them to incorporate the core HIV prevention priorities including promotion of massive condom promotion, 'Get off the sexual network' campaign, Positive Health Dignity and Prevention (PHDP), SMC, supporting virtual elimination of mother to child transmission of HIV through active linkages of expectant and lactating mothers to health facilities, and using HTC as an entry point to link all HIV positive clients for ART assessment. During this period, STAR-EC also continued to support the roll-out of combination HIV prevention to promote behavioral, structural and biomedical interventions in the communities. The behavioral risk reduction interventions focused on delay of sexual debut through supporting activities that aimed at life skills developmentand counseling on the risks of multiple concurrent sexual partnerships (MCP). 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. Biomedical HIV

prevention was promoted mainly through information dissemination and linkages for different services such as SMC, PMTCT and ART as well as promotion of correct and consistent condom use and condom distribution. Several approaches were used including peer-to-peer dialogue sessions, small group discussions and behavioral change programs (BCPs) that promoted HIV prevention messages. STAR-EC supported mentorship for youth and couple programs in a bid to enhance their skills and knowledge in the transfer of information during their community sessions. In partnership with Uganda Health Marketing group (UHMG), STAR-EC has rolled out the 'Get off the sexual network' campaign and condom promotion targeting both the key population and the general population in the region.

### 2.1.6.2 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, building life skills and using bridge model <sup>3</sup> by youth peer educators as change agents to promote behavior change among youth in the community. Among the activities carried out were games and sports, small group discussions and one-to-



*Facilitating on men & HIV; to a group of young men in Kamuli District*

one sessions to promote HIV prevention messages; while embracing combination prevention. The youth were reached with information on SMC and those in need of the service were linked to health facilities. Peers also promoted dialogues on dangers of alcohol and substance abuse, discouraging societal views on male dominance and promoting respect for girls, avoiding early marriages and providing age appropriate information on HIV including basic facts on HIV transmission and prevention. Youth who were sexually active were educated on condom use and supplied with condoms.

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

In promoting mutual fidelity among married couples, model couples and religious leaders engaged couples in the community to promote HIV prevention activities. The model couples used small group dialogue sessions and home-to-home, one-on-one sessions, fidelity talks and community dialogues to promote mutual fidelity and multiple partner reduction counseling. Model couples continued to use families that prosper manuals to build skills and impart knowledge on fidelity. The CSOs target community couple meetings to promote couple HTC and link all HIV positives to health facilities for care. They also provide information on SMC, reproductive health including counseling pregnant women to go for ANC, condom education on



*Mentorship in progress: below on the right is a couple in a one to one couple session, as the group above observes- A model couple group in Iganga District*

<sup>3</sup>Bridge model: involves use of a tool that stimulates thinking and discussion among young people during risk reduction counselling. it presents life as a journey that involves a water body e.g. obstacles that may include: alcohol, and drugs, early sex, unprotected sex) therefore young people need to have life skills(bridge) to help them complete the journey. Those who complete the journey are called winners!



*John helps with the baby as his wife shares with other couples in Namutumba District*

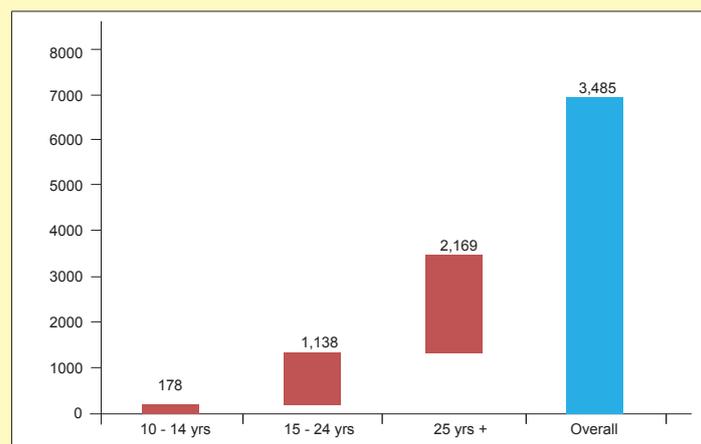
correct and consistent use especially for couples living in discordant relationships. Structural prevention was promoted using the 'Men and HIV' campaign during community dialogues to discuss issues that make women and girls become vulnerable to HIV infections such as gender base violence, forcing girls into early marriages for economic gains, male dominance and permissiveness among women. The community was challenged to discourage and desist from such practices.

"As a model couple I lead by example and support my wife", John and Rose talking about shared responsibility in a family "My husband

always comes in to support me with the baby and other work at home whenever I am really busy". Says Rose

During PY4, Q2, a total of 3,485 (1,839 male; 1,646 female) individuals were reached with risk reduction counseling and combination HIV prevention interventions.

**Figure 7: Number of individuals reached by age group with appropriate HIV risk reduction (Abstinence and Be-faithful) interventions**



Source: STAR-EC program records

### Challenges and way forward

- Limited and unfriendly youth reproductive health services provided at health facilities. STAR-EC will support health facilities to set up youth corners to provide exclusive RH services for young people
- High numbers of teenage pregnancies are being observed among young girls. STAR-EC will continue to support the roll out of structural prevention as well as the 'Get off the sexual network' campaign in the community to promote possible behavior change.

### Lessons learned

- Integration of HTC services in couple fidelity seminars and during couple group meetings boosts the uptake of couple HTC. Couples willfully and freely test together.
- Model couples who are VHT members have a wider spectrum of health issues to promote and it's easier to mentor them to support other couples in the roll out of combination HIV.



The sexual network game at Naluwerere, a key spot for CSWs and truckers during a scenario event

## 2.1.6.4 Promoting HIV risk reduction strategies among key populations

### Engaging partners in rolling out the 'off the sexual network campaign' and condom promotion

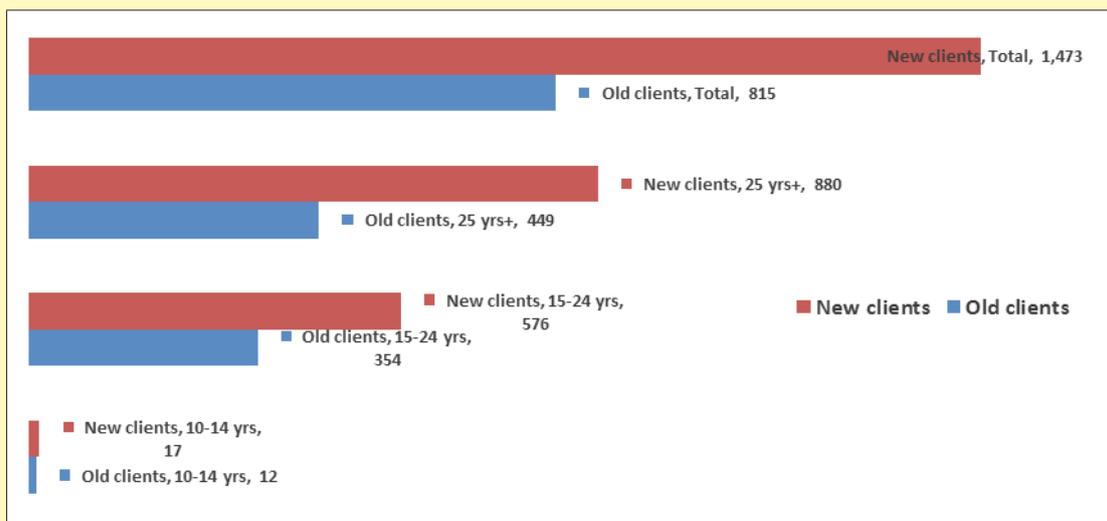
During Q2, STAR-EC worked with UHMG to support the roll out 'Get off the sexual network campaign' and condom promotion in the community. The CSOs were oriented and trained in the sexual network games; this was cascaded to the peer educators on ground who in turn implemented the sexual network game, condom promotion, education & distribution, and risk reduction counseling to key populations. The approaches used included peer-to-peer talk, small group discussions and community dialogues and scenario<sup>4</sup> events.

Taking TB and HIV&AIDS services to key populations living in hard to reach fishing communities on the island of Sigulu in Namayingo district

STAR-EC conducted a joint integrated visit to Sigulu Island and offered comprehensive TB and HIV&AIDS services in conjunction with Namayingo district and supported CSOs operating on the island. Targeted condom promotion and education were carried out by peer educators in the islands, and landing sites through BMU structures and 'knowledge rooms'. During this period, a total of 1,473 key population were reached, of whom, 1,391 (94%) were fisher folk, 4% were sex workers and 2% were truckers. An additional 815 clients who had received messages from this and other past quarters were reached with messages more than once.

Over this period, STAR-EC distributed a total of 32,564 condoms (31,179 male condoms and 1,385 female condoms) through 56 condom outlets targeting key populations in Bugiri, Mayuge and Namayingo districts. Additionally the key populations living on the island were supported to access SMC, ART, STIs and TB screening and management.

**Figure 8: Number of key populations reached by age group with HIV risk reduction interventions**



Source: STAR-EC program records

<sup>4</sup>social community event that is aimed to attract general population in specific places for health education and service

**Table 10: Number of other categories ‘the emerging’ key populations reached with HIV risk reduction interventions during PY4 Q2**

Category of key populations	Number reached
Plantation workers	85
<i>Boda Boda</i> riders	26
Business community	518
Bar and lodge attendants	168
Video hall attendants	147
Youth reached by peers	84
Couples reached by peers	30
Others	9
<b>Total</b>	<b>1,067</b>

Source: STAR-EC program records

### Lesson learned

Conducting scenario events for key populations is one key strategy that can be used to reach out to ‘hidden’<sup>5</sup> populations and target them with comprehensive HIV prevention services.

### Challenge and way forward

There were stock outs of male condoms during Q2; STAR-EC is following up with MoH to establish when the condom consignment which has arrived in the country will be cleared by National Drugs Authority (NDA). STAR-EC has already sent in its stock quantification.

The MARPs study results of March 2012 gave boda boda riders the second highest population estimates among MARPs groups in the East Central region after the fisher-folk category. Additionally, this group was reported to engage in multiple sexual relations more than any other group (excluding commercial sex workers) while at the same time they had the lowest proportion among those using condoms with such partners at last sexual intercourse. It is therefore very imperative to prioritize interventions for this group starting with Quarter 3 of this program year.

#### 2.1.6.5 Promotion of HIV Prevention through positive health dignity and prevention intervention among persons living with HIV in East Central Uganda

During Q2, the existing community support agents (CSAs) promoted and supported other PLHIV in the community to practice positive health dignity and prevention (PHDP) aimed at ensuring that PLHIV do not spread the virus. The following HIV prevention interventions were promoted; condom education and distribution, counseling on safer sex options, supporting HIV positive pregnant mothers to go for PMTCT, ART and adherence counseling, disclosure counseling and family planning among others. The approaches used to promote PHDP among PLHIV included; home to home, small peer support group sessions, community dialogue and interpersonal communication and counseling to support fellow PLHIV in the community to deliver PHDP interventions.

<sup>5</sup> Hidden populations are not easily accessible such as sex workers

# SUCCESS STORY

## Being young, HIV positive and with disability. What does it take?



*'It is because of the Namutumba Group that I can smile today.'* Kasadah Fahadi a 22 year old young positive (who is also blind) has finally found a shoulder to lean on in the support group for young positives. Fahadi's parents and only brother succumbed to HIV&AIDS in the early 2000s.

*'I have been blind right from birth but relatively healthy but in 2009, I started falling sick now and again. My uncle who works in Kakira Hospital in Jinja came to the village and took me for a medical check up where several tests were done and I was given some medication, but he did not disclose to me the findings or the reason I had to take regular medication. It was after time that I was introduced to the ART clinic where I discovered I was HIV positive and that both my parents and sibling had died of AIDS. I was so terrified of death especially because I was also blind; how was I to survive?,'* wondered Fahadi.

After Fahadi began ART he was taken back to his village in Namutumba. *'As an adolescent, life is very difficult. I fear to interact with girls or approach anyone because I am blind and I know they will discover that I am HIV positive. I have experienced social isolation. I dropped out of school. I keep begging...My relatives are even unable to provide for my needs, they have their own children.'*

Through PLHIV Namutumba branch, Fahadi was brought on board to work and support other young positives in the community. This has helped him share his experiences and he is now socially active with his peers who are young positives. He looks forward refocusing his life now that he cannot go back to school.

During Q2, a total of 8,013 PLHIV were reached (5,248 females and 2,765 males), of these 83% were reached more than once. A total of 11,620 (2,183 female condoms; 9,437 male condoms) were distributed to PLHIV in the community through 201 condom outlets.

### Challenges and Way Forward

The different psychosocial peer support groups for young positives and discordant couple clubs were unable to come together to share experiences; STAR-EC is working out a mechanism through the district PLHIV networks to support the psychosocial peer groups to routinely meet and share experiences and support each other in positive prevention.

### Lesson Learned

Without a clearer PLHIV structure on the ground to implement and co-ordinate PHDP interventions, it is difficult to provide peer support services to young positives and discordant couples in the community.

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



*Fishermen from Lake Victoria's Lolwe Islands, Namayingo going through group health education prior to receiving SMC services*

During Q2 (January – March 2012), STAR-EC utilized 18 health facilities to roll out SMC services in the region. The modes of service delivery employed by the supported district health facilities included static clinics, outreach services and circumcision camps. Sites initially located outreaches and camps at HC IIIIs, but this was later adjusted to extend some outreaches to school premises since these were closer to population masses. Fifteen of the 18 sites were supported to conduct static and outreach services while the three new sites only conducted static services. In addition, during World TB day celebrations, the 15 sites were supported to integrate SMC services on outreach basis to the commemoration venues. The program sent 12 service providers for training in the delivery of SMC services at the Kayunga Makerere University Walter Reed Project (MUWRP) site who contributed to the achievements of the quarter.

During this reporting period, STAR-EC worked with trainers from MUWRP to provide on-the-job training for service providers to roll out the Models for Optimizing the Volumes and Efficiency (MOVE) model which has increased the outputs at the current sites. The program procured anesthetic drugs and adjustable couches which have been very helpful in the scale up and the institution of the MOVE model. STAR-EC also received 5,000 pre-packed SMC disposable kits from USAID through JMS to help increase efficiency and outputs especially during outreaches.

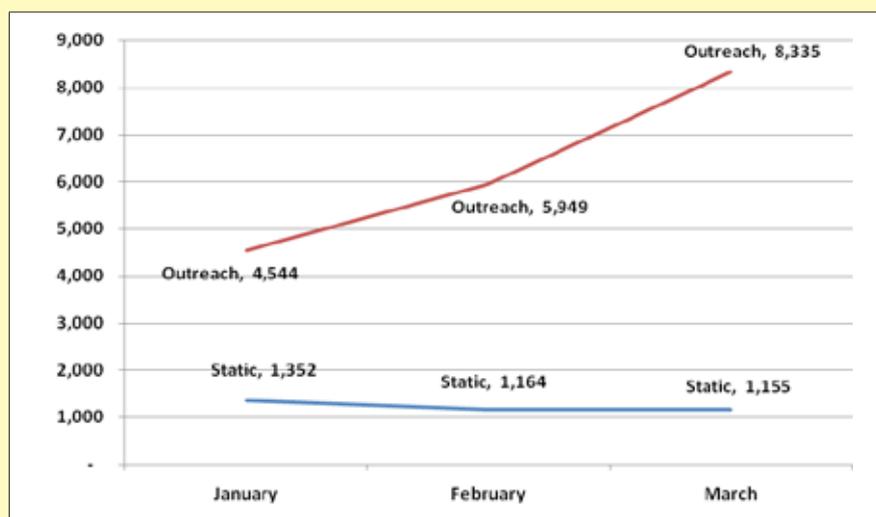


*SMC teams from East Central Uganda during the integrated service delivery visit to Lake Victoria's Lolwe Islands, Namayingo district*

Over this period, the program organized two circumcision camps in which other HIV&AIDS and TB services were integrated at Lolwe Islands, Namayingo district and Sagitu Islands, Mayuge district all found in Lake Victoria. Having learned from the main camps in the Islands, the program set out to initiate camps on the mainland in areas of high HIV prevalence and working through Bugono and Kiyunga HCs IV supported a circumcision camp at Bulongo, Luuka district.

Through the above-mentioned efforts, STAR-EC reached 22,499 clients with SMC services in East Central Uganda during this period thereby accounting for 90% of the Q2 SMC target of 25,000 circumcisions.

**Figure 9: Showing Q2 trend of roll out of SMC services in East Central Uganda by service mode**



As the scale up of outreach services grows, the program has begun to notice a decline in static attendance. This can be attributed to having reduced the distance which clients had to move towards the SMC sites. However, it has also relieved the pressure which SMC static services had placed on the same pool of health workers who still had to deliver other general outpatient and in-patient services at these sites.

#### Lessons Learned

- The MOVE model mentorships which started in late February enabled the program to reach more clients almost hitting 10,000 circumcisions per month.
- The mini camps have also proved promising and low cost compared to the circumcision camps to the islands.

#### Challenges

- There have been stock-outs of anesthetics coupled with the high cost of these drugs.
- The delay to roll out the MOVE model affected the numbers which could have been reached.
- High volume of waste generated from the disposable kits.

#### Way forward

The program will prioritize taking Safe Male Circumcision (SMC) services to MARPs at hotspots <sup>6</sup> of Naluwerere, Idudi, Busowa and Bulanga as well as high HIV prevalence areas such as islands and landing sites.

## 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 Support to strategic information collection and dissemination

#### 2.2.1.1 District performance reviews (DPRs)

STAR-EC conducted district led annual performance reviews for activities implemented between October 1, 2010 and September 30, 2011 covering nine STAR-EC supported districts. Additionally, PY4 Quarter I results were discussed. This review was combined with dissemination of results from the annual LQAS survey that was conducted in July 2011. During the event, participants shared program achievements and identified performance gaps, their causes including the most affected sites. Ultimately, district specific action plans directed to the affected

<sup>6</sup> MARPs Estimates and Behavioural Study in East Central Region of Uganda



*District staff taking lead on LQAS results dissemination and DPR discussions - Kaliro District*

sites were developed to address the challenges. A total of 275 district and CSO folks attended.

### **2.2.1.2. Data quality assurance audits (DQAs)**

STAR-EC conducted DQAs with focus on safe male circumcision (SMC) data. Due to the expansion of SMC interventions, there is an increasing amount of SMC data being collected. Henceforth, there was a need to audit it with an intention of improving and ensuring its quality. DQAs were done on both static and outreach data at nine purposively selected sites representing all the nine supported health facilities and districts namely: Kigandalo HC IV (Mayuge district), Bugiri Hospital

(Bugiri District), Buyinja HC IV (Namayingo District), Kidera HC IV (Buyende District), Kamuli General Hospital (Kamuli District), Bumanya HC IV (Kaliro District), Iganga Hospital (Iganga District), Nsinze HC IV (Namutumba District) and Kiyunga HC IV (Luuka District). Focus was placed on the nine facilities because they are high volume SMC data sites. The findings will be used to improve the quality of SMC data and planning in the region.

### **2.2.1.3. Routine support supervision through onsite mentorships**



*Mentorship on PMTCT data management-Magada HC III, Namutumba District*

During the quarter, SI provided support visits to various sites. The team developed an intergrated support supervision matrix to facilitate integrated support visits. The matrix helps to track the number of health facilities that have been supported (by both technical and SI folks) and nature of support provided on the monthly basis. It is anticipated that this matrix will strengthen coordination and effectiveness of the support supervision. Over the period, mentorships were extended to health workers on PMTCT data management at 45 ART sites. Emphasis was placed on understanding of PMTCT data collection tools, reporting and increased orientation of option B Plus. The team also prioritized support to the 19 newly accredited ART sites in the management of ART records including outreaches at Kandenge-lolwe and Singila HCs II on Sigulu Island.

### **2.2.1.4. Special studies**

STAR-EC carried out a special 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 study which involved 1,218 respondents aimed at obtaining baseline data on the estimates of 'key populations', size and types, knowledge, attitudes and practices of such key populations. The findings have been triangulated with other sources of data from LQAS surveys, health facility assessments, HMIS and routine program activities to identify health service gaps and thus "re-focus for impact" particularly for key populations in the remaining life of the project. Findings have already been disseminated to STAR-EC staff and USAID. Plans are

underway to have them disseminated to local governments, implementing partners and other channels including STAR-EC website in the subsequent quarters.

### 2.2.1.5. Meetings and workshops

**March 23, 2012:** Participated in the MEEPP organized Joint USAID and IPs meeting to update members on requirements for semi-annual report (SAR) 2012 and new PEPFAR indicators on gender mainstreaming. Following this, STAR-EC provided qualitative information on the indicators in the SAR. In the next quarter, SI will develop a specific tool to capture gender mainstreaming quantitative data to be reported in subsequent quarters.

**March 20- 22, 2012:** Participated in the national LQAS meeting organized by the Management Sciences for Health/ STAR-E LQAS project to share experiences and promote the institutionalization of LQAS methodology at district and national levels. During the event, STAR EC made a presentation on her experiences in implementing and utilizing LQAS findings in the region. STAR-EC facilitated eight districts officials from East Central region to attend the meeting. They included District Health Officers, Chief Administrative Officers, District Planners and senior Nursing Officers from the following districts: Bugiri (1), Kaliro (2), Kamuli (2), Mayuge (2) and Namutumba (1).

**February 27-March 2, 2012:** Participated in the training workshop on Alternative Methods for Project M&E at the Africana Hotel in Kampala. Workshop objectives were: (i) To understand and apply qualitative M&E concepts and tools to project cycle management (ii) To learn the principles and uses of different qualitative tools (iii) To understand the ways to analysis and use qualitative data and (vi) to identify opportunity for learning and adapting within the project cycle.

### 2.2.1.6. Information sharing at international level

In addition to the 12 abstracts presented at ICASA in the last quarter, STAR-EC this quarter, had another 12 abstracts accepted for presentation at the XIX International AIDS Conference (AIDS 2012) in Washington, D.C., 22-27 July 2012. This makes a total of 24 STAR-EC abstracts accepted in two consecutive quarters of PY4. The 12 abstracts accepted this quarter were;

#### Oral poster abstract

- Overcoming challenges in supply chain management amidst rapid scale up of anti-retroviral services.
- Poster abstracts
- What does it take to transition from one PMTCT prophylactic regimen to another? Lessons from East Central Uganda.
- Utilizing annual LQAS survey results in strengthening decentralized level planning and decision making: An experience on triangulating HMIS and LQAS data from a newly formed district in East Central Uganda.
- Innovative methods to promote couples HIV counseling and testing: A case study of utilizing certificates of recognition in East Central Uganda.
- Utilizing the quality improvement team approach in East Central Uganda to improve and scale up HIV and TB interventions within a resource limited setting.
- Strengthening eMTCT interventions in East Central Uganda through analyzing client outcomes: Local capacity building and continuous quality improvement involving mentor mothers.
- Moving from tens to thousands: How using multiple approaches in East Central Uganda is rapidly scaling up voluntary male medical circumcision in traditionally non-circumcising areas.
- Lessons from East Central Uganda for improvement of PMTCT and Early Infant Diagnosis (EID) service provision through strengthening of referral processes for mother-baby pairs.
- Improving the diagnostic capacity of peripheral laboratories in resource limited settings through PEPFAR:

Experiences from East Central Uganda.

- Fostering meaningful involvement of people living with HIV and AIDS (PLWHA) in health care service delivery: A case study of utilizing volunteer 'expert clients' at health facility level in East Central Uganda.
- Proactive assessment of people living with HIV (PLHIV) within the care setting enhances identification of clients with unmet contraceptive needs and their linkage to the service; A case study from East Central Uganda.
- Strengthening networks and referral systems to improve access to and utilization of HIV/TB and wrap-around services: Experiences from East Central Uganda.

These abstracts demonstrate STAR-EC success stories and innovations accruing from the implementation of the HIV/AIDS & TB program in the limited resource setting of East Central Uganda.

## 2.2.2 Improving Human Resources for Health

### Training of human resources for health (HRH)

During the reporting period, STAR-EC in collaboration with MoH conducted in-service trainings based on the needs identified. The trainings conducted included ARV logistics management training for the newly accredited ART sites, comprehensive PMTCT using the integrated management of adulthood illnesses (IMAI) and integrated management of pregnancy and child birth (IMPAC) model, condom promotion and education for boda boda riders, nutrition logistics training, pediatric counseling, pediatric HIV care and ART management, routine counseling and testing, as well as a refresher training on TB sputum microscopy. Others included a ToT for point of care CD4/PIMA machines and the third strengthening laboratory management towards accreditation. The numbers and personnel trained are clearly indicated under the different technical areas.

In response to the critical lack of health workers in the region, STAR-EC in collaboration with the Namayingo district health office secured approval to recruit 45 health workers that will be centrally supported by MoH through the deployment fund for a period of one year. It is anticipated that the district will be able to have secured enough wage bill to pay for these health workers. In furtherance of this STAR-EC supported enrollment of one health worker from Hama Islands Namayingo district to undertake a course on comprehensive nursing. This health worker has signed a binding agreement to work for the district after graduation. STAR-EC will continue collaborating with other partners like SDS, and the Uganda Capacity project to help the districts recruit health workers to fill the vacant posts approved by Ministry of Public Service.

## 2.2.3 Injection safety and Waste Disposal Interventions

During the reporting period STAR-EC in collaboration with AIDSTAR-One finalized plans to have a private firm take the responsibility of collecting medical waste to a central incinerator in Iganga District. This private firm is expected to start collecting medical waste beginning quarter three (April – June 2012). STAR-EC will continue providing on job mentorship to health workers on principles of injection safety and proper waste management.

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

In continued partnership with the MoH and in close consultation with the National Reference Laboratories, STAR-EC augmented efforts to strengthen capacity of health facilities in the region to provide essential diagnostic tests on site, and where applicable by referral of patients' specimens from peripheral health facilities to regional hubs for testing to enhance delivery of quality health care services. This has continuously led to increased access to laboratory diagnostic services in the East Central Region.

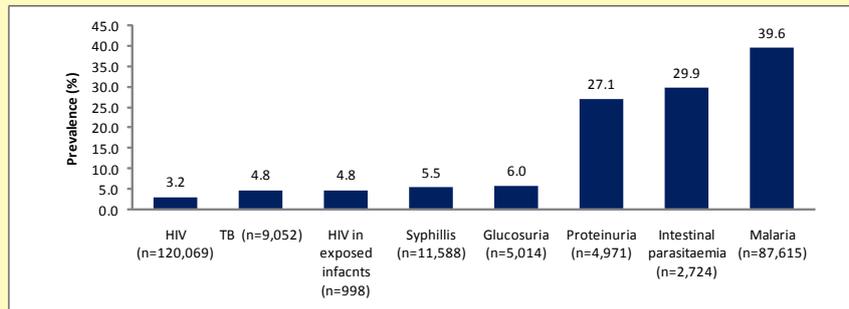
**List of interventions implemented to increase community access to diagnostic services during Q2 PY4**

<p>Implementation of external quality assurance scheme for TB and HIV testing (Figure 13)</p> <p>In-service training of laboratory services providers to enhance their skills. 24 trained in TB Sputum microscopy, 89 trained in Laboratory Logistics &amp; 4 attended Training of Trainers course for use and care of point-of-care PIMA CD4 machines</p> <p>Supported blood specimen referral for CD4 cells enumeration and DNA PCR for ART monitoring and HIV testing for exposed infants respectively</p> <p>Taking laboratory services to MARPs in hard-to-reach areas</p> <p>Provided technical mentorship and support supervision to laboratory staff</p> <p>Improved collection and correlation of laboratory performance data</p> <p>Carried out preventive service and repairs of equipment at 3 General Hospitals</p>	<p>Provided essential supplies to minimize interruption in TB and HIV&amp;AIDS diagnostic and related monitoring services</p> <p>Supported Strengthening Laboratory Management Towards Accreditation (SLMTA) for Kamuli, Bugiri and Iganga General Hospitals. Provided each with a desk top computer, mobile telephone sets, assorted stationery and facilitated 6 staff to attend the 3<sup>rd</sup> SLMTA workshop</p> <p>Participated in and provided technical support to a wide range of working groups/meetings convened by MoH for strengthening advocacy for laboratory services. These included: reviewing of the MoH Laboratory Quality Manual workshop, Infrastructure and Equipment Sub-Committee among others.</p>
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**Performance of STAR-EC supported health facility laboratories during Q2 PY4 based on data collected from the health information management system (HIMS 055b) in selected tests is summarized. The data showed that:**

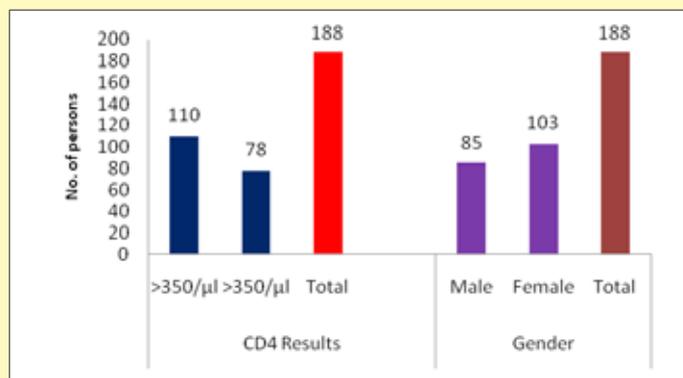
<p>HIV antibody screening (n= 120,069) and blood examination for malaria diagnosis (n=87,615) were the most performed tests</p> <p>Iganga and Namayingo districts reported the highest (n=23,703) and least (n= 8,563) number of HIV antibody tests performed respectively</p> <p>Apart from pregnancy (urine HCG), HIV antibody &amp; HIV DNA PCR tests, Kamuli District reported the highest number tests performed for the rest of the laboratory investigations</p> <p>Namayingo had the highest prevalence recorded from the lab for HIV (6.4%), Syphilis (10.1%) and intestinal parasitama compared to other districts</p>	<p>Districts with the lowest HIV prevalence recorded from the lab were Luuka (1.8%) and Kaliro (1.9%) respectively</p> <p>Iganga District had the highest TB prevalence (10.6%) while Kaliro registered the lowest at 2.2%</p> <p>Bugiri and Namayingo reported the highest prevalence of malaria (59.4% and 57.2% respectively) while Kamuli had the lowest (19.4%).</p> <p>The highest prevalence, 43.2% (n=185) of proteinuria and 9.3% (n=731) of glucosuria were reported in Buyende and Mayuge Districts respectively</p>
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**Figure 10: Q2 PY4 prevalence of clinical conditions based on laboratory tests reported**



Source: STAR-EC Program Records

**Figure 11: CD4 cells count tests performed for MARPs in hard-to-reach Islands of Sigulu during the integrated outreach conducted in Q2 PY4**

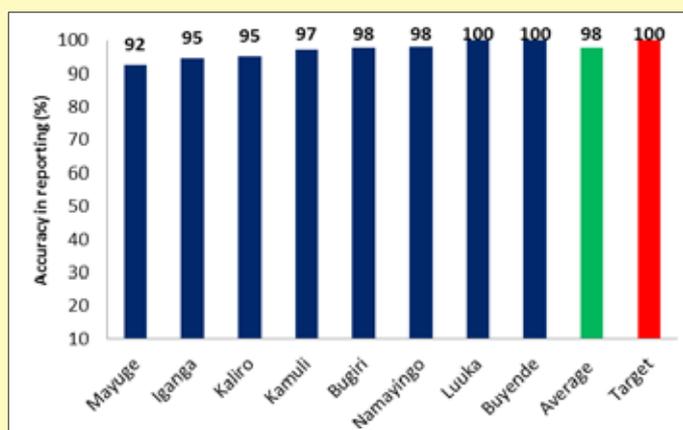


Source: STAR-EC Program Records

### Challenges

- Recurring shortages of laboratory diagnostics and related supplies continued to have a negative impact on service delivery.
- Health facilities continue to face gross under staffing against ever increasing workload.
- Long distances trekked by health workers to transport patients' samples from peripheral HCs to referral hubs for CD4 testing tends to stretch the lean human resource available. There is need to provide more hubs.
- Majority of the newly accredited ART HCs lack capacity to perform basic tests for ART management. Efforts are under way to bridge this gap.

**Figure 12: Performance in MoH TB external quality assessment by HCs from supported districts for Q1 PY4 (Q2 PY4 data to be reported in Q3 PY4)**



Source: STAR-EC Program Records

## 2.2.5 Ensuring Equitable Access to Medical Products

### Improving supply chain management

#### Capacity building of health workers in logistics management of health commodities

During the reporting quarter, STAR-EC collaborated with the Securing Ugandans' Rights to Essential medicines (SURE) program to train 13 Medicines Management Supervisors (MMS) from 6 districts in the Standardized Supervision, Performance Assessment and Recognition Strategy (SPARS). Following this, a meeting was held with DHOs, CAOs, MMS, and the pharmacy division to roll out the strategy and enhance district ownership. SPARS is aimed at augmenting the skills of health workers in management of health commodities through routine mentorship and coaching, joint identification of gaps and targeted step wise improvement.

STAR-EC in collaboration with ACP did an assessment of the 18 newly accredited ART sites to determine their supply chain needs. The major gaps identified included low capacity to handle commodities as well as inadequate LMIS (Logistics Management Information Systems) tools. Subsequently, 40 health workers (23 females and 17 males) were trained and the relevant logistics tools were distributed. Following this support, all the 18 sites submitted their bi-monthly ART orders in time for the NMS order deadline.

Additionally, 28 health workers (10 females and 18 males) were trained in logistics management for Ready To Use Therapeutic Foods. However, supply for new sites that were not under the NULIFE program has been erratic leading to interruptions in service delivery.

#### Improving storage for better logistics management

The program engaged district engineers as well as the district store managers to support 19 priority health facilities in six districts identified by the DHO to quantify storage needs for medicines stores (the SURE program will work to improve storage needs in the remaining three districts). Of the 19 facilities identified, six were newly accredited ART sites, seven were already existing ART facilities and the remaining six are chronic care sites. These facilities are grappling with increased quantities of HIV commodities as shown in photo below below due to rapid enrollment of clients. The program will in the next quarter support the provision of wooden shelving in these health centers in order to improve monitoring of supplies at the storage level in the supply chain cycle. In the meantime, health workers were supported to identify alternative space that could act as medicine stores.

#### Storage needs at some of the ART accredited sites



*Storage needs at some of the ART accredited sites ( Nawandala HC III and Busesa HC IV)*

**Table 11: Distribution of buffer supplies**

Item	Quantity	Recipient	Remarks
TB medicines	20 cartons	10 health centers	Support NMS to reduce lead time to facilities following availability
TDF/3TC 300/300mg	2,000 doses	20 sites	Supply from NMS following placement of emergency orders
SMC anaesthetics, circumcision kits	5,638, 17,040	18 SMC sites	Increased consumption due to outreaches and MOVE model.
Female condoms	840,000 pieces	FLEP, URHB, CSAs at 8 high volume health centers	CSAs at high volume centers acted as condom distribution points

Source: STAR-EC Program Records

### Challenges

- Recurrent stock outs of essential commodities such as cotrimoxazole, and CD4 reagents has led to decline in the number of people accessing chronic care services.
- Inadequate human resource in the districts to act as MMS. Consequently, four HSDs in two districts did not submit candidates to fill these positions.

### Way Forward

- Starting April 2012, STAR-EC will support the MMS in collaboration with the regional referral pharmacist to commence on supervision and performance assessment to improve logistics management of health commodities.

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



*The Ministry of health supervision team reviewing an ART register at Kiyunga HCIV*

### 2.3.1 Health Care Improvement

During the quarter, STAR-EC supported the MoH to conduct integrated support supervision in all the nine districts of the East Central region. In each of the districts, two facilities (both high volume and low volume) were assessed for delivery of services according to national guidelines, presence of policy documents, existence of district coordination structures, availability of supplies and reporting tools, staffing levels among others. Reports showed that most facilities implemented services according to national guidelines. There were no periods of stock outs of ARVs and Septrin although some few facilities had experienced stock out of test kits. This generally showed that logistics management at the facilities has greatly improved. In addition health facilities scored highly on records especially regarding the use of various data collection tools and general record keeping. The ability to have performance data



*District quality team of Buyende guides facility teams in documenting their improvements while the Bugiri teams gets introduced to the 5S principle of improving health care*

displayed in various clinics was commended as it reflected greater involvement of health workers in health care management.

### **Facilitating change through sharing best practices**

Collaborative learning sessions have served as opportunities to share achievements and learn best practices.

Over the reporting period, STAR-EC supported nine districts to hold district based learning sessions. All 84 facilities supported in implementation of quality improvement activities presented their tested changes a process that was led by the district quality teams and presided over by the respective DHOs. This interaction enabled appreciation of the district leadership of the efforts put in by health workers to improve health care and also served as an opportunity to front the challenges faced by the health workers.

### **Addressing the quality of health care through improvement projects**

During the reporting period, STAR-EC adopted an approach of engaging facility teams in competitively improving areas of weakness as identified by analysis of program data. Among the projects launched is the 5S principle of quality improvement; Family planning, HMIS reporting and tracing 'lost to follow up' clients. These have been implemented in the high volume sites and results of these projects will be shared during the next reporting period.

#### **Lessons Learned**

Districts based learning sessions increase district participation in quality improvement and encourage ownership of quality improvement activities by the district leadership. Facility teams are also motivated to share with district authorities and look forward to appreciation of their efforts.

#### **Way Forward**

The program will continue promoting quarterly district based learning sessions and improvement projects to further promote competition between facilities and involvement of the district.

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

### **2.4.1 Strengthening capacity of Village Health Teams (VHTs):**

The Village Health Team (VHT) strategy was established by the MoH to work as a vehicle through which basic health care services are delivered to households in the community. This quarter, STAR-EC supported four districts to



*VHT training in Waibuga Luuka district*



*VHT Trainer of Trainers course at YMCA*

identify and train 30 trainers of trainers (TOTs) for the roll-out of VHT training in their respective sub-counties according to the MoH guidelines. The training that lasted five days and attracted 30 participants from among 13 sub-

counties of the 4 districts Namayingo, Kaliro, Mayuge, and Luuka. VHTs TOTs were trained in basic health promotion packages as well as other add-on modules that meet community health needs.

The districts of Kaliro, Luuka, Mayuge, and Namayingo were supported to conduct sensitization, selection and training of VHTs. Kaliro district trained 50 VHTs from Kaliro Town Council while the VHTs trained from Mayuge district were selected from the islands of Jagusi, Kaaza, Serinyabi, Bumba, and Sagitu. In total, 103 VHT members were trained from Mayuge district while in Luuka district, 270 VHTs were trained from the sub-counties of Waibuga, Bulongo, and Kiyunga Town Council. The VHTs were trained in the five core tasks of recording and examining, conducting home visits, helping to save lives, linkages and referrals between the village and the health unit, community mobilization, and holding monthly review meetings. The VHTs will play key roles of conducting referrals and tracking clients referred to and from the nearest health facility; this will eventually reduce clients lost to follow-up. VHTs are also expected to engage their communities to actively take part in improving their own health by preventing ill-health and protecting their environments.

As a follow up, to ensure that the trained VHTs provide high quality services, during the integrated service delivery visit to Sigulu (Lolwe Islands), STAR-EC conducted a one-day orientation of 80 VHTs on referrals, networking, and community mobilization. During the orientation meeting, 80 VHT registers and umbrellas were distributed as a means of facilitating service delivery and proper records keeping.

STAR-EC identified 100 model VHTs from three model districts. They were all provided with referral forms, VHT registers, and Health Management Information System (HMIS) reporting tools which they use to capture information and report to the MoH. STAR-EC procured 100 raincoats and gumboots which will be distributed to them in the next quarter as further motivation to facilitate effective mobilization and referrals.

### **2.4.2 Strengthening the Capacity of Civil Society Organizations (CSOs):**

During this quarter, technical support supervision for mentorship and coaching was organized to support the STAR-EC grantees and People Living with HIV&AIDS (PLHIV) networks. The organizations visited included FLEP, URHB, Youth Alive, MUCOBADI, FOCREV, IDAAC, and YAWIA, as well as the nine district networks of PLHIV. Each organization was represented by the Chief Executive Officer, head of programs, finance and administration, and other project staff. Thirty-five CSO staff and 45 PLHIV leaders across the nine districts participated in this exercise. A comprehensive support supervision tool was developed basing on the organizational capacity assessment tool domains and the capacity building plans developed by the CSOs. The facilitators visited the organizations for two days each and held focus group discussions. Individual technical support was provided to address unique gaps as raised in the OCA. The objectives for the mentorship and coaching for the CSOs were as follows; to review progress made on organizational development issues; equip CSO leaders with hands-on skills in organizational development; review the draft integrated support supervision tool for CSOs; offer hands-on support on outstanding organizational development issues; and to support the CSOs to draw clear and specific action plans as a way forward on organizational development. The mentorship focused on areas of governance, management systems and practices, financial management, sustainability, information systems, performance management, monitoring and evaluation, partnership and networking, and service delivery as categorised during the OCA. These were looked at with respect to their availability, functionality and competence to operationalize them. Among the emerging issues from the exercise is that most organisations have developed draft strategic plans and are at various stages of development, with some awaiting approval from their Boards of Directors. Some of the organisations have not been able to attract and retain competent personnel due to inadequate remuneration packages.

### **2.4.3 Strengthening the capacity of people living with HIV coordination structures**

STAR-EC provided the District Forum of PLHIV in each of the nine districts with running costs in order to maintain their offices and further supported them to conduct quarterly support supervision visits (including visits to lower

level structures in order to take count of PLHIV concerns in the community and devising means of improving their status) and conducting district based quarterly review meetings. Through these meetings, they share information on psychosocial support, lobbying and advocacy issues, coordination and resource mobilization for PLHIV in the region.

#### **2.4.3.1 PLHIV Water Sanitation and Hygiene (WASH) support supervision:**

This quarter, support supervision and follow-up visits were organized to offer technical support to the PLHIV trained in WASH in the four key water, sanitation, and hygiene (WASH) practices including treating, safely transporting, storing, and serving of drinking water, safe handling and disposal of feces, safe handling and disposal of menstrual blood, and hand washing with soap or ash and water, and demonstrating actions required to implement the WASH practices in home-based care.



*Bugiri WASH coordinators during mentorship & support supervision*

During the support visit, it was discovered that most PLHIV households have adopted WASH practices and have significantly reduced opportunistic infections due to improved WASH practices. Over 300 tippy taps have been constructed in some health facilities, schools, guest houses, and PLHIV households while in the districts of Luuka and Bugiri PLHIV have worked with the LCs to increase latrine coverage. The PLHIV home-base care providers were trained on how to intensify the WASH campaigns during their

home to home visits and other public functions where they play a coordination role. They were also advised to bring political leaders at all levels on board to enforce regulations such as ensuring that each household has a pit latrine to control spread of diarrheal diseases.

#### **2.4.4 Strengthening networks and referrals at community level**

In an effort to increase access to, coverage of, and utilization of HIV&AIDS and TB services in the region, STAR-EC has continued to promote effective referrals and networking 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 and ensuring documentation and follow-up of all referred cases to the different service centers, the results, to date, about referrals and networks indicate that 11,763 (7,075 females and 4,688 males) individual clients were referred for different services where 6,180 were children below 18 years of age.

##### **2.4.4.1 Improving Intra-inter Facility Referral Linkages**

During this quarter, STAR-EC supported the nine districts to conduct networking coordination quarterly meetings at Health Sub district level which aimed at strengthening inter-facility referrals. These meetings attracted participation from all HCs, (from health centre II), VHT leaders, CSOs, and PLHIV structures. As a result, HCsII were brought on board to conduct referrals primarily for PMTCT to higher levels in order to improve on PMTCT performance in the region.

STAR-EC, as a follow-up on the last program year's intervention to engage four facilities as model facilities to improve intra-referral linkages and improving clients retention, during this quarter (PY4Q2), more 14 facilities (high volume ART/PMTCT) were brought on board. STAR-EC is facilitating CSAs to conduct active clients tracking

and supporting internal clients flow at the supported health centers. This has shown improvement in documentation and strategies have been laid among m2m, expert clients, health workers, CSOs, and VHTs to improve on client retention.

Further still, STAR-EC printed 1,000 copies of referral forms and 200 copies of referral registers. Half of these have already been distributed to CSOs and health centers with a few copies to VHTs to facilitate the referral process. The remaining copies are planned to be distributed next quarter.

**Table 12: TB and HIV&AIDS services for which individuals were referred Vs received services for the period January- March 2012**

Referral Type	Total services referred for per type	Total Services Received per type	% of received services per type
1. HCT	2,428	2,264	93
2. Care and Support	671	607	90
3. ANC services	870	716	82
4. PMTCT ( Counseling, testing, ARV Prophylaxis, infant feeding counseling)	708	673	95
5. HAART Services (ART, ART Adherence, CD4, )	1,140	1,133	99
6. TB screening/ Treatment	1,142	1,059	93
7. Treatment for other Medical Conditions	5,091	4,701	92
8. STI services	652	604	93
9. Psychosocial support ( PLHIV group services, Youth groups, discordant couple services, Post test clubs)	427	352	82
10. Safe Medical Circimcision	988	860	87
11. Family Planning	1,068	973	91
12. Homebased care	147	133	90
13. Wrap around services ( Food& Nutrition services, Material support, Education support , legal support, Micro finance, IGAs)	637	474	74
14. Others Specify	551	424	77
<b>Total</b>	<b>16,520</b>	<b>14,973</b>	<b>91</b>

Source: STAR-EC Program Records

### Challenges

- Inadequate skills by the VHT coordinators in collecting, analysing, reporting, and utilising data from the VHT registers
- Inadequate funding for the CSOs has inhibited most of the CSOs from implementing key capacity building interventions for sustainability
- Lack of essential commodities for the promotion of WASH such as jerricans and safe drinking water vessels by major households became a stumbling block towards effective use of WASH practices. This is attributed to poverty where a majority of households in communities lack essential necessities of life.

### Way Forward

- The MOH should conduct regular support supervision to mentor VHT leaders in data collection and utilisation
- CSOs should be supported in strengthening their skills in resource mobilisation and management
- The PLHIV networks should lobby for support to acquire home-based care kits to improve water sanitation and hygiene, especially for bedridden clients.

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



*A health worker hands over a sputum mug to a TB suspect during a sputum outreach in Namayingo district*

During this reporting period, the STAR-EC program continued to reach targeted audiences with relevant messages through: targeted activities; Information Education and Communication (IEC) materials and job aides; interactive one-hour radio program; 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 disseminate TB and HIV&AIDS messages.

### **Applying innovative strategies to improve TB case detection in East Central Uganda**

Borrowing from the successes of the couple HIV Counseling and Testing week campaign, STAR-EC conducted a TB campaign with sputum collection across the nine districts in East Central Uganda. This campaign

that utilized schools health facilities and outreaches up to parish level was designed to contribute to Advocacy Communication and Social Mobilization (ACSM). Mobilization employed a multi-pronged approach which included; the use of VHTs and sub-county health workers to trace TB suspects using index clients, use of a one-hour interactive radio program dedicated to discussing and disseminating TB related information, radio announcements directing people where to get TB information and services and use of a mobile track mobilizing communities for sputum outreaches.

In addition, TB sputum outreaches were organized in hard to reach places with likely TB pockets, places with high HIV prevalence rates and households with TB clients on treatment. A total of 3,564 suspects were identified



*Branding of boats with health messages at Sigulu Island*

in nine districts during this campaign and out of these 81 clients were identified with TB. All suspects were also tested for HIV and 85 patients tested HIV positive. All patients with TB and HIV were linked to care and treatment services.

### **Dissemination of health messages on boats**

During the quarter, 90 boats were painted with health messages on Sigulu Island encouraging fisher folk to test for HIV, use condoms correctly and consistently, reduce sexual partners, and test and treat for STIs. TB prevention messages were also painted on some boats. This dissemination channel reinforces messages disseminated through conventional approaches such as print materials (the brochures, posters and the radio).

### **Augmenting mobilization strategies through puppetry**

CDFU augmented the community mobilization drives for the couple HTC campaign with puppetry performances in Iganga, Bugiri and Namayingo districts. Puppet shows carried out in selected communities worked as a crowd puller for community members to couple HIV testing and counseling outreach sites. As such, it contributed towards addressing gaps of low turn up for couples HTC in the communities

### **i) Intensifying demand through Information Education and Communication (IEC) materials and Job aides**

In an effort to increase demand for services as well as contributing to close of knowledge gaps, STAR-EC disseminated the following IEC materials during this reporting period:

- 15,700 brochures (7,000 Luganda and 8,700 English) on facts about SMC.
- 1,500 SMC posters.
- 60 grain sack SMC flipcharts (for community mobilization).
- 4,000 copies of couple HTC Luganda leaflets received from HCP.
- 3,000 couple HTC certificates.
- 200 STI posters received from the MoH.



*One of the puppet shows at Lugala landing site in Namayingo District*

The disseminated IEC materials re-enforce messages discussed during health talks at the health facilities and VHT interaction with other community members. The posters displayed on the health facility walls and other public places contribute towards closing comprehensive HIV & TB knowledge gaps in the region.

### **ii) Creating demand for services through the interactive One-hour Radio program**

During the quarter, STAR-EC continued to support a 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. Health professionals, VHT members, beneficiaries of health services such as SMC were among the guest speakers. A total of 13 interactive radio talk shows were aired during this period and the topics covered included PMTCT /EID, TB prevention, care and treatment, SMC and couples HCT.

A female caller from Bugiri testified, "When I listened to the discussion on SMC, I really understood the health reason for circumcising men and because of the information I got, I was able to convince my husband to go for the service. Thank you very much for educating us."

### **iii) Commemoration of World TB Day**



*Community members returning sputum mugs for analysis during World TB day Celebration in Namutumba*

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 TB day. The events officiated by different district leaders<sup>7</sup> provided a range of services including health promotion through drama and testimonies by TB recovered clients and PLHIV, TB screening and HTC services, SMC and reproductive health services. In total, 384 people were suspected for TB and 11 people tested positive for TB. Additionally, t-shirts and caps (450 each) were distributed as promotional materials for the commemoration.

#### **iv) Working with other partners to change behaviour**

Working with Uganda Health Marketing Group, STAR-EC has replicated the 'Get off the sexual network' campaign in the East Central region. The campaign is targeted to the general population and the MARPs to reduce the number of sexual partners that put them at risk of acquiring HIV. The East Central region has been highlighted in the AIDS Indicator survey by the Ministry of health as having the highest number of multiple concurrent sexual partnerships. A radio spot aimed at creating awareness of the 'Get off the sexual network' campaign and the dangers of having many sexual partners is being aired on two regional radio stations. STAR-EC and prequalified CSO HIV prevention staff have been oriented on the campaign and the 'Get off the sexual network' game that stimulates a discussion on the dangers of having multiple concurrent partners.

#### **Lessons Learned**

Continued partnerships with other communication initiatives in the country reduce re-invention of the wheel and avoid duplication.

#### **Challenges**

Given that most of the key population like the fisher folk and commercial sex workers are mobile there is need to have continuous communication interventions in order to appropriately reach the changing population.

#### **Way Forward**

- A focused approach to link all BCC activities with key program areas for prevention, care and support will be encouraged. More communication intervention especially among the key populations will be prioritized.
- Scaling up of proven interventions with reduce costs but reaching specific key populations with appropriate messages will be the way to go.

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<sup>7</sup> LCV chairpersons, Chief Administrative officers and Resident District Commissioners

## 3.0 Grants and Sub-Awards

### Pre-qualified CSOs

The three prequalified grantees namely URHB, FLEP and Youth Alive Uganda continued to actively support the implementation of STAR-EC activities through provision of various services as summarized in the table below:

**Table 13: Pre-qualified CSOs coverage of the districts by technical intervention areas**

Civil Society Organizations	Intervention Areas	Districts of Operation	No. of Sub Counties Covered
Family Life Education Program (FLEP)	HTC, AB, OP and CM	Kamuli	2
		Luuka	3
		Mayuge	6
Uganda Reproductive Health Bureau (URHB)	HTC, TB/HIV, AB and OP	Bugiri	6
		Namayingo	1
Youth Alive Uganda (YAU)	CM, AB, CP and HTC	Kamuli	7
		Namutumba	4
		Kaliro	2
		Iganga	7
		Luuka	4
		Buyende	4

Source: STAR-EC program records

Grants and technical staff worked with NACWOLA management to finalize the close out modalities of NACWOLA grant. The planned formal arrangements to work with the grassroots PLHIV structure of CSAs to continue provision of services previously offered by NACWOLA are still underway. The grants team conducted ten visits to provide finance monitoring, mentoring and support to the partners and districts as well as compilation of cost share contributions. This effort has resulted in capturing and reporting substantial amounts of cost share by the program.

### Partners

The four subrecipients, Bantwana Initiative, Communication for Development Foundation Uganda (CDFU), Uganda Cares (UC) and mothers to mothers (m2m) continued implementation of program activities. During the quarter, CDFU augmented community mobilization drives for Couples' HCT campaigns with puppetry performances in three districts to act as a message dissemination channel as well as a crowd puller for community members and couples to the HTC outreach sites. Bantwana Initiative carried out mentorship and coaching of CSOs in organizational development and strategic planning, organized ToT for VHTs in and oriented the VHTs on referrals and networking strategies. In addition, they supported the PLHIV Networks to conduct monitoring, support supervision and quarterly review meetings and organize joint quarterly meetings at health facilities for referrals.

Uganda Cares (UC) carried out a comprehensive HIV care training (IMAI) for staff, mentored Volunteer Expert clients on adherence counseling and support and offered clinical support supervision for ART clinics in hospitals. UC recruited a replacement for an HIV Specialist for STAR-EC. m2m carried out a consultancy on the 2010/2011 Uganda cohort outcome of data analysis for the data generated in their implementation sites. They trained newly registered mentor mothers on PMTCT handling and all mentor mothers on a new initiative of active client follow up.

### Civil Society Organizations (CSOs)

During this quarter, STAR-EC worked on refining the proposals of the new selected CSOs and submitted to USAID

## APPENDIX

### Appendix 1: Health workers trained per technical area

TECHNICAL AREA	F	M	Total
ART PEDIATRIC	46	16	62
CLINICAL ADDITIONAL PEDRIATRIC	26	5	31
HCT	24	8	32
LAB SERVICES	6	28	34
PMTCT	57	27	84
SEXUAL & OTHER BEHAVIOUR RISK REDUCTION	0	10	10
SUPLIES CHAIN MANAGEMENT	33	35	68
<b>Grand Total</b>	<b>192</b>	<b>129</b>	<b>321</b>

### Appendix 2: corresponding prevalence in Q2 PY4

Type laboratory tests		Number of tests reported per District									TOTAL (Average)
		BUGIRI	BUYENDE	IGANGA	KALIRO	KAMULI	LUUKA	MAYUGE	NAMAYINGO	NAMUTUMBA	
HIV antibody screening	Total tested (Prevalence)	14,553 (3.2%)	12,274 (3.8%)	23,703 (2.4%)	10,411 (1.9%)	22,355 (2.9%)	9,631 (1.9%)	9543 (3.9%)	8,563 (6.4%)	9,036 (2.7%)	<b>120,069 (3.2%)</b>
HIV DNA PCR	Total tested (Prevalence)	142 (7.7%)	65 (7.7%)	146 (7.5%)	73 (2.7%)	156 (0.6%)	46 (0.0)	198 (8.1%)	75 (6.7%)	97 (2.1%)	<b>998 (4.8%)</b>
TB testing (Sputum ZN)	Total tested (Prevalence)	1,440 (4.3%)	734 (5.0%)	1,368 (10.6%)	997 (2.2%)	1,548 (4.7%)	774 (3.1%)	595 (5.7%)	583 (3.6%)	1,013 (3.8%)	<b>9,052 (4.8%)</b>
Syphilis antibodies	Total tested (Prevalence)	1,181 (6.9%)	364 (5.5%)	1,231 (4.7%)	1,030 (2.7%)	3,197 (3.2%)	2,406 (4.3%)	1,046 (6.0%)	415 (10.1%)	718 (6.0%)	<b>11,588 (5.5%)</b>
B/S for malaria	Total tested (Prevalence)	10,946 (59.4%)	3,147 (47.2%)	16,508 (37.8%)	6,463 (46.1%)	23,524 (19.4%)	5,608 (34.3%)	10,104 (47.6%)	4,858 (57.2%)	6,457 (57.2%)	<b>87,615 (39.6%)</b>
Stool exam for Intestinal parasites)	Total tested (Prevalence)	500 (28.4%)	113 (44.2%)	188 (6.4%)	189 (20.1%)	653 (17.9%)	164 (22.0%)	610 (31.0%)	129 (49.6%)	178 (49.4%)	<b>2,724 (29.9%)</b>
CD4 cells count	Total tested (CD4<350/ $\mu$ l)	1,497 (32.5%)	379 (39.6%)	754 (28.0%)	250 (36.0%)	1,790 (37.7%)	229 (13.1%)	328 (19.5%)	192 (29.2%)	406 (15.8%)	<b>5,825 (27.9%)</b>
Hb Estimation	Total tested	562	87	1,714	227	2,745	148	76	201	187	<b>5,947</b>
WBC total count	Total tested	197	0	250	0	45	0	0	0	0	<b>492</b>
Blood Grouping	Total tested	482	2	1,075	40	1,799	0	60	18	0	<b>3,476</b>
Pregnancy test (Urine HCG)	Total tested (Prevalence)	281 (33.5%)	526 (37.8%)	331 (36.3%)	161 (32.3%)	450 (30.7%)	81 (21.0%)	107 (21.5%)	92 (39.1%)	70 (48.6%)	<b>2,099 (33.4%)</b>
Urine Protein	Total tested (Prevalence)	867 (31.6%)	185 (43.2%)	448 (29.0%)	396 (23.2%)	1,531 (13.6%)	237 (20.7%)	731 (27.2%)	200 (27.5%)	376 (27.7%)	<b>4,971 (27.1%)</b>

Type laboratory tests		Number of tests reported per District									TOTAL (Average)
		BUGIRI	BUYENDE	IGANGA	KALIRO	KAMULI	LUUKA	MAYUGE	NAMAYINGO	NAMUTUMBA	
Urine Glucose	Total tested (Prevalence)	864 (7.6%)	185 (8.6%)	462 (2.8%)	397 (5.0%)	1,548 (5.8%)	252 (7.5%)	731 (9.3%)	205 (3.4%)	370 (3.8%)	<b>5,014</b> <b>(6.0%)</b>
Blood Glucose	Total tested	372	12	131	6	513	55	0	1	33	<b>1,123</b>
Liver Function Tests	Total tested	11	0	0	0	52	0	0	0	7	<b>70</b>
Renal Function Tests	Total tested	12	0	0	0	119	0	0	0	8	<b>139</b>







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