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

PROGRAM YEAR V, QUARTER 1 PROGRESS REPORT
October 1, 2012 – December 31, 2012



Funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. 617- A-00-09-00007-00





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This program is implemented by JSI Research & Training Institute Inc., in collaboration with World Education's Bantwana Initiative, Communication for Development Foundation Uganda, mothers2mothers, and Uganda Cares.

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List of Acronyms

ABC	Abstinence, Being Faithful and Condoms
ACSM	Advocacy Communication and Social Mobilization
AIDS	Acquired Immuno-deficiency Syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
BCC	Behaviour Change Communication
BIWIHI	Bukhooli Island Women Integrated Health Initiative
BMU	Beach Management Unit
CB DOTS	Community Based Directly Observed Treatment – Short course
CBOs	Community Based Organizations
CD4	Cluster of Differentiation 4
CDFU	Communication for Development Foundation Uganda
CDR	Case Detection Rate
CPT	Cotrimoxazole Prophylaxis Therapy
CPHL	Central Public Health Laboratory
CSAs	Community Support Agents
CSO	Civil Society Organization
CSWs	Commercial Sex Workers
DHO	District Health Officer
DHT	District Health Team
DPRs	District Performance Reviews
DTLS	District Tuberculosis and Leprosy Supervisor
DQA	Data Quality Assessment
EID	Early Infant Diagnosis
eMTCT	Virtual elimination of mother-to-child transmission of HIV
EMR	Electronic Medical Records
FLEP	Family Life Education Program
FOC-REV	Friends of Christ Revival Ministries
FP	Family Planning
FSG	Family Support Group

GBV	Gender Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	Home based care
HC	Health Centre
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information Systems
HSHASP	Health Sector HIV/AIDS Strategic Plan
HSSI	Health Sector Strategic and Investment Plan
HSD	Health sub-District
HTC	HIV Testing and Counseling
ICF	Intensive Case Finding
IDI	Infectious Disease Institute
IEC	Information, Education and Communication
IPT	Isoniazid Preventive Therapy
JCRC	Joint Clinical Research Centre
JDHO	Jinja Diocese Health Office
JMS	Joint Medical Store
JSI	JSI Research & Training Institute, Inc.
LC	Local Council
LQAS	Lot Quality Assurance Sampling
MARPs	Most-at-risk populations
MCPs	Multiple Concurrent Partnerships
MDR	Multi-drug resistant Tuberculosis
MEEPP	Monitoring and Evaluation of Emergency Plan Progress
MoH	Ministry of Health
MOVE	Models for Optimizing Volumes and Efficiency
MTCT	Mother-to-child transmission of HIV
MUWRP	Makerere University Walter Reed Project
NAADS	National Agricultural Advisory Services

NAFOPHANU	National Forum for People Living with HIV&AIDS Networks in Uganda
NBS	Nile Broadcasting Services
NMS	National Medical Stores
NTLP	National Tuberculosis and Leprosy Program
NTLRL	National Tuberculosis and Leprosy Reference Laboratory
OPD	Out Patients Department
PCR	Polymerase Chain Reaction
PEP	Post exposure prophylaxis
PHDP	Positive Health Dignity and Prevention
PICT	Provider Initiated Counseling and Testing
PLHIV	Persons Living with HIV&AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
PNFP	Private not-for-profit
PY	Program Year
QI	Quality Improvement
SACCOs	Savings and Credit Cooperative Organizations
SCORE	Sustainable Comprehensive Responses for Vulnerable Children
SDS	Strengthening Decentralization for Sustainability program
SIWAAO	Sigulu Women AIDS Awareness Organization
SLMTA	Strengthening Laboratories Management Towards Accreditation

STAR-E	Strengthening TB and HIV&AIDS Responses in Eastern Uganda
STAR-EC	Strengthening Tuberculosis and HIV&AIDS Responses in East Central Uganda
STIs	Sexually Transmitted Infections
SURE	Securing Uganda's Right to Essential Medicines project
TB	Tuberculosis
THALAS	Targeted HIV/AIDS and Laboratory Services
TSR	Treatment Success Rate
UDHA	Uganda Development and Health Association
UHMG	Uganda Health Marketing Group
URHB	Uganda Reproductive Health Bureau
USAID	United States Agency for International Development
UVRI	Uganda Virus Research Institute
VMMC	Voluntary Male Medical Circumcision
VHTs	Village Health Teams
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

The program put a lot of emphasis towards enhancing linkage of clients to other relevant services during this quarter. This was mainly done through use of linkage facilitators ('mentor mothers,' 'expert clients,' and 'community support agents') working closely with village health teams. Consequent upon this effort and as elucidated in previous paragraphs, 2,591 (78.4%) of HIV positive individuals were directly linked into care and treatment services over this quarter.

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; tracking and evaluating the progress of project interventions; mitigating stock-outs of essential supplies through continued technical assistance and utilization of the USAID supported centralized procurement mechanism; as well as the continued provision of targeted capacity building to both local governments and civil society organizations (CSOs) in those areas that will foster sustainability beyond STAR-EC's program life. Despite the impressive results registered during this quarter, implementation continued to face a number of draw backs. There were stock outs of anesthetics at some VMMC sites and a prolonged shortage of HIV test kits and CD4 diagnostics for PIMA machines.

Table 1: Summary of STAR-EC Results Vs Targets

Intervention area	Key Indicators (Numbers)	Achievements (Number of Individuals served)										Comments
		PY1* (implementation from July 2009 -Sept 2009)	PY2 (Oct 2009 - Sept 2010)	PY3 (Oct 2010 - Sept 2011)	PY4 (Oct 2011 - Sept 2012)	PY5, Quarter 1 (Oct-Dec 2012)	End of PY5 target	% of PY5 targets achieved	New EOP targets (till PY5 end)	Program Cumulative achievements to date (total PY1*, PY2, PY3 and PY4)	% of end of Program Life Target achieved	
HIV Testing and Counselling (HTC)	Individuals who received HTC and their results (including pregnant women &PNC numbers)	10,376	178,303	447,532	461,544	155,140	654,920	24	1,907,815	1,252,895	66	Indicator measures overall HTC services provided at both static and outreach sites including individuals, couples, young people, pregnant women and those served during post-natal care.
	Individuals who received HTC and their results (excluding pregnant women & PNC numbers)	10,376	178,303	330,966	335,662	119,076	562,000	21	1,536,383	974,383	63	2.8% (3,304 individuals) were diagnosed HIV positive. Overall, 2,591 (78.4%) HIV positive individuals were directly linked into care and treatment services during this quarter.
	Individuals trained in HTC	64	256	356	32	0	0	0	742	708	95	The program conducted sufficient trainings in its early stages which facilitated meeting and exceeding EOP life targets for this indicator. Thus, training of more HTC health workers in PY5 is not a program priority until a needs assessment deems so. However, on-job support supervision of trained workers will continue till end of program life.
	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)	123 static and 239 parishes (outreach sites)	114 static and 80 parishes	123 static	93		140 static sites	% of static sites targeted	The supply of HIV test kits was erratic in some health facilities thus the failure to have services in all targeted health facilities during the quarter

Intervention area	Key Indicators (Numbers)	Achievements (Number of Individuals served)										Comments
		PY1* (Implementation from July 2009 -Sept 2009)	PY2 (Oct 2009 - Sept 2010)	PY3 (Oct 2010 - Sept 2011)	PY4 (Oct 2011 - Sept 2012)	PY5, Quarter 1 (Oct-Dec 2012)	End of PY5 target	% of PY5 targets achieved	New EOP targets (till PY5 end)	Program Cumulative achievements to date (total PY1*, PY2, PY3 and PY4)	% of end of Program Life Target achieved	
PMTCT	Pregnant women with known HIV status (includes tested and received results) excluding PNC	No Implementation during PY1	65,983	104,689	109,746	31,425	92,920	34	404,763	311,843	77	A total of 36,064 ANC, L&D and PNC women were served and received results (29,501 during ANC; 397 with known & documented results; 1,527 labor&delivery and 4,639 PNC). Scale up to HCs II has duly increased mothers accessing this service.
	Pregnant women who received ARVs to reduce the risk of mother to child transmission	No Implementation during PY1	1,759	3,418	3,660	760	2,540	30	12,137	9,597	79	Out of 900 HIV+ pregnant women; 760 were given ARVs for PMTCT during ANC 'only'. As planned by MoH, implementation of Option B+ in the East Central region is slated to start during June 2013
	Persons trained for PMTCT	No Implementation during PY1	177	621	84	0	400	0	882	882	100	No training during quarter but 66 HWs were oriented on male involvement and male participation with support from the MoH. During the scale up of eMTCT, more HWs from new PMTCT sites will be trained while all past trained personnel will be oriented on eMTCT
	Service outlets providing PMTCT	No Implementation during PY1	68	83	94	85	118	72	118	118	100	Annual target could not be achieved as some health facilities (HCs II) were found not to have enough capacity to provide PMTCT services. Such service outlets will be targeted during subsequent quarters to cater for eMTCT demands.
Sexual and Other Behavioral Risk Prevention (General Population)	Targeted population reached with sexual prevention messages (ABC +MARPs)	51,916	132,011	185,776	117,858	21,709	275,840	8	763,401	509,270	67	A total of 31,240 individuals in Q1, PY5 received Risk Reduction counseling (previous years' data is on AB only). These included 4,553 MARPs, 17,156 couples and young people and 9,531 emerging MARPs. Messages included taking an HIV test in accordance with the risk profiles of those individuals. Only three CSOs compared to eleven the previous PY provided these services.
	Individuals trained to provide sexual prevention services	234	564	298	0	0	0	0	1,096	1,096	100	There were no new CSO personnel to be trained during this quarter. The pool of peer educators under pre-qualified CSOs were trained in during previous years

Intervention area	Key Indicators (Numbers)	Achievements (Number of Individuals served)										Comments
		PY1* (implementation from July 2009 -Sept 2009)	PY2 (Oct 2009 - Sept 2010)	PY3 (Oct 2010 - Sept 2011)	PY4 (Oct 2011 - Sept 2012)	PY5, Quarter 1 (Oct-Dec 2012)	End of PY5 target	% of PY5 targets achieved	New EOP targets (till PY5 end)	Program Cumulative achievements to date (total PY1*, PY2, PY3 and PY4)	% of end of Program Life Target achieved	
Sexual and Other Behavioral Risk Prevention (General Population)	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	24,287	4,553	62,400	7	135,655	73,255	54	Only three CSOs compared to nine expected to conduct activities during this PY provided MARPs HIV prevention interventions thus the failure to meet the proportion of targets meant for this quarter. STAR-EC is still awaiting USAID approval for the rest of the six CSOs.
Clinical/Preventive Services-Additional TB/HIV	HIV+ patients in HIV care or treatment (pre-ART or ART) who started TB treatment	0	205	533	421	86	400	22	1,645	1,245	76	In East Central Uganda we continue to observe a low percentage of TB/HIV co-infected patients among TB patients compared to the National figure of 54%
	TB patients who had an HIV test result recorded in the TB register	13	1,802	2,317	1,810	469	2,000	23	8,411	6,411	76	Treatment success rate (TSR) stands at 84.3% during this quarter while the cure rate was at 60.6%
	Individuals trained to provide HIV/TB related palliative care	64	875	250	0	0	0	0	1,189	1,189	100	Rather than train more personnel, efforts were concentrated on consolidating the quality of service being provided by those who had been trained.
Anti-Retroviral Therapy (ART)	HIV + individuals receiving a minimum of one clinical care service (CXT)	283	7,041	16,684	24,335	26,217	47,000	56	94,000	47,000	50	Anecdotes indicate a reduction in stigma in the community and so HIV positive clients are openly coming for enrolment into care clinics
	Adults and children with advanced HIV infection newly enrolled on ART	61	1,776	5,083	5,419	1,535	14,240	11	28,114	13,874	49	End of program life targets were increased basing on population based calculations. Scale up strategies will include: utilization of dedicated teams to re-embark on accelerating ART initiation; addressing challenges on CD4 testing and transportation of samples; and strengthening referrals and linkages.
	Adults and children with advanced HIV infection receiving ART (CURRENT)	372	3,119	7,487	12,278	13,722	22,040	62	35,762	13,722	38	. Note: Going forward, the program is targeting 80% of all new clients to remain active on ART each year
Voluntary Male Medical Circumcision (VMMC)	Males circumcised as part of Voluntary Male Medical Circumcision	0	803	14,327	79,813	32,250	120,000	27	247,193	127,193	51	Harnessing the Models for Optimizing the Volumes and Efficiency (MOVE) model has greatly enhanced the results during Q1.
	VMMC surgical sites	0	7	15	19	19	19	100	19	19	100	16 health facilities were supported to conduct 421 circumcision outreaches yielding 25,589 circumcisions

Intervention area	Key Indicators (Numbers)	Achievements (Number of Individuals served)										Comments
		PY1* (implementation from July 2009 -Sept 2009)	PY2 (Oct 2009 - Sept 2010)	PY3 (Oct 2010 - Sept 2011)	PY4 (Oct 2011 - Sept 2012)	PY5, Quarter 1 (Oct-Dec 2012)	End of PY5 target	% of PY5 targets achieved	New EOP targets (till PY5 end)	Program Cumulative achievements to date (total PY1*, PY2, PY3 and PY4)	% of end of Program Life Target achieved	
Strategic Information	Local organizations provided with TA for SI activities	4	11	11	3	3	3	100	11	11	100	During this quarter, only 3 CSOs were supported as the program awaits approval for additional CSOs from USAID
	Individuals trained in SI (including M&E, surveillance and/or HMIS)	122	379	170	287	93	93	100	379	379	100	58 were trained on the utilization of Open MRS software while 35 on web based ordering of ARVs
	Local organizations provided with TA for HIV-related institutional capacity building	4	11	11	3	3	9	33	9	11	122	During this quarter, only 3 CSOs were supported as the program awaits approval for additional CSOs from USAID
* PY1 (March-September 2009) involved only 3 months of actual implementation, the rest was program start-up activities												

1.0 Introduction

1.1 Brief overview of STAR-EC

The Strengthening TB and HIV&AIDS Responses in East Central Uganda (STAR-EC) program is implemented in nine districts of Uganda namely Bugiri, Buyende, Iganga Luuka, Kaliro, Kamuli, Mayuge, Namayingo and Namutumba. Currently, the region is inhabited by an estimated 3.1 million people, which is approximately 9% of Uganda's current population.

Since inception in 2009, the STAR-EC program has supported TB and HIV&AIDS services delivery in East Central Uganda under the following objectives:

- 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 creation activities for HIV&AIDS and TB prevention, care and treatment services.

During the past four years, STAR-EC has registered significant progress towards improving the scope, quality, geographical coverage and accessibility of HIV&AIDS and TB services in East Central Uganda using a health systems strengthening approach. Key services such as HIV testing and counseling (HTC), prevention of mother-to-child transmission of HIV (PMTCT) and antiretroviral therapy (ART) hitherto limited to hospitals, health centres (HCs) IV and a few HCs III have been taken nearer to people at more HCs III, some key HCs II and within communities. Voluntary Male Medical Circumcision (VMMC) services have since been introduced and are now delivered through 19 health facilities, multiple outreaches and 'circumcision camps.' All public general hospitals in the region have been provided with CD4 count machines and 12 HCs IV and 7 HCs III have received point-of-care CD4 machines from the Ministry of Health (MoH). Demand for services has been created and both medical and lay service providers have been trained to provide quality services and conduct cross referrals between health facilities and communities. However, there still exist key outstanding challenges as highlighted in Box 1.

Given these challenges, STAR-EC has in PY5 embarked on a portfolio of key interventions to be delivered to target sub-populations.

Box 1: Key outstanding challenges in East Central Uganda

- High HIV prevalence, estimated number of PLHIV in the region by 2013 will be 87,000 of whom only 24,000 (30%) are currently in care
- HIV prevalence not uniform across the nine districts with lakeshore and island districts like Namayingo having a high prevalence of 10.3% compared to 3% for Kaliro
- High level of multiple concurrent sexual partnerships (MCPs) estimated at 26% among men (UDHS 2011)
- High prevalence of MARPs in the region (mostly fisher folk, commercial sex workers and truckers)²
- Though prevalence of circumcision in the region is at 45%, LQAS data shows that by 2012, only 32% of adult males were circumcised specifically for HIV/STI prevention purposes. SMC need in region is estimated at 306,000
- Zonal TB reports for 2011 show TB case finding at only 43%

2.0 Priority intervention areas and the progress made during Quarter One of PY5

2.1 HIV testing and counseling (HTC)

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

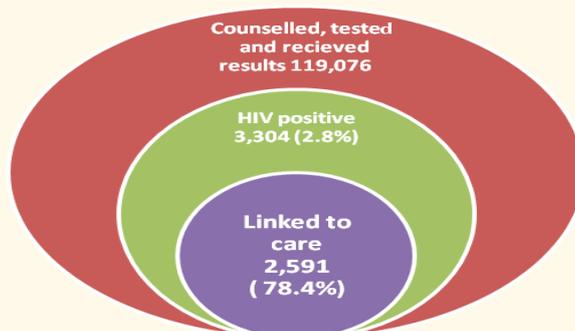
During the October – December 2012 period, STAR-EC continued to harness the momentum of implementation of HTC activities gained during PY4 to further increase the proportion of adults that have ever taken an HIV test in the region (reported at 63.7%, according to STAR-EC LQAS report, 2012).



HIV testing and counseling services during the Bwondha outreach, Mayuge district in October 2012

To achieve this, STAR-EC employed innovative HTC approaches such as Provider Initiated Counseling and Testing (PICT) at facility level that targeted all care points such as OPD, ANC and the wards; and integrated outreaches (the supermarket approach) at community level using the ‘know your epidemic, know your response, ‘know your context and know your cost approach.’ In order to minimize the strain on the few available staff at the high level facilities offering PICT, STAR-EC during the quarter continued to facilitate RCT volunteers to task shift in this regard. Pursuant to this effort, HTC services provision in the nine districts was offered through 114 facilities and outreaches in 80 parishes primarily targeting couples, males eligible for VMMC, pregnant women and MARPs. During the integrated community outreaches, linkages to VMMC for eligible men, TB, PMTCT, immunization and Early Infant Diagnosis (EID), family planning and; care and treatment were optimized through the use of linkage facilitators that included VHTs and the expert clients.

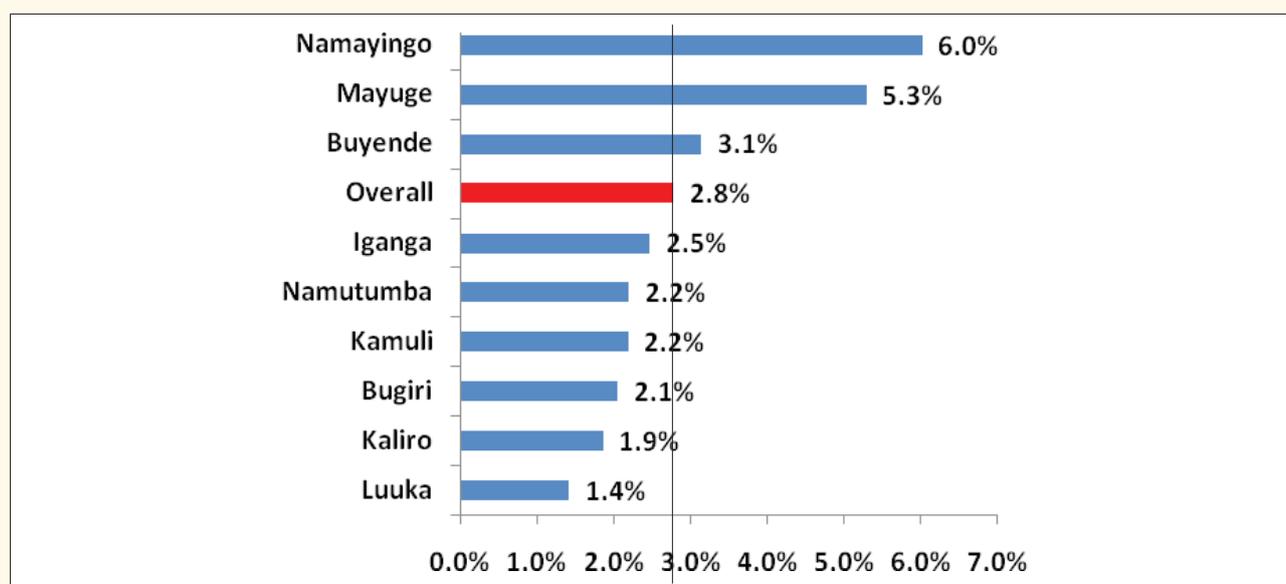
Figure 1: Persons counseled, tested, received results and linked into care (excluding pregnant women and women served during postnatal care)



The stand alone outreaches using the scenario event approach were used to target truckers, fisher-folk and commercial sex workers at the three ‘knowledge room’ sites (Naluwerere, Lugala, and Idudi). During the quarter,

STAR-EC collaborated with UHMG to facilitate a free standing outreach at Bwonda landing site, Mayuge District targeting fisher-folk in which a total of 335 fisher folk (189 female and 146 male) received HTC services with 20 people (14 female and 6 men) being diagnosed HIV positive. Couples were targeted monthly at community level in the nine districts using the integrated couple HTC outreaches; while monthly integrated island outreaches targeted the fisher-folk and commercial sex workers in the districts of Mayuge and Namayingo.

Figure 2: HIV prevalence rate (excluding pregnant women and women served during postnatal care)



Source: STAR-EC program records

Table 2: HTC outputs from the general population (excluding HTC results from VMMC) by approach Q1 of PY5

Site of testing	Nature of activity	Individuals counseled, tested and received their HIV results			Couples counseled, tested and received their HIV results (a subset of individuals)		
		No. Tested	No. Received Results	No. HIV Positive	No. Tested	No. Concordant HIV+	No. Discordant
Outreach	Couple Counseling (C&T)	6,279	6,279	140	1,879	19	26
	Free standing	17,953	17,953	570	273	1	2
	Home-Home	2,650	2,650	70	114	3	3
	KYCHS	410	410	7	-	-	-
	Moonlight	107	107	5	1	-	-
	World Aids Day	259	259	16	6	-	-
	Scenario Event	234	234	2	3	-	-
Outreach Total		27,892	27,892	810	2,276	23	31
Static		59,203	59,203	2,272	950	34	52
Static Total		59,203	59,203	2,272	950	34	52
HTC Total (excluding VMMC)		87,095	87,095	3,082	3,226	57	83
Proportions			100%	3.5%		1.8%	2.6%

Source: STAR-EC program records

All of those diagnosed HIV positive were actively linked to appropriate care and treatment using linkage facilitators (expert clients, mentor mothers and VHTs) both at health facilities and in the community. While STAR-EC had planned to reach 8,000 couples monthly (or 24,000 quarterly) in order to reach the targeted 96,000 couples for PY5, only 3,226 could be reached during this quarter; partly as a result of the slow-down caused by the few CSOs currently on board. Of the couples reached with HTC during the quarter, 1.8% were concordant positive while 2.6% were discordant a precedent similar to that seen in PY3 and PY4. Outreach services contributed 31.3% (n = 87,095) of the overall HTC client load during the quarter with facility based services catering for the bulk as illustrated in table 2.

Overall, STAR-EC achieved 24% of the annual HTC target of 654,920 meant for PY5 (including individuals tested during VMMC, pregnant women and post-natal care). It is hoped that with additional community support organizations coming on board and the continued improvement in the coordination between the districts and STAR-EC regarding SDS funding, the set target for couples will be reached in the course of PY5. STAR-EC will revisit these targets after the completion of Quarter 2 to examine if they still remain realistic.

Table 3: Quarter 1 HTC performance compared to the PY5 Annual target

HTC target population	Outputs	Annual	% performance versus annual target
General population	80,571	250,000	32
Couples (individuals)	6,524	192,000	3
VMMC	31,981	120,000	27
Pregnant women and lactating mothers	36,064	92,920	39
Total	155,140	654,920	24

Source: STAR-EC program records

Challenges:

- The funding mechanism between STAR-EC, SDS and the districts requires to be streamlined further so as to improve on reporting.
- The existing three pre-qualified CSOs in the region are unable to meet the need for community based TB, HIV&AIDS services meaning that there is a need to bring on board more CSOs to cater for this shortfall.

Way forward:

- Improved collaboration between the districts, STAR-EC and SDS during Q2 will go a long way in mitigating both data and implementation challenges that exist presently.
- During Q2 of PY5, it is expected that additional CSOs will come on board to further improve the existing gap especially regarding community outreach HTC services and their related linkages.

2.2 Prevention of mother-to-child transmission of HIV (PMTCT)

During Q1, STAR-EC continued to build on the PMTCT successes registered during PY4 both at facility and the community as a result of the continued strengthening of the intra-facility and inter-facility linkages and facility-community linkages in the nine districts. Particular emphasis was placed on HIV diagnosis using HTC and early infant diagnosis, enrollment and retention of the mother-baby pair on the relevant PMTCT regimen as the core implementation areas. In this regard STAR-EC supported all the 118 health facilities trained to offer PMTCT using Option A through providing quarterly mentorships (mainly to the island and lake shore HCs II), organizing monthly family support group meetings, regular community follow up of missing mother-baby pairs, data/logistics and quality assurance support. STAR-EC through the use of the 'mentor mother' approach, further supported the collaboration between the facility based mentor mothers and their VHT counter parts in the community in order to further improve on the identification, enrollment, linkage and retention of the mother baby pairs onto 'Option A.'

A mother accessing a family planning implant during an integrated outreach at a landing sites in Mayuge district



During Q1, a total of 85 of the 118 PMTCT facilities were supported to offer monthly psychosocial support to pregnant and lactating mothers through Family Support Group (FSG) meetings using the national PMTCT FSG guidelines. These Family Support Groups are designed to serve as a retention/ adherence, behavior change and linkage/referral tool for the 'mother-baby' pairs in order to curtail their continued loss in the community. The group meetings also present an opportunity to the mothers and their partners to receive a comprehensive package of PMTCT services. In addition to taking care of the psychosocial needs of adults through FSGs, STAR-EC supported monthly psychosocial support services for 50 children in two high volume facilities of Iganga Hospital and Kigandalo Health Centre IV using the 'Ariel Children's Club' model developed by the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF).



A mentor mother in Kiyunga providing psycho-social support to a mother at Kiyunga HC IV

STAR-EC, in collaboration with the MoH, continued to support the prevention of mother to child transmission-early infant diagnosis (PMTCT-EID) strengthening process at all PMTCT facilities in the nine districts. This was done through tracking points in the community and at all care points at the facility designed to identify and refer all 'mother-baby' pairs eligible for PMTCT and early infant diagnosis to a central EID care point at the facility (usually at ART or ANC). This innovative approach has helped the program identify, enroll and retain more 'mother-baby' pairs onto PMTCT and EID. The community care points have helped in identifying exposed babies in the community during outreaches and immunization clinics. During the quarter STAR-EC continued to support the 44 pilot sites offering "Provider Initiated Family Planning" with the primary aim of boosting the uptake of family planning (FP) services in the nine districts. In addition, Family Planning services have actively been integrated into all the community HTC outreaches supported by STAR-EC across the East Central Region. As a result, steady improvement in the uptake of FP services has been realized during the quarter, with a total of 3,734 lactating mothers receiving FP services out of whom 284 (8%) were HIV+ women. During Q2, all the supported PMTCT sites will be facilitated to start implementing this Family Planning initiative.

Enhancing access to PMTCT-EID services using the 'Mentor Mothers' model

STAR-EC supported the implementation of the 'mentor mothers' peer model at 28 high volume health facilities with an aim of enhancing access to PMTCT and psychosocial support services for the HIV positive pregnant and lactating mothers. During the reporting period, STAR-EC conducted a site assessment and identified 17 additional sites for scale up of the 'mentor mother program.' The additional sites are mainly situated in places with limited access to services and high HIV prevalence in the districts of Namayingo, Buyende, Mayuge, Bugiri and Luuka. Potential 'Mentor Mothers' have been identified at these new sites and will be offered a pre-service training during quarter two

Figure 3: PMTCT Client Retention and Increased Uptake of Selected Reproductive Health Services at m2m sites Using Select Retention

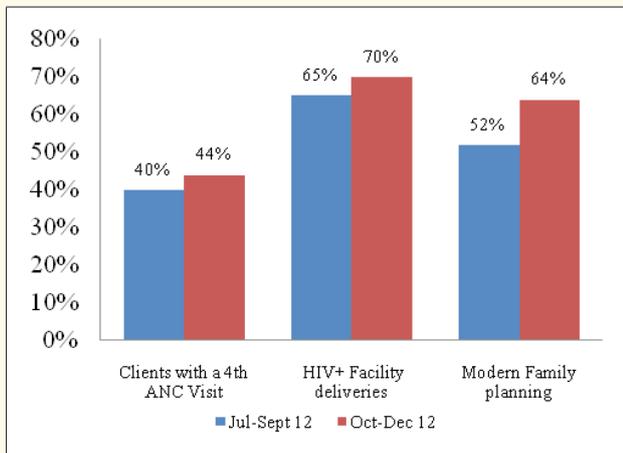
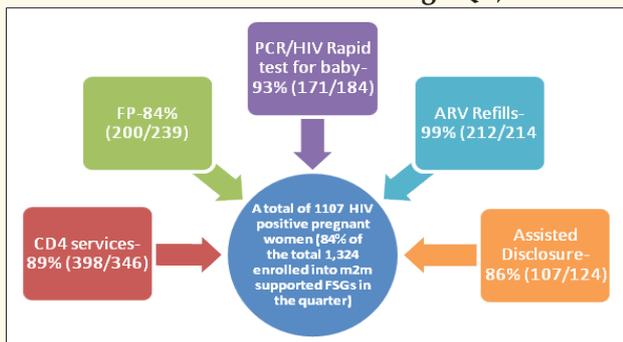
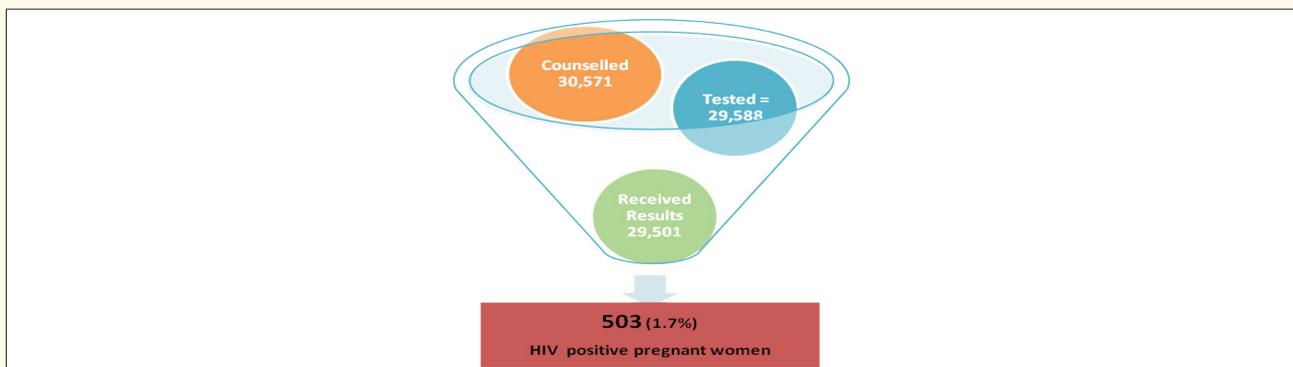


Figure 4: Outputs of the mentor mother facilitated FSG meetings Q1, PY5



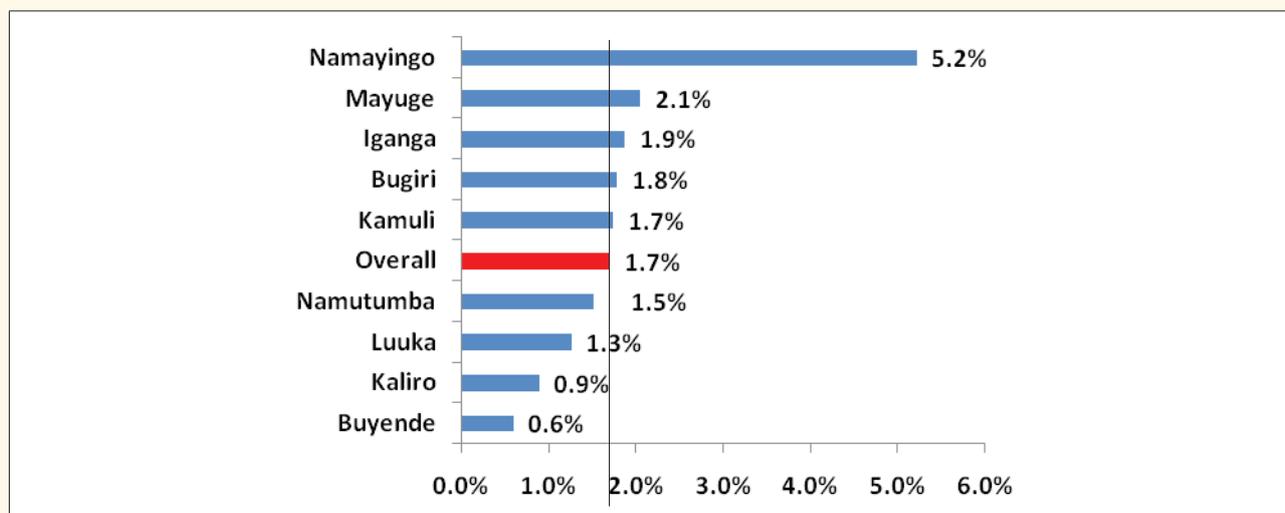
of this program year. After receiving this training, a total of 45 sites (28 old and 17 new) will be engaged in the STAR-EC mentor mother program. The use of ‘mentor mothers’ has continued to serve as a useful advantage in addressing some of the pressing challenges like loss of PMTCT clients along the cascade through proactive follow up of ‘mother-baby’ pairs who have missed any key appointment at the health facilities. A total of 670 ‘mother-baby’ pairs missed key appointments during the quarter. Using ACFU 86% (574/670) were traced and of these 80% (457/574) were able to return and receive the service they missed. The key reasons for missing these key appointments are; lack of transport, forgetting the appointment date and stigma. The mothers that were not traced had relocated to other locations outside the ‘mentor-mothers’ reach. The continued efforts to strengthen community engagement through PLHIV networks and VHTs has seen the active client follow up outcomes improve as mothers exhibit better health seeking behavior. In this regard, 4th visit attendance by pregnant women increased to 44% during the quarter from 40% in quarter 3 of PY4. Similarly improvement is evident regarding health facility deliveries and uptake of modern family planning (see fig 4). The program supported PMTCT services at 118 health facilities mainly focusing on provision of option A. Overall, a total of 36,064 women were served as part of the PMTCT HIV testing package including 29,501 tested during ANC, 397 who turned up with a known and documented HIV positive status, 1,527 during labor and delivery as well as 4,639 that attended PNC. During ANC, 503 (1.7%) were diagnosed HIV positive, while 22 (1.4%) and 64 (1.4%) were found HIV positive during labor & delivery and postnatal care respectively.

Figure 5: HIV testing of pregnant women during ANC, Quarter 1 PY5



A total of 1,324 pregnant and lactating mothers as well as 334 of their male partners were enrolled and retained in the FSGs during the reporting period. In order to improve male involvement and participation in the PMTCT program, STAR-EC plans to pilot the use of various male involvement strategies at nine m2m sites, beginning in quarter two of PY5. This will help the program to gain a better insight into what really works to have the men accompany their wives for antenatal care and postnatal care. To further this intervention, a rapid site assessment exercise was conducted to obtain baseline information on ‘male friendly services’ offered at the selected health facilities.

Figure 6: HIV prevalence rate during ANC

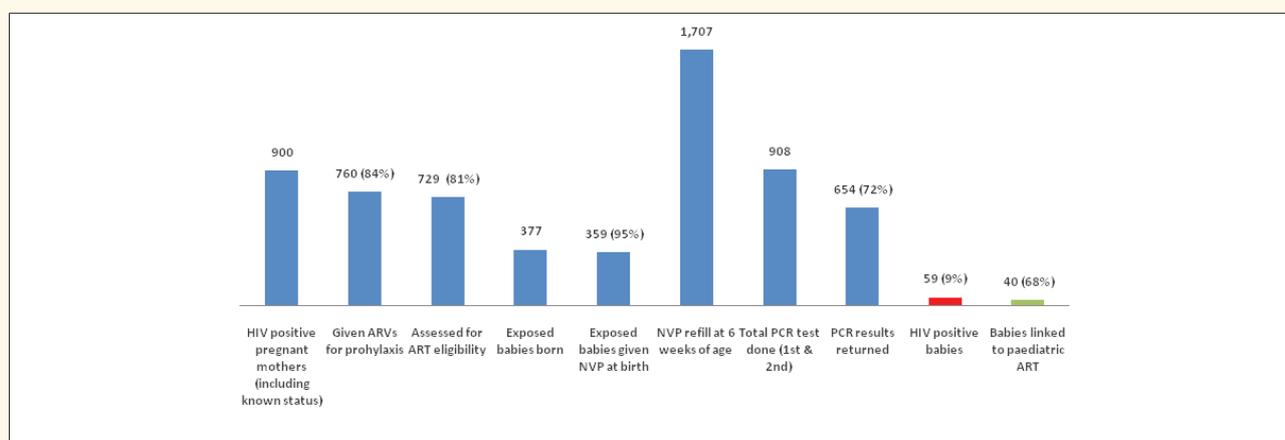


Source: STAR-EC program records

As a result of this assessment a total of 45 (22M, 23F) district leaders from Buyende, Mayuge, Bugiri, Namayingo, Iganga, and Kamuli districts were oriented on the National Male involvement strategy for child health, Sexual Reproductive Health Rights (SRHR), HIV&AIDS and the rapid assessment findings disseminated. On the job orientation of the health centre staff on male involvement and male participation was conducted with support from the MoH. A total of 66 health workers were oriented at 13 sites. The sites were also supported to select male involvement committees comprising of 15 males per sites. During Q2 of PY 5, STAR-EC plans to orient these 'male champions' on their roles and responsibilities to equip them with knowledge and skills to support male involvement campaigns in their respective communities.

As a result of all these strategies, improvement was registered across the quarter's PMTCT cascade. This is more evident in the area of enrollment and retention of the 'mother-baby' pair onto PMTCT. Overall, Figure 3 shows the HTC cascade outputs for the region during the quarter. A further review of this cascade shows that HIV prevalence among newly tested ANC mothers has stagnated at 1.7% (503/29,588) during the quarter. During the quarter Namayingo District posted the highest positivity rate (among ANC women) while Buyende posted the lowest rate(see Figure 6 above).

Figure 7: PMTCT cascade during the quarter



Source: STAR-EC program records

During the quarter, the proportion of HIV positive pregnant women that accessed ARVs for prophylaxis during ANC increased from 82% (765/933) in Q4 of PY4 to the current 87.6% (763/871), in effect ensuring that the region met the 80% national requirement for this indicator.

Table 4: PMTCT ARV prophylaxis trends Q3 PY4 to Q1, PY5

Type of Regimen	PY4		PY5
	QTR3 (n=824)	QTR4 (n=933)	QTR1 (n=900)
AZT	55.70%	61%	56.8%
AZT/3TC&SdNVP	4.10%	4%	4.0%
HAART	17%	17.40%	23.7%
No prophylaxis	23%	18%	15.5%

Source: STAR-EC program records

Between Q4 of PY4 and Q1 of PY5, enrollment of eligible HIV positive mothers onto HAART increased from 17.4% (162/933) to 23.7% (213/900); however this is still below the national requirement of 30 – 40%. The number of pregnant women failing to access any ARV for prophylaxis has progressively reduced from the third quarter of PY4 all through to this quarter as illustrated in table 1. Regarding the provision of ARVs for prophylaxis for the HIV exposed new born, STAR-EC surpassed the national target of 90% (359/377) during the quarter (refer to figure 7).

PMTCT strategies designed to reduce the MTCT rate in the East Central Region Challenges

Facility strategies	Community strategies	MOH & STAR-EC systems strengthening strategies
<ul style="list-style-type: none"> •Active intrafacility linkages using mentor mothers, VVHTs and expert clients •Active interfacility linkages •Family support groups and children's clubs serving as an entry point to CD4 and PCR testing, ART & Septrin prophylaxis refills and adherence counselling •Monthly Phone follow up of accessible mother baby pairs 	<ul style="list-style-type: none"> •Mapping of all pregnant women in the villages by Village Health teams to enable tracking of 1st and 4th ANC visits; and facility delivery of these mothers by both the VHTs and the mentor mothers •Active community based follow up of missing mother baby pairs by a combined health worker/mentor mother/VHT team to minimise loss to follow up while increasing on retention 	<ul style="list-style-type: none"> •Mentorship of the facility based Health workers and the expert clients regarding eMTCT services provision using Option A and B+ approaches •Training of all health worker in eMTCT services provision using Option B+

Source: STAR-EC program records

A review of the quarter's positivity rate among the exposed babies using 1st and 2nd PCR shows that it stands at 9% (59/654); still above the national target of less than 5%. Cognizant of this challenge, STAR-EC has adopted innovative strategies (illustrated in table 2) aimed at improving pregnant women's access to ANC and HIV testing and counseling both at community and the facility level through the use of Village health teams in addition to the other existing linkage facilitators.

These strategies are also expected to further improve the number of HIV positive women and their babies enrolled and successfully completing the PMTCT cascade.

Challenges:

- The expected transition to Option B+ for the East Central Region has been postponed to June 2013 from April 2013, meaning that the region will continue to grapple with the challenges of Exposed baby adherence to Nevirapine syrup.

- Only 67.4% of pregnant mothers (LQAS, 2012) in the region do deliver in a MOH recognized health facility. As a consequence, these exposed babies who turn up at immunization end up clouding the PMTCT-EID outcomes of the region.

Most of the Health centers II that have been supported to offer Option A, few are manned by enrolled nurses or midwives meaning that these will need special attention during this remaining Option A implementing period and during the anticipated roll out of Option B+ in the region.

Way forward:

Support the community-facility linkages that were commenced in PY4, using the mentor mother/VHT collaboration during family support group meetings, community follow up and active linkage between the different facility departments.

Support quality improvement approaches such as mentorships during this remaining Option A implementation period while we ready the facilities to transition unto Option B+.

In order to achieve national targets on enrolment of HIV positive pregnant women on HAART, STAR-EC will among others in the course of PY5 continue to strengthen its support supervisions to all the nine districts on CD4 services using the SDS mechanism so that better value for money can continue to be realised. Additionally, STAR-EC will ensure that health facilities in the nine districts take advantage of the new sample transport hubs that MoH is in the process of inaugurating in the region. In so doing, the proportion of HIV positive pregnant mothers accessing CD4 services as an entry point into ART care will increase to the nationally accepted level. The June 2013 planned transition to option B+ (HAART for life for all HIV positive pregnant women) will also increase outcomes in the East Central region.

2.3 Voluntary medical male circumcision male circumcision (VMMC)

In the promotion of biomedical prevention through VMMC, during Q1 STAR-EC utilized 19 static sites to deliver Voluntary Male Medical Circumcision (VMMC) services, of which 16 were supported to additionally scale-up



A VMMC camp at Bwondha landing site being executed under a tent

VMMC Summary Results

- 19 health facilities supported to deliver VMMC services through weekly static clinics yielding 3,661 circumcisions
- 16 health facilities supported to conduct 421 circumcison outreaches supported during Q1 yielding 25,589 circumcisions
- 16 four-day camps were conducted yielding 3,000 circumcisions

Walter Reed Project (MUWRP), 114 service providers from all supported sites received refresher training on emergency preparedness and response. The program received 13,000 pre-packed VMMC disposable kits from USAID through JMS during Q1. STAR-EC prioritized areas such as landing sites, islands and truck stops along the highway with high HIV prevalence as well as districts such as Buyende, Kamuli and Namayingo which have low male circumcision prevalence for circumcison outreaches and camps during Q1. During Q1, STAR-EC supported sites to take VMMC services to key populations which included integration into the couple HTC campaign where 1,300 men in marital and/or cohabiting relationships were circumcised across the nine supported districts. Overall 12% of the total number of men served in Q1 was from this category of VMMC clients. In collaboration with UHMG, STAR-EC supported delivery of VMMC into an integrated outreach at Bwondha landing site in Mayuge district. The program participated in the national VMMC campaign of December 2012, where over 3,500 men

service delivery through circumcison outreaches and camps. In collaboration with Makerere University were circumcised. All clients reached with VMMC services were provided with both oral and written post circumcison instructions as well as risk reduction counseling, reinforcing abstinence during the healing period.



A health worker demonstrating how SMC works to clients during health education

2.3.1 Scaling up VMMC while ensuring quality service

In December 2012, the program received an external PEPFAR quality assurance/improvement visit where an outreach site at Bugoto landing site was assessed. The visiting PEPFAR QA/QI team noted that staff running the outreach site were committed and hardworking; that clinical record keeping was good; and that appropriate anesthesia, surgical procedure and dressings were being done. The team noted good post-operative management including written instructions provided to clients,

clear follow-up appointment information provided and high rates of follow-up. Following this visit where emergency

the effects of stock outs.

- Collection of waste from districts which do not receive SDS support to a central incineration place is still a big challenge. STAR-EC is still negotiating with AIDSTAR-One to start collecting this waste.

2.4 Other combination HIV prevention interventions

2.4.1 Promoting sexual behavioral risk reduction (SBRR) and structural prevention strategies within combination HIV prevention

In addition to biomedical HIV prevention strategies already described in earlier sections of this report, STAR-EC promoted HIV prevention through Sexual and Behavioral Risk Reduction (SBRR) and structural interventions. The pre-qualified CSOs and the district health workers were supported to deliver a range of HIV prevention services in an integrated approach. The major activities implemented during the reporting period were as shown in table 5. Risk reduction counseling was facilitated by linkage facilitators that comprised VHTs, peer educators and model couples. Sessions were conducted as one-to-one and in small group discussions. Job aids including flip charts, cue cards, video clips and posters were utilized as reference materials during risk reduction sessions. Special focus was made to deliver services to key populations like sex workers, truckers; other categories such as ‘Bodaboda’ (motorcyclists), bar and local video hall (Bibandas) attendees as well as to married couples.

Table 5: Synopsis of key activities and outputs for PY5 Q1

Key activities:	Summary of outputs:
<ul style="list-style-type: none"> ▪ Promotion of risk reduction strategies among targeted key populations and emerging MARPs ▪ Installation of condom dispensers to increase outlets in hot spots ▪ Provision of age appropriate ABC messages and linkages to the relevant services ▪ Conducting Get off the sexual network campaigns ▪ Boosting the knowledge room based services ▪ Integrating risk reduction strategies among youth and couples in the general population ▪ Promoting HIV prevention among persons living with HIV&AIDS through PHDP activities 	<ul style="list-style-type: none"> ▪ A total of 4,553 key populations were reached (25% were reached more than once). Of these 85% were fisher folk, 9% were sex workers and their clients and 6% truckers. Additionally 2,741 were bodaboda (emerging key populations) ▪ 329,010 pieces condoms were distributed of which 84,635 of these were given to key populations. A total of 295 condom outlets were active during the quarter and on average 922 condoms were distributed through the outlets ▪ A total of 17,156 couples and youth from the general community were reached with combination prevention. 34% was reached more than once. Approximately 52,203 condoms were distributed to youth and couples

2.4.2 Promoting combination HIV prevention among MARPs and ‘emerging MARPs’

During Q1, sex workers and their clients, truckers, fisher folk and as well as other populations at high risk of HIV infection including Bodaboda, bars, lodges and guest house workers and operators and Bibanda attendees were reached with HIV prevention interventions already mentioned above. The means used included conducting integrated service delivery outreaches, ‘knowledge room’ based services, community structures comprising peer educators and village health teams.

2.4.2.1 Efforts to reduce risk among sex workers

During Q1, special efforts were made to reach sex workers through the knowledge room, integrated outreaches to hotspots, as well as mentor buddies who provided interpersonal communication to promote risk reduction counseling. Selected ‘experienced’ sex workers (working as mentor buddies) from Naluwere, Bugiri Town Council,

Idudi and Iganga Municipality who double as bar and lodge attendants were identified and oriented in peer education skills. The program reached the sex workers with moonlight HTC, condom promotion - especially female condoms, linking sex workers for ART, PMTCT, FP services as well as STI management. The mentor buddies offered interpersonal communication with the aim of increasing risk perception associated with sex work and counseling on alternative sources of income and risk avoidance through getting off the sexual network (See section below for the numbers of sex workers reached).

Sylvia, a mentor buddy at Naluwerere, shares on the challenges of switching from sex work: “This work is not easy; I do it because I need some money. I have 3 children whom I need to fend for... but... through the peer education trainings; I feel empowered with information and I need to start a better life. I now have a retail business and for sure this will support me to provide for my children...”

2.4.2.2 Promoting combination HIV prevention among long distance truck drivers

The known busy truck stop-points along the northern transport corridor include; Naluwerere, Busowa, Idudi, Bulanga and Magamaga. During the quarter, ‘brokers’ (mobilizers) most of whom are VHTs and peer educators reached truckers with condom education and distribution. Services were received from their park yards, in the knowledge room at Naluwerere and in bars and lodges where condom dispensers were installed.

2.4.2.2.1. Efforts to increase access to condoms in ‘hot spots’ the trucks stop points

During Q1, STAR-EC supported installation of condom dispensers in selected hot spots of Naluwerere, Idudi, Iganga Town council, Bulanga and Magamaga. Thirty (30) recreational facilities (bars, lodges, guest houses and Bibandas) were identified and selected for installation of condom dispensers. The managers and/or bar owners were oriented and trained on condom promotion. Selected VHTs from hotspots were attached to the recreational facilities. Their major roles are to ensure regular supplies of condoms to recreational facilities and as well as providing condom education.

2.4.2.3 Promoting combination HIV prevention among the fishing communities



During the quarter, fisher folk were reached through the Knowledge room and integrated service outreaches to landing sites and islands. STAR-EC mobilized and supported two integrated community service outreaches at the landing sites of Bwondah and Bugoto in Mayuge District. STAR-EC partnered with UHMG and STRIDES for family Health project to provide a wide range of services. The synergy obtained in the partnership arrangement; whereas STAR-EC focused on service delivery, UHMG actively engaged in social marketing/ mobilization and targeted messaging. The demand creation component employed mobile music/public address system, puppetry and drama performances, display and dissemination of IEC materials, and small group discussions and the community accessed services that ranged from FP, VMMC, HTC, condom promotion and ART. Below we share how more men

are involved in health care through the Knowledge Room¹



Fisher folk at Lugala landing site in Namayingo district assemble for recreation and health education at the knowledge room

During Q1, a total of 4,553 key populations (25 % reached more than once) with risk reduction counseling and linked to access other biomedical services. Of these, 3,850 were fisher folk, 398 were sex workers, 266 truckers and 39 were others (street kids and uniformed service

Improving male involvement in health care; the experiences through the knowledge room

STAR-EC uses knowledge rooms to deliver health services to key populations. The picture above is Lugala Knowledge room in Lugala landing site which is primarily for fisher folk. Many fisher folk spend their leisure time at these venues before their next night duty in the waters. At the knowledge room, different services are provided including recreation (board games, pool table) health educations, condom education and distribution, HTC, couple HTC, TB screening, referrals and linkages for other biomedical services. More men are attracted to the knowledge room because of the recreational facilities and at the knowledge room they are counseled and linked to access other services. During the reporting period, a total of 1,288 individuals were reached at this kno of which 835 (65%) were male and 452 (35%) were female.



A Police Officer in Iganga District who is a peer educator among Police Officers (trained by Straight Talk Foundation) in a session with Bodaboda focusing on health education

personnel). Overall a total of 329,010 pieces of condoms (299,146 male condoms; 29,864 female condoms) were distributed through 265 outlets.

¹ A community resource centre which is utilized for recreation, health education and provision of health services

2.4.2.4 Promoting combination HIV prevention among 'emerging MARPs'

The nature of work for Bodaboda in most cases does not allow them to access services during integrated outreaches due to limited waiting time since they are always on a look out for customers. During Q1, STAR-EC supported all the nine districts to offer integrated outreaches targeting Bodaboda. The district health teams, Bodaboda Associations and the respective District Police officers participated. The role of police was critical in mobilization as well as addressing structural issues from the perspective of the law. Through this strategy a total of 2,152 Bodaboda motorcyclists were reached with combined HIV prevention interventions during Q1 PY5.

Lessons learned:

- Integrating recreational activities into health care acts as one of the effective means of attracting men to both preventive and care services.
- Engaging the Police and Bodaboda Associations in integrated HIV outreaches serves as one of the best means of mobilizing Bodaboda cyclists to receive HIV prevention services.

Challenges and way forward:

- Bodaboda have limited waiting time for services during integrated outreach. Some expect compensation for the waiting time. STAR-EC will continue to work through the Bodaboda Association for ease of co-ordination and with police to reinforce structural prevention.
- Some bar and lodge managers were not willing to have condom dispensers installed in their bars since this would jeopardize their sales of condoms. STAR-EC conducted an orientation for all bar managers; this helped to allay their fears.
- High STIs prevalence reported among sex workers. STAR-EC will support health workers to offer special STIs clinics at Idudi and Naluwerere trading centres, Wakawaka landing site and Sigulu island that have the highest concentration of sex workers.

2.4.3 Promoting age appropriate Abstinence, Being faithful and Condom use (ABC) in the general population

In order to reach the general population, community mobilization interventions were premised on the key activities of; interactive radio talk shows, one-on-one sessions with "linkage facilitators", infotainment community activities, and dissemination of Information Education and Communication (IEC) materials. The intervention also harnessed the complementary efforts of other partners including districts local governments within the region.

Individuals from the general population that were targeted during the quarter included married and/or individuals in cohabiting relationships, youth in the community, business community, individuals at places of work e.g. plantation workers, bars, lodges and Bibanda attendees. While peer educators, VHTs, model couples plus local and religious leaders promoted risk reduction counseling, condom promotion and distribution among individuals, the mass audience is reached through radio programs. For other biomedical services including HTC, VMMC, FP, eMTCT and ART; referrals and linkages are made to points of health care both in the community and to health facilities.

Utilizing an interactive radio program to create demand among the general population for services

The live radio talk shows conducted weekly on NBS Kodh'eyo 89.4 FM are programmed to reinforce and complement various campaigns, promotional messages, products and services from other sources. During the quarter, a total of 14 topics were discussed over the radio talk show including; Couple HTC, Goal oriented ANC and Commemoration of World AIDS Day. Guest speakers during the shows included District Health Educators, District Health Officers, VMMC Surgeons and District HIV focal persons. Specific attention was given to issues detailed in Fig 9.

Figure 9: Topics discussed during Interactive radio talk shows this quarter



Source: STAR-EC program records

2.4.3.1 Promoting combination HIV prevention for couples

Married and/or cohabiting partners were reached through integrated CHTC activities; during community based psychosocial couple support groups meetings and in their homes. Model couples and VHTs as linkage facilitators conducted risk reduction counseling among couples focusing on issues of multiple partner reduction; fidelity using 'families that proposer', manual aiming to build positive couple communication and planning together for their family; condom promotion and distribution. Structural prevention was promoted using Men & HIV model to discuss issues that make women and girls more vulnerable to HIV infection such as gender based violence, forced marriages, male dominance and permissiveness by women. Efforts were made to link couples and youth to biomedical services including HTC, VMMC, family planning and ART for HIV positive individuals (see table 6) for the total number of couples reached during Q1.

David is part of a model couple, a VHT and HTC counselor working in Bulidha Sub County in Bugiri District. He shared how his work as a linkage facilitator has helped his family and the entire community:

"As a model couple, I practice what I preach to the married. Marriage is not smooth, there are always conflicts, but how you handle the conflict is what matters; openness and communication is the answer! I work in the community and at Wakawaka health centre II. I enjoy counseling couples to test together and share their results, it is one of the ways a couple can protect and care for each other once they have shared their HIV results. I was circumcised in June 2012..... my testimony has since motivated many men whom I have linked for VMMC..." David concludes.

2.4.3.2 Promoting combination HIV prevention for youth

Youth aged 10-24 years were reached with activities that promote delay of sexual debut, while building life skills. Youth peer-educators as change agents were supported to promote behavior change among youth in the community. Among the activities carried out were games and sports, small group discussions and one-on-one sessions to promote risk avoidance; while embracing combination prevention. The youth were reached with information on VMMC 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 given condoms.

During the quarter, a total of 17,156 individuals (10,644 were male: 6,512 were female) reached with age appropriate ABC information, of which 28% were couple and 25% were youth from the community. A total of 23.5% were reached more than once (see table 6 below) for the results.

Table 6: Number of individuals reached with age appropriate Abstinence, Being faithful and condom use (ABC) in the general population by category during Q1

Category of other population	Number reached
Plantation workers	182
Business community	1,708
Bar and lodges attendants	1,314
Video hall attendants	1,953
Youth reached by peers	915
Couples reached by peers	593
Others	125
Overall Total	9,531

Source: STAR-EC program records

Lesson learned:

- The state of unemployment among youth poses a unique challenge to HIV prevention efforts
- Economic empowerment is critical for out-of-school youth in ensuring that they adopt and sustain risk reduction strategies

Challenges and way forward:

- There is high level of unemployment among youth; some of them are forced to engage in dangerous practices like casual sex and substance abuse. STAR-EC will continue to support linkage of organized groups to micro finance saving schemes through initiatives like Savings Cooperatives and Credit Societies (SACCO) in the communities.
- Reported high numbers of unintended pregnancies and STIs among youth. STAR-EC will support youth corners at health facilities to offer appropriate reproductive health services to young people.
- The mushrooming of radio stations has impacted on the reach of mass media interventions because the audience is at times split according to their preferred local radio stations. However, STAR-EC plans to contract two other local radio stations to boost our health communication reach through mass audience.



An expert client in a one-to-one session in Bugiri District

HIV prevention interventions that were promoted include; counseling on safer sex negotiation, condom use, and adherence and importance of disclosure, supporting HIV positive pregnant mothers on eMTCT, ART and family planning among others

2.5 Care and support

2.5.1 Promotion of HIV prevention through Positive Health Dignity and Prevention (PHDP) intervention among persons living with HIV in East Central Region

During Q1, the PHDP interventions were promoted both at community and health facility level. Expert clients and VHTs Conducted risk reduction counseling among PLHIV at individual level and during peer support group activities for young positives and discordant couples. The approaches used included; one-to-one interpersonal communication and counseling in the homes, in small group discussions and community dialogues.

Two technical staff participated in the MoH mid-term

review of the PHDP pilot in Ngora District, Northern Uganda. Subsequently, STAR-EC has modified its facility-level data capture tool, and the PHDP monthly report form to harmonize reporting and ensure compliance with MoH as well as PEPFAR. During Q1, a total of 333 (M; 239 F; 94) were reached with a minimum package of prevention with positives. Of these, 61 % (n=333) were reached more than once.

Lesson learned

- Building capacity of the existing PLHIV networks and their structure at community level plus minimal facilitation promotes sustainability of PHDP activities among persons living with HIV&AIDS.

Challenges and way forward

- With the absence of a PLHIV network among the partners in the STAR-EC program, coordination of PLHIV is a challenge especially on data and reporting in terms of timeliness. STAR-EC will continue to work with existing structures at community levels to ensure timely reporting.
- Reporting of activities done is challenging as fewer forms were returned during the quarter. If the proposed PLHIV forum gets support in PY5, it will address this structural challenge.

2.5.2 Post Exposure Prophylaxis (PEP)

STAR-EC facilitated MoH to conduct an on the job mentorship on infection prevention and control for 125 health workers at 4 Hospitals, plus 140 students of Kamuli School of Nursing. Later, the Nurse PEP Officer of Iganga Hospital participated in the national PEP stakeholders' meeting that reviewed the new PEP policy guidelines by the World Health Organization. STAR-EC's role shall be to support the dissemination of the policy guidelines and protocol to facilities. During this quarter, the following 21 victims of exposure to potential HIV infection were served with the 28 days course of ARVs for PEP at 6 facilities (3 Hosp, 1 HC IV, 2 HCs III):

Table 7: Number of individuals that received ARVs for PEP

Type of exposure	# that received ARVs for PEP		
	Females	Males	Total
Occupational exposure	4	2	6
Rape /sexual assault	9	0	9
Other non-occupational exposures e.g., condom burst or slipped off, human bite, body scratch, etc	5	1	6
Total	18	3	21

Source: STAR-EC program records

2.5.3 Care and support (clinical)

During the period October – December 2012, USAID requested for key pivot strategies which were developed, agreed upon and incorporated into the PY5 annual work plan, namely:

1. Proposal to scale up ART services to fishing communities
2. Proposal to increase community linkages to pediatric services
3. Proposal to integrate management of acute malnutrition into HIV care at 4 hospitals

STAR-EC staff also participated in several activities/forums with good programmatic outcomes (see table 8):

Table 8: Key meetings that STAR-EC participated in

	Meeting or Forum	Action point for STAR-EC / Outcome
National level	4th Annual HIV Updates meeting. JCRC disseminated research on emerging ARV drug resistance; viral load tests and HIV genotype resistance tests are thus critical.	Support periodic viral load tests to diagnose treatment failure.
	Accreditation assessment in preparation to roll out EMTCT option B+. Field data from 100 facilities (63 HCs III, 37 HCs II) was submitted into electronic database for MoH to analyze.	MoH recently accredited 14 HCs III (seven PNFs). Provide start-up support to new sites.
	Dissemination of the Chronic Care Model by Health Care Improvement project – management of non-communicable diseases (NCD) co-existing with HIV&AIDS, e.g., diabetes mellitus and hypertension.	Await MoH treatment guidelines for NCD; then implement at 4 Hospitals.
	Nutrition – HIV coordination meeting – MoH shared plans for a Nutrition/ EMTCT quality improvement intervention, coined Partnership for HIV Free Survival (PHFS).	Collaborate with SPRING project to implement PHFS in Namutumba district.
District level	Strengthening Decentralization for Sustainability (SDS) program meetings e.g.: review of CD4 sample transportation in 6 districts; District Management/Technical Planning Committee meeting; District Management Improvement Plan dissemination workshop; and “Grant B” request for applications workshop.	Agreed to increase budget allocations to cater for variations in distance from facilities to CD4 laboratory; Supported districts to write SDS “Grant B” proposals.
Facility level	ART support at Iganga Islamic Medical Centre – rationalization meetings held with Inter-Religious Council of Uganda (IRCU).	w.e.f. October 2012, Iganga Islamic HC III was transitioned to IRCU program
	Deliberations with USAID and TASO regarding support for ART services at Banda HC III and Lugala HC II (Namayingo district). STAR-EC was directed to resume support to Banda HC III.	Banda conducted five ART outreaches to Lugala, served 42 PLHIV with ARVs, 92 got Cotrimoxazole and CD4 tests.

Source: STAR-EC program records

Supporting the ‘continuum of response’ through linking PLHIV to service delivery points

In a bid to support proactive tracking of linkages, health facilities were provided with triplicate referral forms and referral registers. Referral focal persons based in 60 ART/PMTCT sites were oriented on tracking intra and inter facility referral indicators and reporting. During Q2 of PY5 all the 60 facilities will be reporting on these indicators. District referral coordinators were engaged in facility mentorships to ensure a harmonized understanding of the indicators and proper tracking of all the referrals.

In a further effort aimed at supporting PLHIV and OVC linkages to health and other wrap around services, collaboration meetings were conducted with SCORE representatives in Bugiri and Namayingo districts. Consequent to this effort, Sub county networks for Muterere, Bulidha and Budhaya sub counties in Bugiri district; and Buswale, Mutumba and Muhemba sub counties in Namayingo district were linked to SCORE program. Four (4) PLHIV groups in Mutumba Sub county were trained in village savings and members have started making contributions for their savings. In addition, one group in Burundira Parish (Mutumba Sub County) was provided with tomato seeds and thereafter started growing tomatoes. To pursue this further, discussions are underway to link all the other identified critically vulnerable PLHIV households to these services.

In the same vein, 40 PLHIV households through their psychosocial support activities were linked to a community development grant (CCD) program; they have since accessed some funding for their projects. For instance, 40 PLHIV network members in Bukooma Sub County, Luuka District started a small scale soap making factory. As a result, these families no longer buy soap from the market and the little money earned from this project is used to meet other household needs and provide scholastic materials to their children in school.



Left the PLHIV at work making soap, right display of readymade soap

More still, PLHIV from Namungalwe Psychosocial support group mobilized themselves and one member provided land for cultivation. To date, they have planted one acre of banana plantation and pineapples. Similarly, the groups which started village saving schemes are progressively increasing on their savings.



PLHIV group members show casing their garden as a result of psychosocial support

USAID-funded IPs jointly developed guidance on “Linkage Facilitators” and subsequently the program engaged PLHIV expert clients and assigned them some of the recommended roles e.g., physically escorting clients between service points. As a result, linkages from HIV testing to care service points started improving, though slightly, as follows:

- HTC → 2,591 (78.4%) new HIV positive clients were also newly enrolled into care PMTCT → 760 (84.4%) new HIV positive pregnant women were also newly enrolled into care
- EID → 40 of 59 (68%) newly identified HIV positive babies were enrolled in care/ART

Challenges

- Low motivation of facility and community based CSAs affects the effectiveness of the referral system.
- Poor coordination of OVC service providers and inadequate information about their coverage has hindered proper linkages to OVC services.

Way forward

- Steps to engage NAFOPHANU are underway through which CSAs shall be facilitated to continue working.
- Updating the service providers’ directory and initiating coordination meetings with OVC partners to ascertain their uptake in the continuum of care.

Mitigating the loss of clients receiving care and support

Basing on the lessons learnt from the CHAI pilot, STAR-EC rolled out the new file system intervention that was proven to reduce patient waiting time (time of file retrieval) and to minimize misplacement of patient records. About 71 metallic file racks and 1,000 suspension file folders were procured and distributed to 71 care sites; at 24 of these sites about 96 health workers plus 24 volunteer expert clients were oriented on how this new filing system works - the remaining 47 sites will be oriented during Q2.

Interventions aimed at improving pediatric care

From its national EID database, MoH shared with STAR-EC a list of 207 PCR HIV positive babies between January and June 2012, and tasked the program to follow them up. A total of 19 Pediatric HIV Counselors visited all 207 homes, provided counseling support to parents/caretakers of HIV positive babies, and gave out copies of the translated patient education booklet “Okulabirira abaana abayina akawuka ka silimu...” As a result, 115 babies were found alive and active on ART, while 5 babies found not yet on ART were immediately initiated. However, 41 babies had died, and 44 babies got lost to follow-up due to wrong address or had migrated. This shows a very high attrition rate of 42%, which needs to be halted. Going forward, the pediatric HIV Counselors will work closely with the EID care point to conduct monthly follow-up of all new and old PCR positive babies to strengthen the psychosocial support to caretakers and parents. Following this rigorous follow up exercise, a total of 184 HIV positive children <15yrs were newly enrolled into care by 102 facilities and about 1,765 children active in care were served in Q1.

Addressing quality in the provision of chronic care services

Support for Quality Improvement (QI) at 84 facilities included on-job mentorship/clinical coaching and support supervision by QI mentors (STAR-EC, Regional and District based). Issues handled were: effective collection of data from all the testing points, updating of pre-ART and ART registers, repeat testing during pregnancy and labor, and proper documentation of intra facility referrals. Also, STAR-EC together with district based clinical mentors conducted an integrated support supervision of 16 health facilities and 128 health workers and found that: filing of patients records has generally improved; stock out of point of care machine (PoC) reagents exists hence no CD4 tests done; Provider Initiated Counseling and testing was being done at all the sites; trained health workers absent from site hence affecting clinical team composition and most of the work at facilities done by lower cadres. The five QI collaborative projects that had earlier commenced during PY4 continued running during this quarter. They include:

1. The ‘5S’ (sort, set, shine, standardise and sustain) principle of QI;
2. Improving the uptake of family planning;
3. Improving HMIS reporting;
4. Active identification of eligible clients; and
5. Tracing lost clients. However patient attrition has not dropped – 46% last quarter vs. 45% in Q1.

Quality improvement in supply chain management

With the goal of attaining ‘Good Pharmacy Practice’ accreditation in collaboration with National Drug Authority, and as part of the recognition and rewarding of facilities for improvements in supply chain management, mentorship visits were carried out in some facilities by the medicines management supervisors (MMS) to facilities in Buyende, Namayingo and Luuka as well as Kaliro Districts.

Bi-monthly ordering of commodities was carried out during this reporting period and 94 out of 118 facilities managed to do it in a timely manner, a reporting rate of 80%. In order to improve the logistics management information systems (LMIS), STAR-EC rolled out e-health interventions at 34 health facilities geared towards improving availability of commodities at the last mile. This was done through training of the MMS and other focal persons from health facilities in web based ordering. All the accredited sites will start submitting their bi-monthly orders through the web based ordering system starting with the upcoming ordering cycle in February. The program will rely on the infrastructure already made available through previous programs at the district level, specifically computers and internet. Subsequently, the trained MMS and focal people will be used to train other health workers such as the district ART focal persons, selected district and ART facility staff. STAR-EC will then routinely support the sites to submit these orders in a timely manner. The program will also use the MMS to disseminate information on supply chain rationalization to emphasize the need to place accurate orders.

Challenges

Facilities are still faced with the issue of stock outs due to poor accuracy of submitted orders.

Way forward

STAR-EC will work closely with MMS during their quarterly supervision of vertical program logistics management to ensure that special attention is paid to the quality of reporting.

Ensuring selection and quantification of relevant products from the national system

The necessary tools such as updated order books, consumption logs were disseminated to health facilities so as to capture the relevant data that would help in doing the forecasting and quantification of medicines in the various intervention areas of essential medicines, ARVS, and TB medicines.

Increasing availability of commodities at HCs II through improving the distribution function

STAR-EC supported the district and health sub-district MMS to improve availability of commodities through distribution and monitoring the stock status of these commodities as a way of averting the problem of stock out of commodities at the lower level health facilities that do not directly order from NMS.

Addressing the human resource constraints to scaling up care and treatment

PEPFAR responded to the critical shortage of Human Resources for Health (HRH). Following this undertaking, STAR-EC collaborated with SDS to disseminate information and support all nine Districts to identify 92 critical positions to be recruited under this HRH support that is separate from the ongoing MoH-led massive recruitment. We await SDS to run adverts for those cadres.

Strengthening health information management for appropriate implementation and monitoring of care and treatment interventions

STAR-EC leveraged resources from SDS to set up an electronic patient monitoring system at six facilities (Kamuli General Hospital, Kamuli Mission Hospital, Namwendwa HC IV, Bumanya HC IV, Nsinze HC IV and Bugiri Hospital) where the Open MRS® system was installed and Records Assistants and Nurses trained. In addition, the 35 facilities that had poor documentation and that failed to generate care reports in the previous quarter were provided with on the job mentorship on using /updating the pre-ART register. Consequently, 102 facilities (in total) have been able to report quality data this quarter compared to 96 that reported last quarter.

Overall, 102 facilities provided chronic care (minimum service of Co-trimoxazole prophylaxis) to 26,217 active clients of whom 1,766 were children aged <15yrs (6.7% vs. national target of 15%). A total of 39 PLHIV received ready-to-use therapeutic foods (RUTF) for the management of severe malnutrition co-existing with HIV and AIDS.

Lesson learned

Numerous implementing partners provide Districts with significant resources to respond to the HIV epidemic, e.g.: STAR-EC, SDS, STRIDES, PLAN, MoH, WHO, SCORE, Global Fund, CSF, etc. So we need to leverage resources through partner-level collaborations.

Challenges

District focal persons and implementers were overwhelmed by the numerous donor-supported activities. This was noted to cause delayed implementation of certain activities.

Way Forward

- Re-engage the District Health Management Teams to efficiently schedule priority activities.
- Seek for technical assistance and work closely with the Applying Science to Strengthen and Improve Systems

(ASSIST) project that is mandated to support our quality improvement efforts at all levels.

2.6 Antiretroviral therapy (ART)

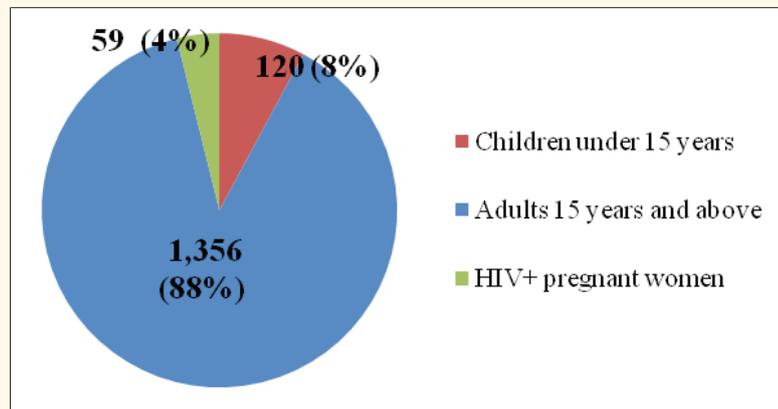
During the reporting period, considerable efforts were placed on increasing enrollment of medically eligible clients on ART and strengthening facility-community linkages to enhance retention of clients in care as well as adherence to treatment.

2.6.1 Strategies to increase enrolment of medically eligible clients on ART

Strategies to increase enrollment on ART included ART outreaches to 40 lower level health facilities on the mainland and 31 on lakeshores and islands targeting fisher folks. These were conducted for a period of two to three days on a monthly basis. Special focus was placed on targeting groups like HIV positive children, HIV positive pregnant women, HIV/TB co-infected and MARPs. As a result, a total of 1,535 PLHIV were newly enrolled onto ART. The different categories can be seen in figure 10 below.

To address the low enrollment of pediatric patients into care and treatment, the program supported health facilities with logistics and facilitated integrated clinical mentorships to identify HIV exposed infants and children through Young Child Clinics, all health facility service delivery points and immunization outreaches. As a result the proportion of eligible children initiated on ART increased from 7.6 % in the last quarter to 8.0%. This program year the target is to provide ART to 14,240 new PLHIV (9,300 adults, 2,400 children and 2,540 HIV positive pregnant women).

Figure 10: Clients newly initiated on ART (n= 1,535)



Source: STAR-EC program records

The cumulative number of clients ever started on ART increased to 16,967 and of these 13,722 clients were found active on ART. Approximately 584 clients were transferred out, lost to follow up or died.

2.6.2 Strengthening laboratory services delivery

The program continued implementation of laboratory activities for health systems strengthening and providing integrated diagnostic and monitoring services in support of HCT, ART, PMTCT, TB, EID and other clinical conditions. STAR-EC collaborated with CPHL, NTRL and UVRI/HRL to improve community access to a wide range of basic diagnostic tests at HCs III, IV and General Hospitals in region.

Performance of supported HC laboratories

Laboratory data collected from HIMS 055b showed that:

- More tests (apart from Hb estimation) were reported by the HCs III level facilities than HCs IV and General Hospital (see Figure 11). This demonstrates that the program has made laboratory service more accessible, available and closer to the communities.
- HIV (n=132,830) and malaria (n=84,279) were the most performed tests by the laboratories.
- Malaria, intestinal parasitic infections and proteinuria were the most prevalent conditions diagnosed compared to HIV whose prevalence (taken from laboratories) was lowest at 2.4% (Fig 11). This calls for integrated interventions for provision of prevention and treatment of these conditions besides routine TB and HIV&AIDS care.

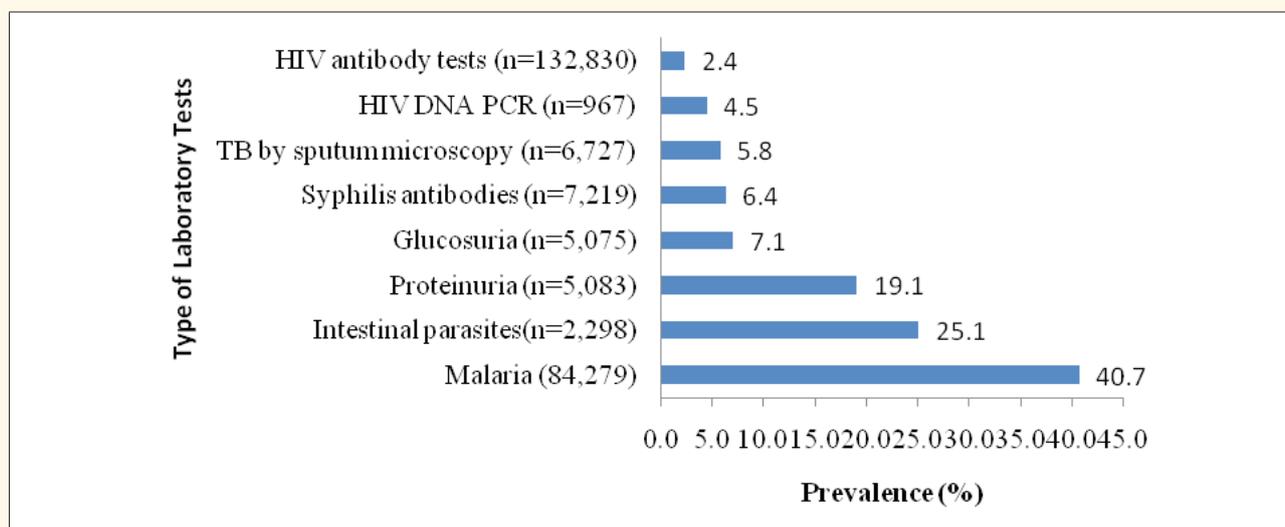
Key laboratory interventions implemented in Q1, PY5

- Implementation of the Strengthening Laboratory Management Towards Accreditation (SLMTA) program at 3 General Hospitals. Mid-term assessment was conducted by STAR-EC in collaboration with MoH/CPHL. In addition, these General Hospitals were supported to participate in international quality assessment schemes that are coordinated by MoH/CPHL, namely UK-NEQAS for CD4 pheno-typing and Afriqualab. The AfriQualab is a structure created with collaboration of the Centers for Disease Control (CDC) to support the development of an HIV related proficiency testing program for medical and clinical laboratories in Africa
- Roll out of the Laboratory Quality Management System (LQMS) at 26 health facility laboratories
- Implementation of the National External Quality Assessment Schemes (NEQAS) for HIV and TB at all supported HC laboratories in the region.
- Provided laboratory equipment (Binocular microscopes) to 2 HC laboratories to foster their capacity to perform onsite TB and malaria including other microscopic procedures.
- Equipment maintenance (service and repair) was provided to Iganga General Hospital to avert interruptions of CD4 testing services.
- Facilitated targeted technical follow-up mentorships for the PIMA machines in order to augment MOH efforts to avail point-of-care CD4 testing services at 20 peripheral HCs in the region that received the devices in 2012.
- In collaboration with SDS Program, STAR-EC maintained supporting and coordinating blood specimen referral from peripheral HCs to regional hubs for CD4 and HIV DNA PCR testing for ART monitoring and early infant diagnosis of HIV respectively, outputs reflected under ART and PMTC sections.

Key Laboratory outputs

- 6,727 TB sputum microscopy tests performed yielding 320 TB cases diagnosed
- 5,895 CD4 cells count tests for ART initiation and monitoring reported contributing to the new ART enrolled
- 975 HIV DNA PCR tests for EID of HIV among exposed reported leading to 59 babies diagnosed HIV positive
- 132,830 HIV antibody tests performed
- Kamuli General Hospital laboratory attained a one star score during the SLMTA mid-term evaluation by MoH/CPHL

Figure 11: Prevalence of various clinical conditions based on laboratory tests reported during the quarter



Source: STAR-EC Program records

Participation in MoH-National External Quality Assessment Scheme (NEQAS)

During the March, 2012 TB survey coordinated by NTRL, 355 sputum proficiency test panels were reviewed from 77 participating laboratories and their overall average score for the 71 respondents is 92.82%. However, four false positive (1.12%) and 18 false negative (5.07%) smears were made; 2 quantification errors were recorded, 0.56% of total slides reviewed. On the other hand, reports for HIV proficiency testing panel coordinated by UVRI/HRL were received. Efforts are underway to provide onsite mentorship visits to those HCs that performed poorly in NEQAS.

Challenges

- The health facilities experienced prolonged shortage of HIV test kits and CD4 diagnostics for PIMA devices. STAR-EC will continue to support the district based structures to liaise with the National Medical Stores to address this situation.
- The region continues to face inadequate availability of human resources for health laboratory services delivery in the region. District authorities commenced recruitment processes during the quarter and deployment of the laboratory staff is expected soon.

2.6.3 Improving adherence to treatment and retention of clients in care

The program facilitated expert clients to conduct home visits and trace clients who missed appointments for > 3 months. A total of 490 clients had missed appointments and were followed up, but only 70% (343) of the clients returned. The rest had died, migrated to other towns and gave wrong addresses. This approach not only strengthened community follow-up support and ongoing counseling, but also helped to reduce the LTFU status of clients from 18% in last quarter to 16% as seen in figure 12 below.



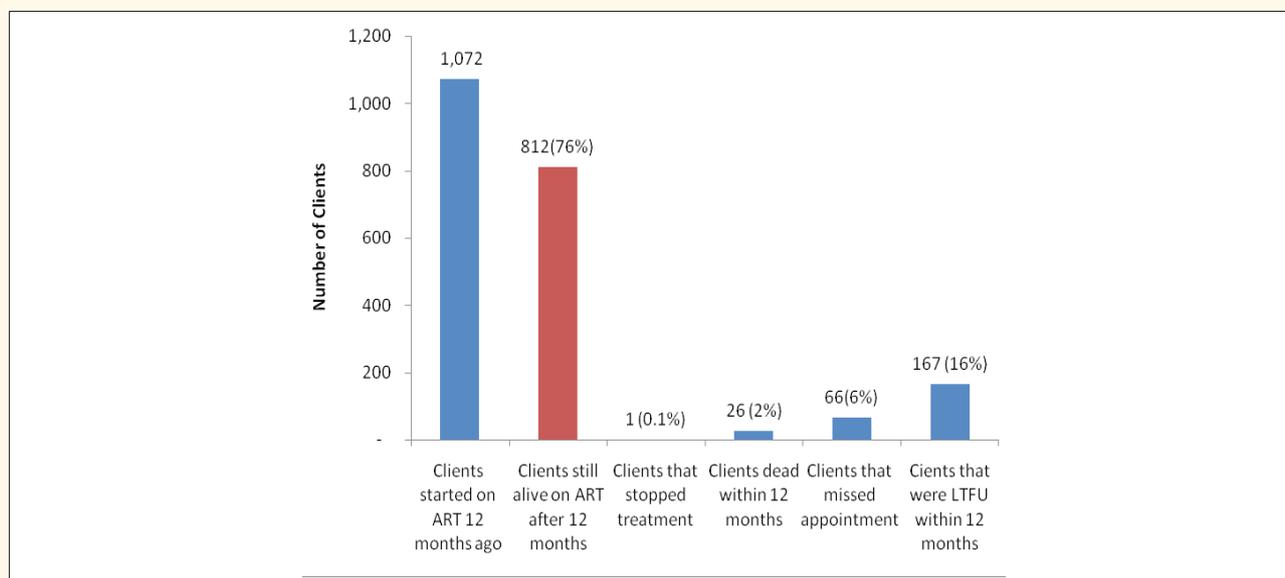
Metallic filing rack at Kidera HCIV

The patient management and follow up intervention was also rolled out to all ART sites; metallic filing racks, master index cards and appointment books were procured and supplied to the health facilities.

About 40 health workers, records assistants and expert

clients were mentored on the use of master patient index cards, utilization of the appointment book system and record filing system. This approach has helped to reduce on the waiting time for clients during clinic days because files are retrieved faster and has also improved identification of clients that missed appointments.

Figure 12: Twelve months ART cohort analysis outcomes



Source: STAR-EC Program records

Despite the above efforts, client retention in care and ART is below the recommended < 90%; (See figure 12). This could be attributed to the highly mobile nature of the fisher folks in the Islands that become lost to follow up.

Challenges

The slight decline in enrolment of new clients on ART can be attributed to the slowdown in the focused drive for accelerated initiation on ART. This was as a result of irregular CD4 testing from health facilities that have PIMA machines because of stock out of cartridges and transportation challenges of CD4 samples to the regional hubs.

Way forward

- Scale up ART services by supporting accreditation of an additional 22 health facilities and building capacity of the clinical teams to offer comprehensive HIV care services. As a result, weekly static ART outreaches will be carried out as opposed to the monthly outreaches and more clients will easily access care and treatment services.
- To achieve the set ART targets, the program will utilize dedicated teams to re-embark on the focused drive of accelerated initiation for all those medically eligible and not yet on ART; address challenges related to CD4 testing and transportation of samples to the regional hubs.
- Enhance linkage and referral system within the current pediatric care and treatment program in order to improve EID and retention of infants and children who are exposed to HIV.

2.7 TB/HIV collaborative activities

During PY5, the program is focusing on strengthening the community and facility based TB control initiatives in order to increase adult, pediatric and MDR (Multidrug resistant TB) case detection, ART enrollment for TB/HIV co-infected patients and the treatment outcome of all forms of Tuberculosis (TB).

2.7.1 Increasing TB case detection at facility and community level

Efforts to increase CDR were focused on intensified TB case finding at facilities, TB campaign outreaches in high prevalence districts/sub-counties and contact tracing by SCHWS for index cases. STAR-EC conducted one day TB

intensified case finding orientation meeting to 85 PLHIV sub county networks. This attracted 729 participants all equipped with skills and knowledge to identify TB suspects from the community most especially among the PLHIV households and refer them appropriately. Following this training, PLHIV structures have conducted TB sensitization campaigns in their respective sub counties and conducted home visits to fellow PLHIV households to sensitize them on signs and symptoms of TB.

During the quarter, a total of 468 cases of all forms were detected and of these 320 (31%) were smear positives. During this quarter, TB campaigns were conducted in Mayuge, Namayingo and Iganga districts. Despite all these efforts, the region consistently detects low TB cases.

Table 9: Case detection rate for each district during Q1 of PY5

District	Expected No. of cases	No. detected	CDR
Iganga	170	87	51.2
Kamuli	170	28	16.5
Kaliro	74	23	31.1
Mayuge	157	68	43.3
Namutumba	74	22	29.7
Bugiri	145	46	31.7
Luuka	89	5	5.6
Namayingo	79	27	34.2
Buyende	84	14	16.7
Overall	1042	320	30.7

Source: STAR-EC program data.

SUCCESS STORY

Using Innovative Strategies to Improve TB Case Detection in the East Central Region of Uganda

Borrowing from the lessons learned from the couple week outreaches, STAR-EC conducted a three day long TB campaign in Mayuge, Namayingo and Iganga, the districts with highest number of notified TB cases in an effort to improve case detection rate in East- Central Uganda. The niche specific community campaign was premised on two components of; emphasizing intensified TB case finding, and targeted communication to build awareness especially among the vulnerable groups. The three day long campaign employed a strategic approach of positioning health care provider teams in slum settlements, landing sites and high prevalence sub counties. A team of 'linkage



During one of the outreaches in Namayingo

facilitators' including local council leaders, VHT members and SCHWs supported the health workers in mobilizing their respective communities. Additionally, radio announcements were placed informing people where to obtain TB information and services; a mobile truck with a public address system was employed to move around the identified communities mobilizing and informing them of sputum outreach sites. Through this innovation, a total of 33 new smear positive cases out of the 798 suspects were identified and started on treatment. The suspects were tested for HIV too.

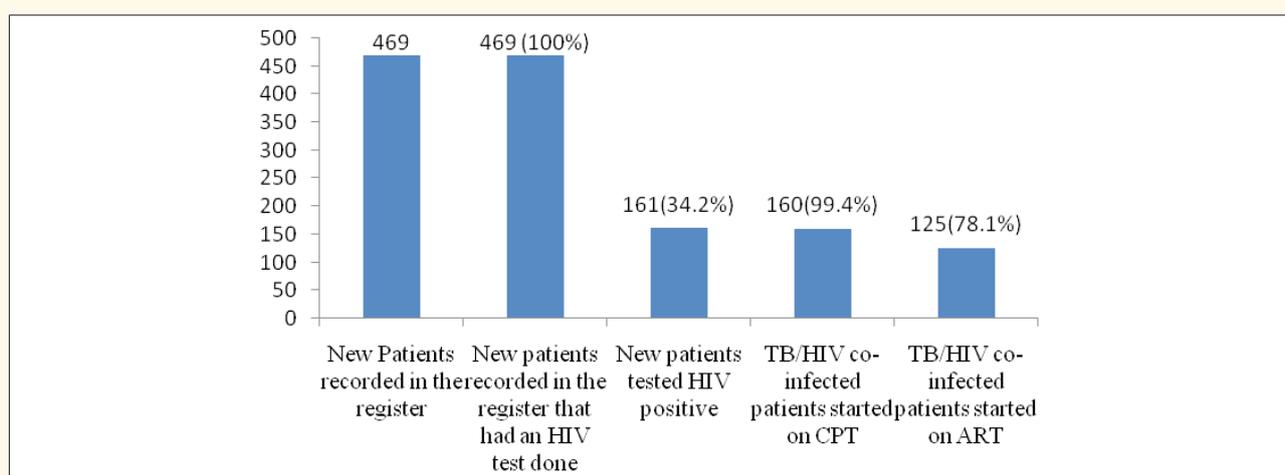
2.7.2 Improving TB treatment outcomes

Treatment success rate (TSR) has been above the National target of 85%. During Q1 of PY5, a total of 249 patients were evaluated and out of these 210 (84.3%) patients succeeded whereas the cure rate was 60.6%, an improvement from 47% and 53% of Q3 and Q4 of PY4 respectively. In addition, the regional default rate is 5.2% compared to the national target of 5%. The increase in cure rate is as a result of the support given to SCHWs to prepare and transport slides to diagnostic facilities from the communities.

2.7.3 Improving TB/HIV collaborative activities

To consolidate the facility TB/HIV integration, the program implemented the following strategies: mentorship and support supervision to the health care providers in 85 facilities, improving linkages between TB and HIV chronic care services, enhancing internal and external referrals between TB and HIV service points and performance review meetings. Consequently 78% of the TB/HIV co infected patients were enrolled on ART by the end of the quarter compared to 70% which was achieved in PY4. ART enrollment in the East Central Region has been consistently higher than the national achievement of 32%. Though the national estimated TB/HIV co infected patients is at 53%, the number in this region has consistently remained below 35%.

Figure 13: Achievements on select TB indicators for Q1 of PY5



Source: STAR-EC Program Records

Table 10: TB status in HIV chronic care services (Care & ART) for Q1 of PY5

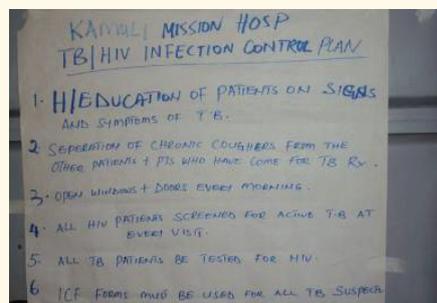
Indicator	Current clients seen during the quarter	No. of clients screened for TB	% screened for TB	No. of suspects investigated for TB	No. of clients started on TB treatment
Iganga	4302	4256	99	34	28
Kamuli	5075	5059	100	34	9
Bugiri	4256	4247	100	10	3
Namutumba	1987	1987	100	26	7
Kaliro	1671	1671	100	43	10
Mayuge	2619	2596	99	4	3
Buyende	2244	2244	100	10	3
Luuka	1040	1026	99	-	7
Namayingo	3023	3023	100	51	17
Overall	26,217	26,109	99.6	220	86

Source: STAR-EC program records

A total of 26,217 patients were reviewed during the quarter and out of these 26,109 (99.6%) were screened for TB.

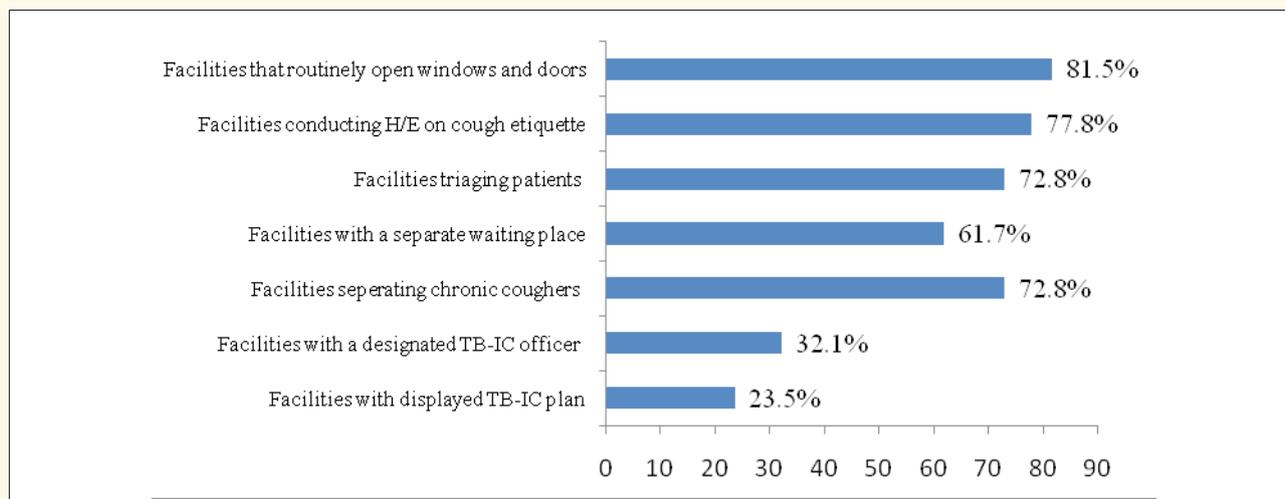
2.7.4 Promotion of TB infection control

STAR-EC continued to provide technical support to facilities to implement the first line (administrative and environmental) TB infection control measures. Though this support has been ongoing for the last three program years, there had never been an assessment conducted to establish the level of implementation. During this quarter, an assessment was conducted in 81 facilities and the results are shown in Figure 14. Immediate support was provided to facilities with gaps in implementation as well as writing and displaying TB infection control plans. In addition, the results of the assessment show that the number of health workers that have suffered from TB has been declining over the years. In 2010, nine health care providers suffered from TB, six in 2011 and only two were treated for TB in 2012.



TB-IC plan displayed at Kamuli Mission Hospital

Figure 14: Status of TB infection control implementation at facilities



Source: STAR-EC Program records

2.7.5 Addressing the emergence of multi-drug resistant (MDR) TB

STAR-EC continues to support delivery of samples for MDR testing. However no case of MDR TB was reported during the quarter. All the 19 TB cases so far identified are awaiting treatment.

2.7.6 Strengthening the identification and management of TB in Children

Although mentorship on management of childhood TB was conducted during the PY4, management of childhood TB is still a challenge amidst scarce X-Ray services in the region. A total of 16 children out of 469 TB cases were identified with TB during the quarter.

2.7.7 Ensuring un-interrupted supply of TB logistics

During this reporting period, out of the 85 facilities that have TB clinics, 72 managed to do timely ordering of drugs from NMS and the Joint Medical Stores (JMS). This is a reporting rate of 85%. Follow up is being done on the facilities that were unable to do timely reporting.

2.7.8 Advocacy, communication and social mobilization (ACSM) for TB services

A range of targeted integrated activities aimed at increasing TB case finding were implemented to create awareness among the general population and in identified communities with high prevalence. The multi-pronged approaches included; dedicated radio talk show programs, mobile music/public address system, puppetry drama performances, display and dissemination of IEC materials and small group discussions. Additionally community leaders including local council leaders were utilized to conduct mobilizations within their respective communities.

Challenges, way forward

- Though screening for TB in chronic care settings is routinely done, TB diagnosis among HIV positive patients by sputum microscopy is still a major challenge. STAR-EC has planned to support delivery of sputum samples for Gene X-pert technology examination to Jinja Regional Referral hospital and Buyinja HC1V; unfortunately this was not possible during this quarter because of stock outs of cartridges.
- Stock outs of microscope slides affected sputum follow up and contact tracing by SCHWs. STAR-EC will continue to support facilities on logistics management.

Lessons learned

- Preparation and transportation of slides to diagnostic facilities by SCHWs plays a critical role in improving the treatment outcome and cure rates.
- Strengthening community structures plays a critical and sustainable role in TB control.

3.0 Improving the capacity of Districts, CSOs and Communities to plan, deliver and sustain a 'continuum' of HIV&AIDS services

This quarter STAR-EC performed a reassessment of the three prequalified CSOs (FLEP, URHB and YA). The program also performed an assessment of the other two organizations that were supported to implement activities in 2010 (FOCREV and MUCOBADI). The results indicate significant progress in most of the capacity domains assessed. Significant progress was registered in the area of leadership and Governance and financial management. There were still challenges in human resource management due to high staff turnover owing to inadequate incentives to recruit and retain high quality staff. Sustainability was also registered as a challenge since most of the CSOs depend on a single source of funding for their activities. MUCOBADI was exceptional in this regard since it had attracted more funding sources during the review period that include IFAD, GOAL, Comic Relief, STAR-E, CSF and IDF; and now has the potential to attract new ones with the growth it has attained.

3.1 Support to strategic information collection and utilization

3.1.1 Client satisfaction survey

Over the period of this quarter, STAR-EC conducted a client satisfaction survey to assess the level of clients' satisfaction among beneficiaries of SMC, ART and PMTCT services at STAR-EC supported health facilities. This study involved use of both quantitative and qualitative survey methodologies and was conducted in all STAR-EC supported districts among randomly selected health facilities of different characteristics that included the volume of clients at site; those with newly initiated services as well as health facilities in the order of their usual performance. Information generated has already been used in developing strategies to address some quality issues that were raised by beneficiaries.

3.1.2 Assessment of the utilization of service performance assessment and improvement (SPAI) process in STAR-EC supported districts

During the quarter, STAR-EC together with the STAR-E LQAS Project conducted an assessment on the progress of STAR-EC supported districts in the utilization of SPAI process. SPAI was introduced in 2010 to promote use of data generated from LQAS household and health facility surveys in triangulation with health management information system (HMIS) for planning and decision making on an annual basis. However, due to different data use processes that exist in districts, there was need to assess whether the SPAI process was still helpful to districts. Overall, six districts; Namutumba, Bugiri, Mayuge, Iganga, Kaliro and Kamuli were assessed. Results showed that only two districts (Namutumba and Mayuge) were actively using SPAI mainly due to the presence of active SPAI focal persons. A full report on findings will be shared by the STAR-EC LQAS Project.

3.1.3 Support to district management improvement plans (DMIPs)

During this quarter, STAR-EC, SDS and other USAID implementing partners provided technical assistance and other inputs towards the development of district management improvement plans (DMIPs) for Kaliro and Iganga districts. The DMIP is both a short and long term district owned plan that helps to prioritize district activities as well as the resources required to execute such activities aimed at improved service delivery. Specifically, STAR-EC provided data and information which was used by the districts as a basis for identifying underserved health service areas. Jointly with the districts, underperforming areas were identified, discussed and action points developed with the aid of routine data. These activities thus formed key components of the DMIP.

3.1.4 Districts led performance reviews

During the quarter, STAR-EC conducted both the staff in-house and district performance review meetings (for all the nine districts) where PY4 data from HMIS and LQAS results were disseminated. This is normally a quarterly activity. With technical assistance from STAR-EC's SI and technical teams, district staff was able to review their performance in relation to sub-county, district, regional and national targets by technical area. Challenges, experiences, lessons learned and the way forward were mapped by participants and as such quarterly district owned action plans were developed. These included new strategies aimed at realizing their PY5 targets and improving the quality of services.

3.1.5 Routine support supervision through on-site mentorship

STAR-EC conducted support supervision field visits in a number of selected health facilities in the nine STAR-EC districts. This activity involved on spot feedback to health workers after assessing: the quality of services being offered at the health facility; the availability of skilled manpower and essential drugs/equipment used when handling clients; availability of HMIS tools and the status of the current data systems as well as the quality of data reported to the Districts, STAR-EC and MOH. In addition, routine Data Quality Assessments and Improvement (DQAI) field visits which are primarily aimed at improving data quality, timeliness and system strengthening at our LG supported HFs and CSOs were conducted. These mainly targeted ART accredited voluminous sites (Hospitals, HCs IV and HCs III) and the hard-to-reach HCs II where HIV care and PMTCT services had been recently scaled up.

3.1.6 Review of existing data tools

In order to cater for the ever increasing new 'Next Generation PEPFAR indicators', MOH and PEPFAR policies (e-MTCT, gender and PHDP), STAR-EC finalized the process of reviewing existing in-house tools and developing new tools without necessarily compromising or altering existing MoH HMIS tools. Changes in the tools were also incorporated in the STAR-EC database. Pretesting of these tools, subsequent training/use commenced among primary users.

3.1.7 Enhancing clients' records management and quality

STAR-EC together with a team from the Clinton Health Access Initiative (CHAI) have been providing HIV Care clients cards, suspension and spring files, metallic filing racks as well as onsite training and mentorship of health workers on filing, use of master patient index cards, appointment book strategy and general patient's records management. In this quarter, the intervention was scaled up from seven health facilities which had been piloted in the last quarter of PY4 to 64 other sites making a total of 71 health facilities (by the end of this quarter). The onsite orientation and mentorship will be ongoing to ensure that the acquired knowledge, skills and good practices of



Let's do it now! VHTs during the training practicing data recording

records management are fully embraced by health workers at the benefiting health facilities. In this quarter, 75 metallic filing racks, 3000 files (1000 suspension and 2000 spring files) were procured and distributed among all the afore-stated 71 health facilities.

In a bid to improve on VHT data collection skills, 186 Sub County and parish VHT coordinators from 30 sub counties in the nine districts were oriented on data collection, recording and reporting. This helped to improve on the quality of data reported by VHTs though a few challenges still linger on. Following this orientation, STAR-EC facilitated sub county VHT coordinators to collect and report monthly data by providing them with monthly transport assistance and stationery. A number of VHTs can today collect referrals data and report

"I really benefited from the data management training. I was equipped with knowledge to collect quality data, I can now realize the logic flow of data and I am able to interpret

it. Secondly, I am now able to teach my parish coordinators how to fill in referral summary forms appropriately. The training also eased by support supervision, I now know what to do during such visits". Mr. Kibira Muhamad, VHT coordinator Ibulanku Sub country proudly mentions!

3.1.8 Training of health workers in the use of Open Medical Records System (Open MRS)

STAR-EC during last quarter trained Health workers from Bugiri, Iganga, Kamuli, Kaliro and Namutumba districts in the use of Open MRS. A total of 60 health workers from 13 health facilities benefited from this training. The cadres trained from each health facility included; In Charges, Medical Records Assistants, Nursing Officers, Biostatisticians, Data Entry Clerks, HMIS Focal Persons and ART Focal Persons.

3.1.9 Key meetings and workshops held with other partners

STAR-EC participated in a series of meetings at the MSH (STAR-E LQAS Project) aimed at improving the quality of the consolidated 2012 national LQAS survey report. Feedback was particularly provided on HIV&AIDS, TB and STI results and trends for indicators in the East Central Region. Other implementing partners that attended included: STAR-E; STRIDES, STAR-SW and SUNRISE. Other meetings attended during the quarter included those on the progress towards LQAS institutionalization as well one HMIS strengthening with the MoH Resource Centre.

3.2 Supporting VHTs in reaching out to the underserved and most-at-risk populations

In an effort aimed at supporting MoH to operationalize VHT structures in East Central Uganda, STAR-EC continued to provide technical support to VHTs in the nine districts with much emphasis on Namayingo and Mayuge. STAR-EC supported VHT district and sub county coordinators to conduct support supervision to parish and Village VHTs which was intended to ensure VHTs register households in their villages, promote sanitation, mobilize households for immunizations, promote general health by conducting appropriate referrals and improve on documentation and reporting. Further, STAR-EC supported 100 model VHTs from nine districts to conduct planning and review meetings. Gaps were discussed and operational work plans to improve service delivery were developed which are to be implemented next quarter (Q2 PY5).

As result, referrals were strengthened for all intervention areas resulting in increased utilization of services and clients' satisfaction of the referral process. In the following story, one of the clients speaks highly of her "neighbor Doctor."

SUCCESS STORY

Little did I know that my neighbor could be my doctor...



Florence 33, mother of five from Ibulanku Sub County happily tells her story. "It was 2010 July, when I fell so sick to the extent that I could not help myself. Under the care of my two sons (6 and 8 years old), I had sores and wounds all over my body. One morning while confined in my bed, my neighbor Mohammed visited me introducing himself as a trained VHT. He assured me of his support to me through counseling and linking me to health services. At first, I did not take him serious because I had all the symptoms of "witch craft." He insisted and later he carried me on the motorcycle and took me to Busesa HCIV where I tested HIV positive and my CD4 were too low.



A VHT member conducts a risk reduction counseling session for women during a community outreach in Bugoto -Mayuge District

I was enrolled into care and "my doctor" continued supporting me and picking ARVs for me until I gained strength. I am now fine, I can do domestic activities, gardening and taking good care of family. I thank my 'neighbor doctor' and the program (STAR-EC) which trained him. He is always available to us whenever we call him. Many people die unknowingly, so the program should train more VHTs to save many other lives..."

The presence of 'Linkage facilitators' in the community has opened a new front of utilizing unique opportunities to conduct health discussions, education and sensitization in communities. VHTs and other peer educators have sensitized communities during social gatherings/celebrations and club meetings which have enabled them to have personal contact and tailor communication messages to respective needs of their communities. This has encouraged and improved health seeking behavior. "When Minisa (VHT from Lugala), talked to me, I felt I had met a friend; she understood my problem and helped me know that I needed to go to the hospital and not to our doctors in the village" one member of Lugala-Namayingo District said.

3.2.1 Fostering active involvement of PLHIV networks in delivery of HIV&AIDS services

STAR-EC continued to provide quarterly support to district PLHIV forums and sub county networks. The district forum conducted support supervision to sub county networks to monitor services received from facilities and the community by PLHIV. Additionally, the forum strengthened the feed loop to health facilities on the issues raised by PLHIV networks. Stake holders and PLHIV review meetings were also conducted these enabled them to share experience and testimonies about their life styles, encouraging each other to continue adhering to clinical services and providing psychosocial support to fellow PLHIVs.

3.2.2 Strengthening the role of civil society and community based organizations in effectively reaching the communities

During Q1 PY5, the three pre-qualified CSOs were supported to continue mobilizing, referring and linking clients to key services. They also supported PLHIV to advocate for increased access to care and treatment and the right to live

free of stigma and discrimination. This was achieved through door-to-door mobilization, community sensitization and participating in integrated service delivery. As a result, the CSOs were able to make 20,273 referrals for a variety of services and only 18,275 (90%) received services for which they were referred.

3.2.3 Grants to Civil Society Organizations

During Q1, the three pre-qualified CSOs namely FLEP, URHB and Youth Alive continued operations focusing in areas with high HIV prevalence; although with a slow start of activity implementation while awaiting approval of the annual work plans and budgets. In addition, six other community based organizations (CBOs) identified through a competitive bidding process to implement activities in the MARPs areas continued to await approval. Once approved, the CBOs will operate in the Islands of Sigulu, Jaguzi, landing sites in Namayingo, Mayuge, Buyende and trading centers along the northern transport corridor (see summary in Table 11).

Table 11: CBOs to target Islands and hot spots along the northern transport corridor

	Name of organization	Area of operation
1	Sigulu Women Aids Awareness Organization (SIWAO)	Bugana, Buduma, Biisa Yebe islands - part of Sigulu Islands
2	Bukooli Islands Women Integrated Health Initiative (BIWIHI)	Golofa, Kandenge, Singila landing sites and 'mainland' on Lolwe East and Lolwe West on Lolwe Island - part of Sigulu Islands in the upper waters
3	Friends of Christ Revival Ministries (FOCREV)	Manga, Bumalenge, Nampongwe, Rabaki, Mukani on Sigulu island; Lutolo, Buwoya, Bujwanga, Lugala, Buchumba landing sites / lake shores on the mainland in Namayingo
4	Jinja Diocese Health Office (JDHO)	Buyende Town Council, Kagulu - includes Iyingo landing site
5	Uganda Development Health Association (UDHA)	Iganga Municipality Central and Northern division, Buyanga, Namungalwe,
6	National Forum of People Living with HIV&AIDS Networks in Uganda (NAFOPHANU)	Health centres and communities in all the nine districts

Source: STAR-EC Program records

3.3 Collaboration with the Strengthening Decentralization for Sustainability (SDS) in the implementation of district-led activities

During the first quarter of PY5, the SDS program put much emphasis on the completion and establishment of mechanisms for implementing District Development Plans (DOP) in the districts that had not yet signed off the DOP by the close of PY4. Significant effort was also put in supporting districts to develop District Management Improvement Plans (DMIP), conducting performance evaluations exercises, as well convening various SDS partners meetings.

(i) Field validation exercises for “Category A” supported activities:

STAR-EC participated in performance evaluation exercises for the districts of Mayuge, Bugiri, Iganga, Kaliro, Namutumba and Kamuli. The evaluation exercise revealed that many of the districts supported by SDS in various regions of the country scored less than 100% according to the set performance score matrix. Most districts therefore, did not qualify to receive 100% disbursements for the next quarter (Qtr 2). Some of the reasons for this underperformance included but not limited to; districts failure to provide adequate, accurate and timely financial and program accountability for some activities, failure by the districts to meet their cost share contribution to support the implementation of the activities and late release and access of funds by the implementers to be able to implement the activities within the agreed time frame. To address the above issues, SDS and other USAID funded partners met key district leaders (CAOs, DHOs Planners, and SDS focal point persons) and agreed that henceforth; districts had to meet their cost share contribution, DBTAs have to review and approve all activity reports before submission to SDS and that COAs have to approve of district accountabilities before they are submitted to SDS.

(ii) Development of District Improvement Management Plans (DMIP):

DMIP documents were finalized by the districts of Mayuge, Namutumba, Kaliro, Iganga and Bugiri. The DMIP documents provide a framework that the districts can use to set priorities to address the service delivery gaps as well as soliciting for funds from different development partners to address service delivery gaps. Additionally, the DMIP documents provide vital information that districts can use to make projections for the district development plans and well as annual budget framework papers. STAR-EC supported districts to make plans, budgets and to operationalize the DMIPs.

(iii) District Operational Plans (DOP) and District Management Committee Meetings.

Formal signing ceremonies for District Operational Plans were held for the districts of Kaliro, Mayuge and Bugiri between, USAID, SDS and District Based Technical Assistance (DBTA) programs/ implementing partners. The DOPs provide a framework for improved, planning, budgeting and coordination of activities for USAID funded partners working within the same district. DOP management committees meetings were also attended for the districts of Mayuge and Kamuli, during which meetings, participants reviewed the performance of the districts against the set targets for the quarter. Areas of improvements and strategies for better communication and coordination between and among USAID supported partners were also discussed.

4.0 Conclusion

This report has articulated the various strategies that were utilized by STAR-EC to increase access to and utilization of TB and HIV&AIDS in the East Central Region. The program employed lessons learned and best practices from the past four years of implementation to package and deliver quality services to the targeted populations. In particular, we scaled up outreach services targeting MARPs using an integrated approach; worked closely with partners such as SDS, UHMG and STRIDES for family Health project to provide a wide range of services; and supported the 'continuum of response' through linking PLHIV to different service delivery points. As the program pursues increased access to services through supporting accreditation of additional health facilities, community engagement through PLHIV networks and VHTs will be imperative in stepping up active client follow up as well as improving health seeking behavior. Since there are current opportunities for districts to recruit additional human resources, we shall continue to work with the SDS project to address the critical human resources gaps that impede the envisaged scale up of services.

STAR-EC would like to acknowledge the invaluable efforts of the Ministry of Health, USAID, SDS, district local governments, JSI head office, STAR-EC sub partners, and other implementing partners working in East Central Uganda; all of which greatly contributed to the achievements detailed in this progress report. We are optimistic that with such a high level of commitment among the partners, the technical, human resource, logistical and structural challenges highlighted in this report will be systematically addressed and the ambitious program targets for PY5 will be achieved.



**Kampala Liaison Office
STAR-EC**

Uganda Health Marketing Group

**Plot 20 - 21/ 27 - 28, Martyrs Crescent, Ntinda, P.O. Box 40070, Nakawa, Uganda
Tel : (+256) 414 222864, (+256) 312 262164**

STAR-EC Headquarters

**Plot 10 Kiira Lane, Mpumudde Division, P.O Box 829, Jinja
Tel: +256 434 120225, +256 434 120277, +256 332 260182, +256 332 260183
Fax: +256 434 120232
www.starecuganda.org**