

Strengthening TB and HIV & AIDS Responses in Eastern Uganda (STAR-E) Project: Annual Report PY2 OCT 2009- SEP 2010

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Date of Publication: October 2009 – September 2010

Development objective:

The goal of the project is to empower communities in eastern Uganda to respond effectively to the challenges posed by the HIV/AIDS and TB epidemics.

The general objective of the project is to increase access to, coverage of, and use of, quality, comprehensive HIV/TB prevention, care, and treatment services within district health facilities (HFs), with emphasis on high volume facilities and their respective communities.

Suggested Keywords: STAR-E, TB, HIV&AIDS, Annual Report, PY2, Eastern Uganda

This report was made possible through support provided by the US Agency for International Development and the USAID Uganda, under the terms of Cooperative Agreement Number 617-A-00-09-00006-00 and Nancy Kleinhaus. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the US Agency for International Development.

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STAR-E PROJECT, EASTERN UGANDA District-Based HIV/TB Program



Cooperative Agreement # 61 7-A-00-09-00006-00

STAR-E PROJECT ANNUAL REPORT FOR THE PERIOD OCTOBER 2009–SEPTEMBER 2010

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Cover page photo: Outreach HCT in one of the fishing communities in Pallisa district.

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ACRONYMS AND ABBREVIATIONS

ABC	Abstinence, Being faithful, and using Condoms
ADP	AIDS Development Partners
AIC	Aids Information Center
AIDS	acquired immunodeficiency syndrome
AIM	AIDS/HIV Integrated Model District Programme
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral (medicine)
BCC	behavior change communication
CAO	Chief Administrative Officer
CB	community-based
CB-DOTS	Community-based Directly Observed Therapy, Short Course
CBO	community-based organization
CCA	community counseling aide
CCT	center coordinating tutor
CDR	case detection rate
CHAI	Clinton Foundation HIV/AIDS Initiative
CHS	Center for Health Services [MSH]
CHW	community health worker
CME	continuing medical education
COMU	Country Operational Management Unit
COP	Chief of Party
CPHL	Central Public Health Laboratory
CS	civil society
CSO	civil society organization
CSW	commercial sex worker
CT	counseling and testing
CTX	co-trimoxazole
DACC	District HIV/AIDS Coordinating Committee
DBHT	District-Based HIV/TB Program
DBS	dried blood spot [diagnostic test]
DCOP	Deputy Chief of Party
DHA	District Health Advisor
DHE	District Health Educator
DHO	District Health Office/Officer
DHT	District Health Team
DHMT	District Health Management Team
DLFP	District Laboratory Focal Person
DOTS	Directly Observed Therapy, Short-course [TB]
DP	development partner
DTLS	District TB and Leprosy Supervisor
DTU	District TB Unit

EBF	exclusive breast-feeding
EID	early infant diagnosis
ELISA	enzyme-linked immunosorbent assay
EMR	electronic medical record
EQA	external quality assurance
FBO	faith-based organization
FBT	Field-Based Team
FFSDP	Fully Functional Service Delivery Point
FP	Family Planning
GIS	global information system
GOU	Government of Uganda
HAART	highly active antiretroviral therapy
HBC	home-based care
HC	health center
HCI	Health Care Improvement [MOH initiative]
HCP	Health Communication Partnership
HCT	HIV counseling and testing
HFA	Health Facilities Assessment
HIV	human immunodeficiency virus
HMIS	health management information system
HRD	human resources development
HSD	Health Systems Development [Programme]
HSSP	Health Sector Strategic Plan
HU	health unit
IAC	International AIDS Conference
ICF	intensified case finding
IEC	information, education, and communication
IH	institutional home
IMAI	Integrated Management of Adolescent and Adult Illness
IMCI	Integrated Management of Childhood illnesses
IMPAC	Integrated Management of Pregnancy and Childbirth
IP	implementing partner
IR	Intermediate Result
IRCU	Inter-Religious Council of Uganda
ISAE	Institute of Statistics and Applied Economics
IT	information technology
JCRC	Joint Clinical Research Centre
JMS	Joint Medical Stores
LATH	Liverpool Associates in Tropical Health
LCV	Local Council V
LG	Local Government
LMIS	logistics management information system
LMS	Leadership and Management Sustainability Project [MSH]
LNGO	local nongovernmental organization
LTFUR	lost to follow-up rate

LQAS	Lot Quality Assurance Sampling
MAP	Multi-country AIDS Program [World Bank]
MARPs	most-at-risk populations
MCH	maternal and child health
M&E	monitoring and evaluation
MEEPP	Monitoring and Evaluation of Emergency Plan Progress
MMC	male medical circumcision
MOES	Ministry of Education
MOH	Ministry of Health
MOU	memorandum of understanding
MSH	Management Sciences for Health
MUSPH	Makerere University School of Public Health
MTCT	mother-to-child transmission
NACP	National AIDS Control Programme
NACWOLA	National Community of Women Living with HIV/AIDS
NCC	National Coordination Committee [TB]
NGO	nongovernmental organization
NMS	National Medical Stores
NTLP	National TB/Leprosy Program
NUMAT	Northern Uganda Malaria, AIDS & Tuberculosis Program
OI	opportunistic infection
OR	operational/operations research
OVC	orphans and vulnerable children
QA	quality assurance
QAI	Quality Assurance Initiative
QI	quality improvement
PACE	Post-Abortion Care and Education Project
PBF	performance-based financing
PBG	performance-based grant/grantee
PCR	polymerase chain reaction
PEP	post exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHA	people living with HIV/AIDS
PI	performance improvement
PICT	provider-initiated counseling and testing
PLWHA	people living with HIV/AIDS
PMP	Performance Management Plan
PMTCT	prevention of mother-to-child transmission
PREFA	Protecting Families against HIV/AIDS
PWP	Prevention with Positives
PY	project year
Q	Quarter
QCI	Quality of Care Initiative
QI	quality improvement
RCB	religious coordinating body

RCT	routine counseling and testing
RDT	rapid diagnostic test
RESPOND	Regional Expansion of Services to People of Need Project
RFA	request for applications
RH	Reproductive Health
RUTF	ready-to-use therapeutic food
SCHW	sub-county health worker
SDS	Strengthening Decentralization Systems
SMMC	safe medical male circumcision
SMT	Senior Management Team
SO	Strategic Objective
SOP	standard operating procedure
SPAI	Service Performance Assessment and Improvement
SPH	school of public health
SPS	Strengthening Pharmaceutical Systems Program
STAR-E	Strengthening TB and AIDS Response–Eastern Region
STI	sexually transmitted infection
STRIDES	STRIDES for Family Health Project
STTA	short-term technical assistance
SURE	Securing Ugandans’ Right to Essential Medicines
TAG	technical advisory group
TASO	The AIDS Support Organization
TB	Tuberculosis
TB CAP	Tuberculosis Control Assistance Program
TOT	Training of Trainers
TSR	treatment success rate
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UHMG	Uganda Health Marketing Group
UMEMS	Uganda Management and Evaluation Management Services
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASO	Uganda Network of AIDS Support Organizations
UNICEF	United Nations Children’s Fund
UPHOLD	Uganda Program for Human and Holistic Development
URC/HCI	University Research Corporation/Health Care
USAID	US Agency for International Development
USD	US dollars
USG	US Government
UVRI	Uganda Virus Research Institute
VCT	voluntary counseling and testing
VHT	Village Health Team
WCAT	Work Climate Assessment Tool
WHO	World Health Organization
ZTLS	Zonal TB/Leprosy Supervisor

ABOUT THE STAR-E PROJECT

Strengthening TB and AIDs Response – Eastern Region (STAR-E) is a five-year USAID-funded project, which was awarded on March 9, 2009, to Management Sciences for Health (MSH) through Cooperative Agreement 617-A-00-09-00006-00. Initially the mandate of STAR-E was to support services in eight districts: Budaka, Bududa, Bukwa, Busia, Butaleja, Kapchorwa, Pallisa, and Sironko in Eastern Uganda. This mandate has since June, 2010 been expanded to include Mbale district. This brings the total population covered from 1,824,000 to over 2,226,000. In addition to HIV/TB services, STAR-E PROJECT has a component that supports the institutionalization of LQAS which mandate covers all the districts of Uganda funded by USAID to improve social services.

The goal of the STAR-E project remains to empower communities in Eastern Uganda to respond effectively to the challenges posed by the HIV/AIDS and TB epidemics. The general objective of STAR-E is to increase access to, coverage of, and utilization of quality comprehensive HIV/TB prevention, care, and treatment services within district health facilities and their respective communities. The specific objectives of the STAR-E project include:

1. To strengthen district and sub-district public and private-sector health facilities (hospitals, HC IVs, HC III).
2. To expand access to community services.
3. To facilitate the establishment of efficient and functioning referral systems within and among health facilities and communities.
4. To create awareness, increase knowledge of service points, and show the advantages of early utilization of HIV services.

STAR-E is implemented by a consortium of five partners that include:

MSH (as the lead), joined by Joint Clinical Research Centre (JCRC), National Community of Women Living with HIV and AIDS (NACWOLA), Inter Religious Council of Uganda (IRCU), and Liverpool Associates in Tropical Health (LATH) and Policy Exchange

STAR-E Project Districts: Geographical Coverage



EXECUTIVE SUMMARY

During the reporting period, MSH together with its STAR-E project partners, was able to support the implementation of most of the planned HIV/AIDS and TB activities in an integrated and comprehensive manner within the targeted health facilities and communities. This has led to increased access and utilization of services by the communities including those in remote and hard to reach areas.

The main strategic approach was increasing the number of HIV/TB service service delivery points within health the health delivery network of facilities and communities and improving the quality of services being offered. At the same time STAR-E has worked hand in hand with the district level health stakeholders and the Head Office of the MoH to improve health systems at the district level including leadership and management, health financing, health human resource capacity, health supplies logistics and commodities management and quality improvement initiatives.

The Project was able to attain 100% recruitment of its planned staff including those working in Mbale on the HIV/Tb component and those working on the LQAS component of the STAR-E project.

In an effort to streamline the support to the districts, the Project has been able, together with the district partners to develop district specific plans and formalized the project relationship with the districts through development and signing of MOUS.

On June 17, 2010 the STAR-E project was officially launched at a colorful ceremony at Puti Puti grounds in Pallisa district. The launching ceremony was presided over by the Hon. Minister of Health (MP), Dr. Stephen Malinga, and attended by, among others the USAID/Uganda mission Deputy Director, MSH representatives, and representatives from partners and district local governments.

The project has been able to achieve and surpass most of its set targets for all the key results areas. In those key results areas where targets were not met , the project staff have already put in place corrective measures to address the situation. The project had set a target to reach 100,000 individuals with HCT. We managed to reached 187,486 individuals, significantly surpassing the set target (187% of set target). In PMTCT, the project had planned to reach 20,000 mothers with PMTCT services in 60 lower level health facilities but we managed to reach 43,647 mothers. There was a transition of PMTCT support in March 2010 in the districts from PREFA to STAR-E. Most of the clients testing positive were able to be channeled into chronic care both in their communities and in health facilities. Overall over 10,206 clients have been reached with chronic care as compared to the set target of 5300 clients. The project has also been able to support 13 ART sites which are fully accredited and 9 sites which are in the final process of being accredited though they have started recruitment of ART patients as outreach sites of the accredited sites. In these sites, 1376 new clients have been enrolled on ART which is 67 % of the

set target of 2040 clients. The set target was not achieved inspite of the fact that there are several clients on chronic care.

The main reason for this has been the limited ART sites which limit access of clients. This will be addressed as more sites will be accredited. The second reason is the unavailability of opportunities to have clients evaluated through CD4 estimations before they can be enrolled. The project has been mainly depending on one CD4 testing facility at JCRC Mbale and supporting the transportation of samples from facilities and results back to facilities. The turnaround time and tracing of patients for their results has not been perfect. The JCRC CD4 machine at Mbale has also not been functional throughout the year. The project has however procured motor cycles and allocated these to every health sub district. In addition the project has procured vehicles and each of the nine districts will have a vehicle to support district program activities including transportation of samples. Through the partnership with Policy Exchange, the project will at a minimum provide 2 CD4 machines, one in Kapchorwa and one in Busia and these will help to increase the number of people able to be evaluated through CD4 testing.

The Project has been able to achieve the set Pediatric HIV care targets and is currently handling a smooth transition from Baylor Uganda supported sites to STAR-E.

The project has not been able to achieve the prevention set targets other than those for PWP. This is mainly because the major strategy of reaching communities with prevention services was through the award of PBG. These have not been awarded as the process has taken longer than what had been anticipated. The PBGs are now being fast tracked and approval is expected from USAID within the first quarter of PY3.

There was a revision and acceptance of the strategic approach in the institutionalization of LQAS at national level. The application of LQAS in the 9 STAR-E districts has happened and in August 2010 all the nine districts were able to conduct LQAS surveys.

All these successes did not come without challenges. The key challenges have remained the limited human resource to maximize the support given by STAR-E. Specific areas of concern include doctors and laboratory staff. The other challenges have been unpredictable supply of medicines which results in stock outs of the key medicines needed in the chronic care of patients. Some challenges are directly related to the physical nature of the area as many places are difficult to access during most parts of the year. These are characterized by floods and landslides.

As we go into PY3, STAR-E will continue to support the scaled up services with emphasis on continuous quality improvement. STAR-E will also ensure that the community related services including prevention are available through the PBG.

Table 1: Progress on Project Core Indicators

	Indicator	PY2 Target	Q1	Q2	Q3	Q4	Cumulative	% Performance	Comments
HCT	Number of service outlets providing Testing and Counseling (T&C) services according to national policy.	97	65	97	97	102	102	105%	Target achieved
	Number of individuals who received T&C services for HIV and received their test results during the reporting period.	100,000	28,760	44,073	63,061	51,592	187,486	187%	Target achieved and surpassed due to combined strategies of using static and outreach points as well as having a grant to AIC.
PMTCT	Number of service outlets providing antenatal clinic (ANC) services that provide both HIV testing and antiretrovirals (ARVs) for PMTCT on site	60			97	97	97	162%	Target was set when STAR-E did not envisage takeover of all PREFAsupported sites, which however occurred in April 2010.
	Number of new ANC clients	20,000			20,629	23,018	43,647	218%	Target was set when STAR-E did not envisage takeover of all PREFAsupported sites, which however occurred in April 2010.

	Indicator	PY2 Target	Q1	Q2	Q3	Q4	Cumulative	% Performance	Comments
	Number of pregnant women counseled, tested and received results	20,000			21,611	24,466	46,077	230%	This figure has repeat testers and hence is higher than the no. of new clients attending ANC
	Number of pregnant women who tested HIV-positive	1,060			458	597	1055		
	Number of HIV-positive pregnant women who received ARVs to reduce the risk of mother-to-child-transmission	1,060			431	655	1086	102%	
Sexual Prevention	Number of the targeted population reached with individual and/or small-group level preventive interventions that are based on evidence and/or meet the minimum standards required (ABC)	300,300	7,200	12,659	30,209	28,046	78,114	26%	Start-up of prevention services has been slow. Most prevention work is to be done by CSOs under PBGs, which start in Q1 of PY3.
	Number of targeted population reached with individual small-group level preventive interventions based on evidence (AB)	121,892	1,239	4,749	24,269	18,965	49,222	40%	Start-up of prevention services has been slow. Most prevention work is to be done by CSOs under PBGs, which start in Q4.

	Indicator	PY2 Target	Q1	Q2	Q3	Q4	Cumulative	% Performance	Comments
	Number of MARPs reached with individual and/or small-group level preventive interventions that are based on evidence and/or meet the minimum standards required	No target	322	1,303	4,910	3,209	9,744		Some good progress made. STAR-E will soon do a baseline for MARPs.
PWP	Number of people living with HIV/AIDS (PLHIV) reached with a minimum package of prevention with PLHIV (prevention with positives/PWP) interventions	3,710		4,922	11,977	10,031	11,977		The initial target was set on the assumption that PWP services will reach only new patients testing positive. However a cohort of HIV positive clients before STAR-E is being reached as well.
Pediatric Care	Number of infants born to HIV-positive women who received an HIV test within 12 months of birth	587	106	77	241	319	743	127%	Slow start, but on track following remedial actions, including trainings in EID.
	Number of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth.	587	112	35	104	478	729	124%	Follow up of mothers and the exposed children has improved with introduction of EID and its integration with

	Indicator	PY2 Target	Q1	Q2	Q3	Q4	Cumulative	% Performance	Comments
	Number of service outlets providing pediatric HIV/AIDS services	11	1	1	1	1	1	9%	PMTCT. STAR-E had planned to offer comprehensive Pediatric HIV services in 11 facilities. In 10 of these facilities these services are being offered by Baylor Uganda a USG funded agency. Baylor Uganda will be transitioning these sites to STAR-E beginning PY3.
Adult Care	Number of HIV-positive persons receiving CTX prophylaxis	5,300	6,677	8,650	10,206	9,825	9,825	185%	
Adult ART	Number of adults and children with advanced HIV infection newly enrolled on ART	2,040	230	380	367	399	1,376	67%	Good progress in meeting the target.
	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	2,255	476	2,137	3,101	3,337	3,337	148%	More of the STAR-E buffer stock is being used to support clients who were on treatment before STAR-E.

	Indicator	PY2 Target	Q1	Q2	Q3	Q4	Cumulative	% Performance	Comments
TB/HIV	Number of service outlets providing TB services according to the national standards (SO8)	97	102	102	102	102	102	105%	97 included all hospitals, HC1V and all HC111s.
	Number of TB patients who had an HIV test result recorded in the TB register	2,280	247	201	259	503	1210	53%	
	TB case detection rate (%)	40	36.8	35.6	37	36	36		Target of 40% was set as the baseline was very low, at only 26%
	TB treatment success rate (%)	85	76.7	71.5	77.9	77	77.0		

INTERMEDIATE RESULT 1: INCREASED UPTAKE OF COMPREHENSIVE HIV/TB SERVICES WITHIN SUPPORTED DISTRICTS

Intervention area: Increasing access and uptake of HCT services

By end of PY 2 STAR-E project targeted to reach 100,000 people with HCT in the Project area. This has been done through 97 health units offering static HCT and outreaches to communities. There has also been a strong partnership between the STAR-E and AIC which has enabled hard to reach populations access HCT services. The Strategy for increasing HCT coverage and uptake hinged on addressing the communication gaps to reduce on stigma and discrimination for those who test HIV positive, increasing awareness on the benefits of knowing ones HIV sero status, increasing HCT outlets and entry points and awareness on available HCT services, streamlining commodity flow, targeting MARPs, streamlining of data collection and improving on quality of reporting, ensuring quality HCT services thorough training of service providers, support supervision and support external quality control. Overall 125 health workers were trained.

By the end of the reporting period, 187,486 people had been counseled and tested for HIV as compared to the target of 100,000 that had been set. The main reason of surpassing the target was the multiple strategies that were applied including the use of outreaches, HCT at static sites, the introduction of RCT into hospitals and the partnership between AIC and STAR-E which targeted hard to reach populations and MARPS and made 250 outreaches.

Health facilities were assisted to acquire enough testing kits, through the NMS, UNICEF donation and buffer stocks were bought by the project to serve facilities that unexpectedly ran out of stock as a result of the increased number of clients.

Referral for those who tested positive was made for ongoing care, support and treatment at respective health facilities. On average, about 75% of clients testing positive were referred for care.

Figure 1 compares the quarterly HCT achievements against the set targets.

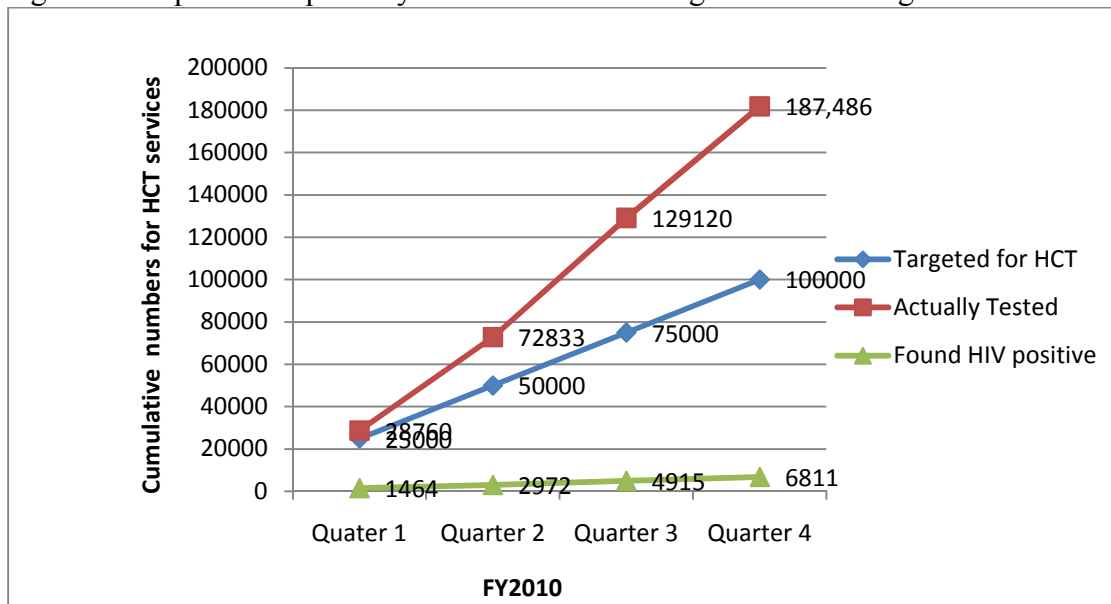


Figure 1. Trends in HCT uptake throughout PY 2

Figure 1 depicts the overall annual performance of HCT, which surpassed the targets for each quarter. The overall HIV prevalence averages 3.8 percent. This tends to be lower in community outreaches than HCT at the facility level. There are also variations in prevalence among the districts ranging from 2.9 percent in Pallisa, Budaka, and Bududa, and 7 percent in Busia.

Figure 2 shows district-specific HCT results.

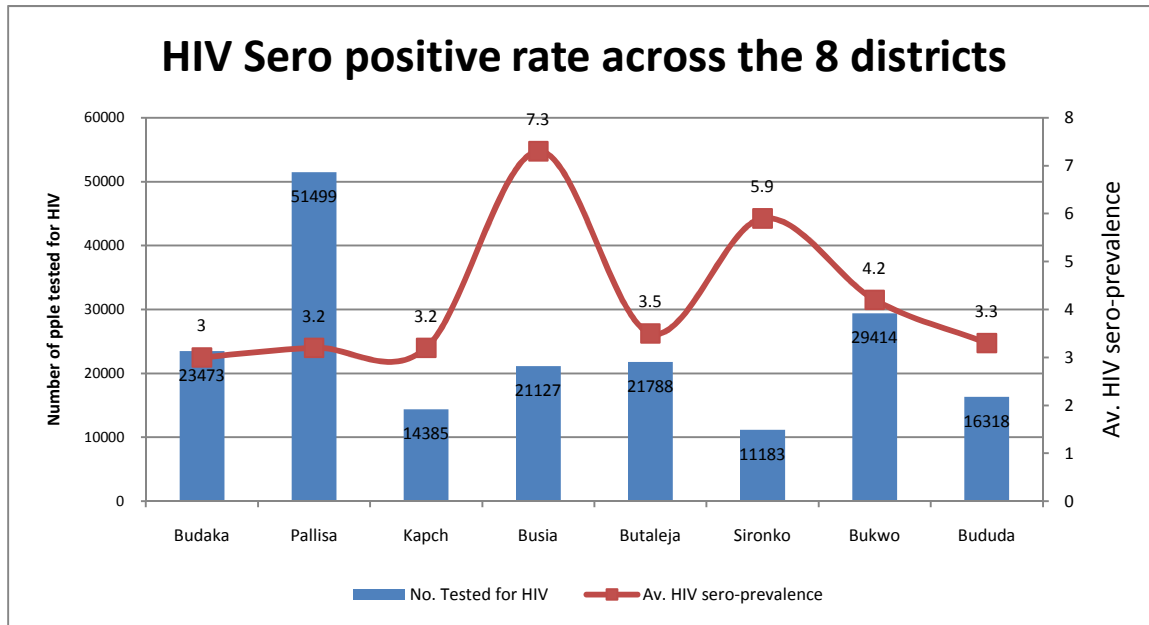


Figure 2. Seropositive rates across the eight original project districts

There were challenges during this period, including an erratic flow of test kits from NMS. This was overcome by procurement from STAR-E to provide buffer stocks and also mobilizing of kits from partners like UNICEF and Uganda Cares. Accessibility of many of the hilly areas was a big problem. These challenges were coupled with heavy rains and landslides and AIC had to be contracted to camp in some of these areas and offer HCT.

Way forward

STAR-E plans to use the same strategies to reach more people with HCT. In addition RCT will be scaled up to all hospitals, all HC1V and selected HC111s.

SUCCESSION STORY: RELIGIOUS LEADER FIGHTS STIGMA

Early in the year 2010, Mr. Francis Okwi was sickly and very weak. He believed that he was bewitched so he regularly visited a traditional healer for treatment. On two occasions, he visited Bukwo Health Centre IV but failed to take an HIV test due to stigma. His condition continued to deteriorate till he could no longer afford to work. His wife struggled to sell firewood in order to raise funds for food and other basic home requirements for their family of 3 children. During a baptism service which was conducted at Riwo Church on 25th April 2010 by Fr. William Ojulo, a Catholic priest of Bukwo parish assisted by Mr. Peter Wanyonyi, the Catechist of Riwo, the two Religious leaders had an opportunity to sensitize the congregation about HIV prevention and encouraged people to seek HCT services. Fr. William and Mr. Wanyonyi are among the selected 30 religious leaders in Bukwo, who underwent training in HIV prevention, care and support which was organized by STAR-E in March 2010. Francis was touched by the day's sermon. At the end of the church service, he approached Fr. William Ojulo and confided in him about his unending illness. Fr William counseled him and encouraged him to visit Bukwo Health Center IV, for an HIV test. The following day (26/4/2010) Francis walked 8 km from Riwo to Fr. William's residence at Bukwo Catholic Parish. He was tired and exhausted. Fr. William accompanied him to the Health centre. Francis was tested and found to be HIV positive. He was later initiated on ARVs. Francis was able to disclose his HIV sero status to his wife. The wife also went for testing but across the border in Kenya. She also tested positive. The two have now agreed to begin getting their care and treatment in one place; Bukwo HCIV. The family with the support of Fr. William has agreed to take all their children for testing at Bukwo HCIV.

Francis is indeed grateful to Fr. William for providing him with food and bean seeds which his family planted early May, 2010 and further, for introducing him to the District Internal Security officer (DISO)-Bukwo, to receive some potato vines. "We now get some food from our small garden" said Francis.

Francis is thirty eight years old, with a wife and three children. He prematurely retired from the Army due to ill-health but presently, he is reasonably strong and happy. He was recently selected as a Basic Christian Community (BCC) leader in his area. Besides, he is serving as an assistant Catechist in Riwo church. The church leaders continue to visit Francis's family for pastoral care and support. Francis now talks about HIV and AIDS freely and counsels his peers to go for HCT and those who are positive to access early treatment.



Pastoral Visit: Fr. William Ojulo visits Francis's family in Riwo Camp, Bukwo district. This was early Oct, 2010.

Intervention Area 2: Increase coverage and uptake of comprehensive PMTCT

The project in PY2 targeted initially to support 60 health facilities offer comprehensive PMTCT services. There was an overlap with PREFA and the facility based PMTCT support to facilities started after March, 2010 when PREFA phased out from the region and this supported covered 97 facilities and targeted to reach 40,000 mothers with comprehensive PMTCT services. STAR-E supported social mobilisation activities to increase awareness on HIV transmission risk factors and prevention in partnership with NACWOLA, IRCU at community levels and in ANCs clinics health workers provided health education talks on HIV and AIDS and availability of HCT and PMTCT services. Together with MoH, STAR-E trained 29 on IMAI-IMPAC from selected sites. STAR-E through its mentors worked with 97 facilities through mentoring and coaching to order for PMTCT input from NMS. The project distributed and disseminated job aids and policy guidelines to all the 97 facilities during mentoring sessions as well as during support supervision. Various community resource persons (CCAs, PHAs, VHT) were identified and oriented in doing HIV counseling and together with trained case managers, helped in referrals and linking women who took an HIV test to facilities and general health care system. Provided buffer stocks of the ARVs particularly for PMTCT up to HCIII. The project facilitated meetings at HFs to enhance integration of PMTCT into RH/FP and strengthen linkages between HCT, care and treatment for pregnant women.

Table 2. PMTCT Performance for 2 Quarters Supported by STAR-E

OUTPUT	Q3	Q4	Cumulative	Remarks
No. of ANC sites providing PMTCT services	97	97		All hospitals, all HC1V and all HC111s.
1.No of new ANC clients	20629	20828	43647	
2. No. pregnant women who had HCT and got results	21611	22198	46077	These include revisits.
No. of pregnant women who tested positive	458	597	1055	
2a.HIV status Unknown status at entry	21611	22198	46077	
2b. HIV status Known/documented status at entry	45	64	109	
3. ANC prevalence of HIV	2.3%	2.9%	2.5%	
4. No pregnant women who received ARVs to reduce MTCT	571	514	1085	
4a- on single-dose nevirapine	189	98	287	
4b-on combination (2ARVs)	273	330	603	
4c-on combination (3ARVs)	109	47	156	
No HIV+ women on HAART	12	27	39	
5.No HIV + pregnant women assessed for ART eligibility	442	497	939	
7.Total No exposed infants by feeding option:	222	239	461	
7a.Exclusive breast feeding	171	210	381	
7b.Exclusive formula feeding	25	18	43	
7c.Mixed feeding	26	11	37	
6.No exposed infants on prophylactic ARVs	154	201	355	

No HIV + pregnant women newly enrolled on HIV care	192	220	412	
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The project supported more PMTCT sites than targeted, reached all pregnant mothers expected during the financial year and managed to test them for HIV. Observed HIV prevalence at 2.3 percent is relatively low compared to earlier reports. Some of the challenges facing PMTCT implementation include: Delivery at HF is still low despite of high ANC attendance. This is related to cultural reasons and sometimes the attitude of staff who handle the deliveries. The community support system is still weak resulting in loss to follow up, this is will be further strengthened in PY3 through award of grants to CSOs. Supplies from NMS for PMTCT such as gloves, antiseptics and cotton is not regular and this further discourages mothers from coming to health units. The state of most of the maternity units is poor and remain unattractive for mothers. This is coupled with the poor communication network which disadvantages mothers from delivering in facilities.

Way forward

The key emphasis for PY3 will be to support the roll out of the new MoH policy guidelines on PMTCT in all the facilities. Ensuring that all pregnant women begin ANC in the first trimester, being tested for HIV and screened for other illnesses and those positive started on HAART and followed within their communities. STAR-E will work with other organizations to make deliveries in facilities more attractive.

Intervention Area 4: Increase Uptake of AB Comprehensive HIV Sexual Prevention

In FY2 the project planned to reach 165,164 individuals with AB prevention methods, targeting small groups or individuals with messages for HIV prevention methods known to be effective. To achieve this, the project in collaboration with partner FBOs trained 80 youths from Sipi and Kapraron Archdeaconry as Peer Educators. They have since been involved in sensitizing fellow youths in and out of school, on HIV prevention focusing on Abstinence approaches. Religious leaders and Youth FBO workers visited schools both primary and secondary schools for spiritual counseling and to sensitize pupils and students on HIV prevention focusing on abstinence messages. Youth camps have been organized in various districts to reach youth with AB messages. Over 500 youth have participated in these camps. Following the youth camps, participants formed youths associations based on the respective sub counties through which they are mobilizing their peers to adopt safe life practices and prevention of HIV/TB infection.

The project has supported the training of 181 religious leaders in HIV/AIDS prevention. Religious leaders have since engaged individuals and small groups in their respective districts, to sensitize them on HIV/AIDS & TB prevention and to discourage risky behavior which predispose individuals to HIV infection. Key prevention messages focusing on “Abstinence” and “Being faithful” were emphasized to community members.

The project’s focus was on three categories of MARPs namely Fisher men, commercial sex workers, and truckers. The peer-to-peer approach was used to reach the various MARPS. The unique behaviors with the MARPS that STAR-E has been working with are multiple sexual

partners and having unprotected sex. Overall more than 9,984 various MARPS have been reached with various prevention messages over the desired behaviors and condoms have been distributed. STAR-E has continued to follow up the peer educators among the MARPS to discuss topical issues that influence their peers' behaviors.

Plans for the next quarter

We shall select at least two youths from each subcounty (a boy and a girl) and train them as peer educators. The trained youths will be based at HC III's to give support to their adolescents who come for services at the health facility.

Table 3 summarizes key prevention achievements.

Table 3. Key Prevention Achievements in PY3

Performance Indicator	Annual Target	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Cumulative	%
Number of the targeted population reached with individual and/or small-group level preventive interventions that are based on evidence and/or meet the minimum standards required (ABC)	300,297	7,200	12,659	30,209	16968	50,068	17%
Number of targeted population reached with individual small-group level preventive interventions based on evidence (AB)	121,892	1,239	4,749	24,269	22091	52,348	43%
Number of MARP individual and/or small-group level preventive interventions that are proven effective	No targets	322	1,303	4,910	310	6845	-

Success story: Fishing community takes leadership to prevent the spread of HIV in their community.

Opeta is one of the hard to reach landing sites found in Gogonyo sub county Pallisa district and underserved with HIV/TB services. Opeta is 25 km south of Pallisa district headquarters and has about 23,000 people. . The life of people around the landing site rotates entirely around fishing, many of them spending as much as 90% of their time on the lake. The demographic, occupational, behavioral and social factors place them at increased risk for contracting HIV as captured by the submission below from one of the leaders from the site.

“This landing site acts as a sanctuary/safe haven for people who commit crimes from different neighborhood districts then come to hide here”). Also people from across the lake come to this landing site. There has been a lot of un safe sexual activity taking place here. For us here no man owns a wife; if you go fishing another man automatically takes over the woman, and it’s a normal trend”; Says Ramadhan the chairman of the landing site.

He also added that *“Early marriages and pregnancies are rampant, school drop-out rate is high, “Many people have died in this place due to HIV/AIDS, TB related illnesses. Unfortunately, no health worker has ever come to talk to the people here about HIV/AIDS, TB. Whenever a person falls sick and dies in this community it will be associated with witchcraft.*

STAR-E together with Pallisa district DHMT reached out to Opeta fishing community. Engaged their leaders and came up with behaviors that need to change as far as preventing HIV. They selected among themselves 30 people that STAR-E trained as Peer Educators. The peer educators together with community members came up with an action plan with activities that were to address the identified behaviors. These included peer education, condom promotion, social mobilization, monthly meetings among others. They formed an active drama group that they use in the community to impart HIV/AIDS, TB messages. The group has an executive with an office/desk at Opeta landing site.

A strong partnership between STAR-E , the landing site community, the district leadership and the neighboring Gogonyo Health Centre III has developed resulting into 2,715 people being tested for HIV and screened for Tb through outreaches originating from the health center. 30 peer educators among the fish folks facilitate discussions as peer educators with technical follow up from STAR-E as they addresses various topical issues related to behaviors of their communities. Nontraditional condom distribution outlets have been established and in a period of 3 months a total of 14,307 pieces of condoms had been distributed.



Prevention with positives

The project had planned to reach 3,710 PHAs with a minimum package of prevention with positives (PWP) interventions. The minimum package for PWP consisted of protection from HIV re-infection through abstinence from sex, consistent use of condoms and being faithful to one sexual partner for those who decide to remain sexually active, disclosing HIV status to partners. Others include; those who are already pregnant to utilize existing PMTCT services, for those who are already on ART, taking ARV medications consistently and properly, using services for screening for STI and cancer of the cervix and taking cotrimoxazole prophylaxis as prescribed by health workers. This was supported through 97 health facilities and also through a net work of community structures including PHA groups which have been crucial in supporting PHAs disclose their sero status to their sexual partners, promoting positive living and stigma reduction

Over 58,073 pieces of condoms were distributed to 9000 PHAs and total of 14,311 PHAs were reached with PWP services.

Way Forward

Continue to identify and with PHA, discordant couples and young positives and working with them to promote positive prevention, self esteem and positive living

Intervention Area 6: Promotion of Safe Medical Circumcision (SMC)

The project had targeted to support 16 sites to provide SMC services and circumcise 160 individuals as part of the minimal prevention package.

We engaged the communities to identify attitude behavior and practices and potential barriers for safe male medical circumcision in the region. After their exercise a behavior change communication strategy (BCC) on SMC for nontraditional circumcising area and circumcising areas were developed in partnership with health communication project. An assessment of readiness of facilities to conduct circumcision was done in partnership with Walter Reed Project. Thereafter four high turnover health facilities were targeted for the training of the teams to spear head circumcision in each unit. Four teams of three people each have so far been trained from the respective four selected facilities. Seventy-five people have been circumcised as part of the comprehensive package for HIV prevention in four health facilities that are currently active namely Busia HC IV, Busolwe, Masafu, and Pallisa hospitals. We conducted joint support supervision to the health facilities that offer SCMC in partnership with with Makerere Walter Reed Project (MUWRP) on SMC to ensure standard for SMC are not compromise the standards.

Challenges

There is still need to improve on the infrastructure in some health facilities to make them suitable for circumcision. There is need to set aside (where possible) a theater for circumcision separate from the major theatre since circumcision is considered a minor operation which does not take priority where there is a life threatening operation to be done.

We have held discussions with hospital management of Pallisa and Busolwe hospitals where this problem is being experienced and plans are under way to equip the mini theatres for circumcision through the Policy exchange project. STAR-E has planned to support these health facilities that conduct SMC with buffer stocks of minor theatre supplies and consumables in PY3.

Some communities in this region that have circumcision as their tradition in our project area (Gishu and Sabinies) have some reservations to embrace SMC due to fear of losing their cultural identity.

Some people perceive it as an attempt to Islamize them (turn them into Muslims)

Way Forward

Vigorous campaign using local radios through radio talk shows and adverts/spots, music dance and drama, posters, bill boards, leaflets and brochures to increase awareness on and uptake of SMC and building the capacity of 20 sites to offer SMC.

Intervention Area 7: Control of STIs

In PY2, STAR-E has supported service providers in health units and communities to integrate STI screening and management into their routine work as part of prevention. Refresher trainings were conducted to selected health on STI syndromic management. The strategy used to help other health workers apply the syndromic management approach, CME sessions, and on job training was done through the TOTs. STI treatment algorithms to assist health workers on implementing syndromic approach were supplied to health facilities, and drugs required for the syndromic approach are being procured through the NMS. Other activities being supported through health facilities include partner notification, routine screen for STIs among all PHAs and in ANC clinics, health education talks in clinics and general community on the relationship between HIV and STIs

Intervention Area 8: Increasing coverage and uptake of other Bio medical prevention services

Promoting Infection control through Injection safety, proper handling and of medical waste management and PEP.

Different HIV and AIDS interventions particularly HCT and other lab services at facility and community levels generate a lot of medical waste. STAR-E works with its partners to contribute to activities of waste management.

An integrated assessment of practices, supplies and equipment for injection safety, MWM, and PEP was done. The assessment was done in partnership with AIDS STAR One.

The assessment covered the districts of Kapchorwa, Budaka, Butaleja, and Bududa. The assessment guided the training at HU levels and subsequent support supervision and mentorship program.

The results of the assessment were shared in the covered districts in feedback meetings to guide on planning and future action

After the assessment and dissemination of results, STAR-E conducted an integrated TOT for injection control, medical waste management, and PEP. The TOT covered 22 health workers (health inspectors, DHTs, and STAR-E clinical mentors). Then the training cascaded downward to health facilities and covered 65 HU staff. These have been able to conduct supportive supervision and CME sessions on waste management. Support supervision visits also reinforced the habits and practice of segregating medical waste in color-coded bins

Health facilities were assisted to procure gloves, detergents, and disposable needles and syringes from the NMS through training on quantification, ordering, storage and use. Twenty-three health facilities were directly supplied with protective wear such as gloves, aprons, and boots, detergents, and color-coded medical waste disaggregation and collection bins.

Health unit management committees mobilized local resources to dig rubbish dumping pits and HU units infection committees ensure the burning of medical waste dumped in these pits.

Intervention area 9: Increased Uptake of Pediatric HIV/AIDS Services

For this project year, we planned to have one thousand sixty (1,060) HIV-exposed infants tested for HIV infection with a DNA PCR test and to start the same number of children on co-trimoxazole prophylaxis. The target number of children to be tested (those > 18 months using rapid tests) was fifty thousand (50,000) of which 20,000 would be under five years of age. We also targeted initiating 198 infants below one year on ART and 852 children aged one year and above on ART. Eleven sites would be offering paediatric ART.

The focus this year was to complete the trainings needed by the health facility staff in order to equip them with knowledge and skills needed to effectively care for HIV-infected children especially those who need ART. In particular, equipping staffs with the knowledge they need to identify HIV exposed and infected children early, and to ensure that they are tested and initiated on treatment as soon as possible.

Accomplishments

Trainings: 60 health workers were trained in IMCI complementary HIV/AIDS course, 27 in comprehensive nutrition care for children living with HIV/AIDS, 63 in the Early Infant Diagnosis Systems Strengthening curriculum.

Through collaboration with the Ministry of Health, two staff were sent for a one-week placement at the MildMay Centre in Kampala.

Following the nutrition training, health workers are now able to monitor growth and development for children as well as assess children for malnutrition. RUTF (ready-to-use therapeutic food) is given to those who are found to be malnourished. The RUTF was provided through collaboration with the CHAI. The sites have been equipped with the EID tools and the equipment need for the program, including weighing scales for the different age groups, infantometers and stadiometers, head circumference tapes, MUAC (mid-upper arm circumference) tapes, and tongue depressors.

This has facilitated early identification and diagnosis of infants as reflected in the increased number of children having a DBS test. Together with the Ministry of Health teams, participants from the districts who were trained by STAR-E in EID and the STAR-E staff, EID mentorship of health workers was done for 13 health facilities.

We held mass mobilization and testing campaigns at 13 sites supported by STAR-E project in paediatric HIV care and treatment. The aim of this exercise was to sensitise the communities about the additional services that are now being offered at these sites, sensitizing them on the importance of testing children early and to test those who had not had an opportunity to do so. Ten sites were identified and prepared for accreditation in form of training health workers, improving on their laboratories to mention but a few. In the third week of October 2010, a team from the MoH will visit these sites to assess their readiness for accreditation. A process of transition from Baylor Uganda support to Paediatric HIV in the region to STAR-E has been finalised and Baylor-Uganda will hand over 10 sites to STAR-E before the end of October 2010. Lastly we supported nine DHOs and 24 ART clinic heads to attend the fourth National Paediatric HIV Conference in Kampala.

Results

Table 4. HIV-Exposed Infants Tested and Given Co-trimoxazole in PY2, by Quarter

Performance Indicator	Annual Target	Q1 No. Realized	Q2 Actual	Q3	Q4	Total	% Achieved
Outlets providing pediatric ART services	11	1	1	7	7	7	
Number of infants born to HIV-positive women who received an HIV test within 12 months of birth (DNAPCR)	587	106	77	241	391	815	139 %
Number of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within 2 months of birth	587	112	35	104	478	729	124%
Tested HIV-positive						12	

All 12 identified HIV-positive infants were initiated on ART as per guidelines of Ministry of Health. In total 54 children below 15 years were newly enrolled on ART, bringing to 223 the number of children below 15 years currently enrolled on ART and supported by STAR-E.

Way Forward/Planned Activities

STAR-E will continue to support comprehensive pediatric HIV services in all the sites that are offering adult HIV comprehensive care.

Intervention Area 10: Increasing Access to and Uptake of adult Chronic Care Services

The project planned to reach 5,300 PHAs with chronic care services both in facilities and community service networks. By the close of PY2 10,031 PHAs had accessed chronic care services.

The chronic care package included putting all HIV-positive clients on co-trimoxazole as a prophylaxis, screening for and treating identified TB cases, treatment for other opportunistic infections (OIs), home visits to offer ongoing psychosocial support, hygiene education, promotion of safe water use, pain and symptom management and counseling on nutrition and linking needy clients to specialized agencies for food support and other social support services.

The strategy used to roll out the chronic care package hinged on strengthening the capacity of Health units to deliver quality comprehensive HIV care, augmenting the linkages between HCT and care and support services, quality assurance and improving data collection and use and improving coordination at all levels of the health systems in respective districts.

A critical mass of health workers has been trained to offer comprehensive HIV care services and this has been further supported through mentoring and coaching. Activities at health facilities are further being supported by case managers who are expert clients and facilitate fellow PHAs to navigate through.

Training and deployment senior PHAs as case managers at health facilities, who link patients to health care system and community support systems. PHAs in the community have been sensitized on various aspects of their care.

For each PHA, there is ongoing psychosocial support primarily in respective PHAs groups and at individual levels through trained counselors and case managers.

Revamping the logistical system through training on LMIs, supervision and coordination with NMS to ensure constant flow and adequate inputs for chronic care

Intensifying supportive supervision through district based quality assurance teams and clinical mentors

Holding regular program review and coordination meetings at District, Sub-District and Health units levels

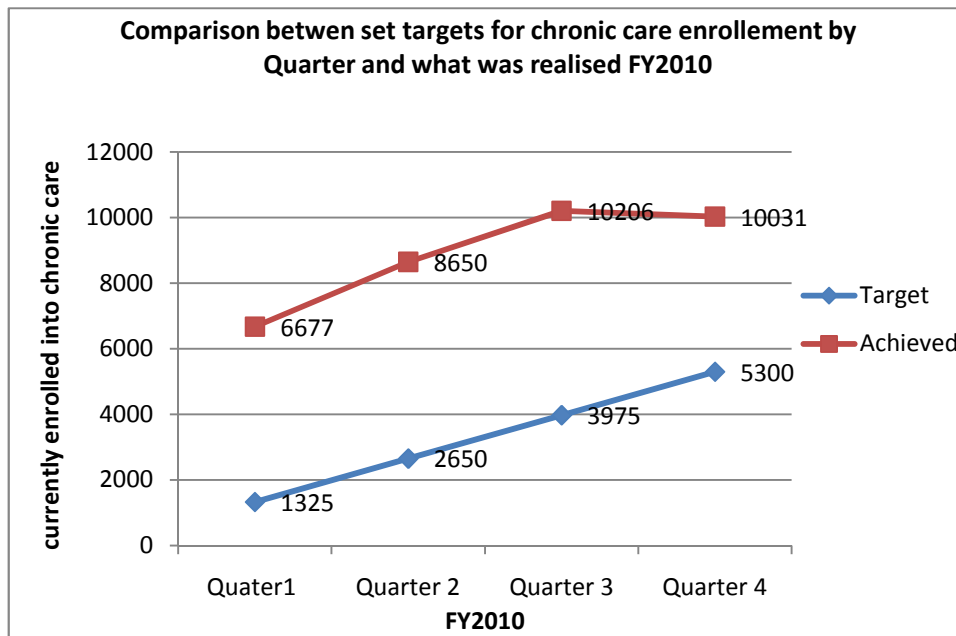


Figure 3. Chronic care enrollment for PY 2: achievements versus target

Much as there has been marked success, there are have also been challenges, including significant losses to follow-up of patients as the existing community networks and the case managers are overwhelmed. This will be addressed in PY3 as PBGs become functional and more CBOs get involved into the care of patients.

Intervention Area 11: Increased Uptake of Adult ART

The project had targeted to enroll 2,040 clients on ART and overall support 2,255 clients on ART in 23 ART sites. The project however managed to enroll 1376 (67 percent of the set target) clients on ART and 3,354 clients are currently on ART. This was possible through training of health workers in various aspects of comprehensive HIV care including ART management. This has further been followed on by mentoring and coaching of the respective health workers by STAR-E mentors and specialists. STAR-E has also supported an efficient system of supply chain management for ARVs to the facilities where by JMS directly delivers ARVs to the responsible sites. The medicines logistics management at facilities has been further strengthened through integrated logistics trainings for health workers and support supervision. Facilities are now able to quantify and make timely orders to NMS. Activities for adherence have been supported and these are mainly training health workers and clients in adherence counseling and linking up the clients with peers in the communities.

Figure 4 shows the newly enrolled clients against the set targets

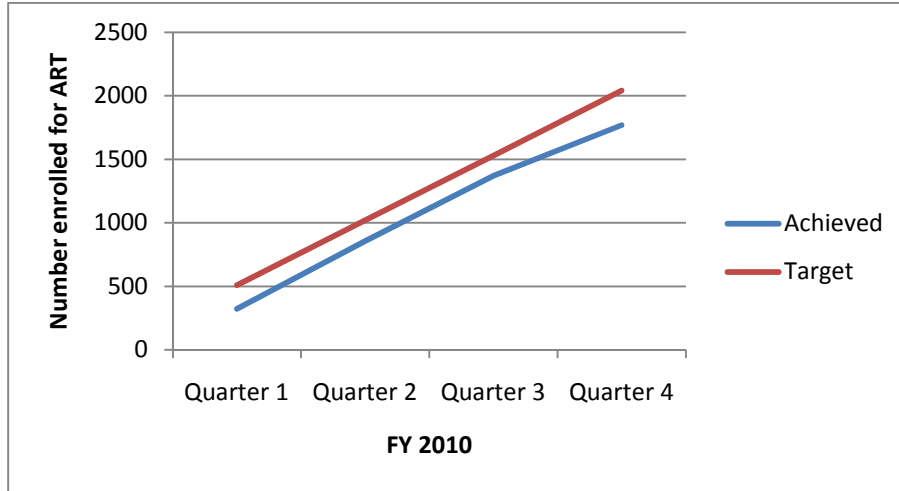


Figure 4. New enrollment on ART: achievement versus target for PY2

Figure 5 shows the clients currently on treatment against the set targets.

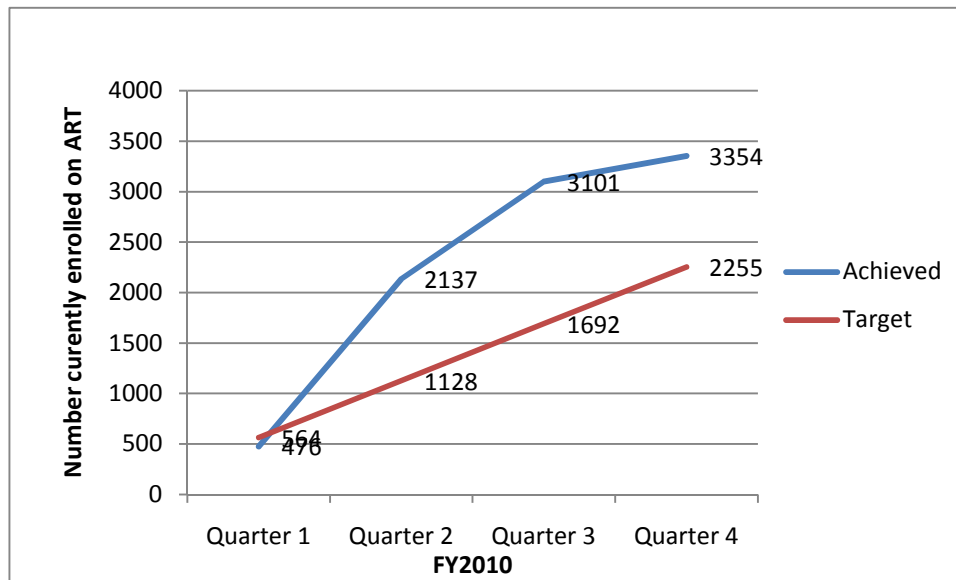


Figure 5. Current total ART enrollment: achievement versus target for PY2

There were key challenges which are likely to have affected the failure to achieve the set targets as regards the newly enrolled clients. The project was not able to have 10 sites accredited and therefore be able to recruit patients.

One of the biggest problem has remained access to ART services within a reasonable distance. Up to until the third quarter, there were only 13 sites offering ART services as compared to 97 facilities able to do HCT.

The other key challenge has been the accessibility to CD4 testing which can only be accessed at JCRC laboratory at Mbale and the whole process has bottlenecks from facilitating the sample referrals to getting the results back and tracing their owners. STAR-E will in PY 3 facilitate the process of accreditation of 10 new sites, which will bring services nearer to the people. Through the partnership with Policy Exchange, STAR-E will be able to have at least two CD4 machines in the region which will help in the evaluation of patients as they await enrolment.

Intervention Area 12: Increased Uptake of TB /HIV Services

The main objective for TB for the PY 3 was to increase the case detection rate from regional baseline average of 28 percent to 40 percent and treatment success rate from 84 percent to 85 percent by the end of September 2010.

Table 5. Core TB Indicators for PY 2, by Quarter

	Indicator	PY2 Target	Q1	Q2	Q3	Q4	Cumulative /Average	% Performance	Comments
TB/HIV	Number of service outlets providing TB services according to the national standards (SO8)	97	102	102	102	102	102	105.15%	Targeted support was for 97 sites. 102 HFs are involved in TB work as by end of sept 2010.
	Number of TB patients who had an HIV test result recorded in the TB register	2,280	247	201	259	214	921	31.01%	
	TB case detection rate (%)	40	36.8	35.6	37	36	36.35		
	TB treatment success rate (%)	85	76.7	71.5	77.9	77	75.8	89.2%	50% Of districts achieved target

TB-related activities were carried out at the district, at health facilities as well as in the communities. Joint HIV/TB meetings were facilitated in all the districts, and key personnel from all districts were able to attend and participate in zonal quarterly review meetings and TB and

TB/HIV district quarterly review meetings. Sixty health workers were trained in TB logistics management information system and the recording and reporting greatly improved thereafter.

Twenty-six health workers were trained in TB/HIV co-management; the target group for this training was for those people from the health district and sub district level who could do facility based on job continuous medical education thereafter. Five district TB leprosy supervisors from Bukwo, Busia, Kapchorwa, Sironko, and Bududa were supported and attended a one-month DTLS course at Buluba Hospital. All the districts were supported to do intensified case finding of TB in people living with HIV, contacts of smear-positive cases and in HIV care settings. The DTLSs were given an orientation on the use of the ICF tool and were supported to roll it out to all the health facilities in all the STAR-E districts. The ICF forms and the TB suspect registers were hence distributed to all the participating health facilities.

Quarterly supervisory visits for the district TB leprosy supervisors and the sub county health workers were supported in all the districts. Centrally, STAR-E also supported two Joint partners TB/HIV support supervisory visits in the region and they were indeed very rewarding.

Several IEC materials were printed and distributed to health facilities in all the STAR-E districts in an effort to increase awareness about TB, TB/HIV within the communities. The IEC materials included; TB/HIV counseling flip charts (950), TB case management desk aides (450), posters in Luganda, Lumasaba, and English (900), Correct approach to pulmonary TB diagnosis flow chart (300), Diagnosis of TB in a know HIV patient flow chart (300), Intensified case finding for TB chart (200), and Clinic flow of TB patients for RCT (200).

Achievements in TB

Table 6. Annual TB case detection (CDR) and Treatment success rate (TSR) trend

District	CDR in % (2008)	CDR in % (Q1 PY2)	CDR in % in % (Q2 PY2)	CDR in % (Q3 PY2)	CDR in % (Q4 PY2)	TSR in % (2008)	TSR in % (Q1 PY2)	TSR in % (Q2 PY2)	TSR in % (Q3 PY2)	TSR in % (Q4 PY2)
Budaka	12.5	36	53	42.8	44.6	89.2	81	90.9	87.5	95.6
Bududa	39.8	36.9	15.8	30.6	54.7	87.1	47.6	15.4	42.1	54.1
Bukwo	21.7	20	13	20	15	75	80	100	100	50
Busia	29.3	63	58	38	40	-	76	47.2	65	57
Butaleja	36.6	22.1	16.4	27	16.2	86.3	68.4	80	82	72
Kapchorwa	20.9	25.7	52.7	50	32.3	66.7	77.7	72.7	81	100
Pallisa	28.1	50	22.3	36	39.2	93.3	97	75.8	82	90.1
Sironko	36.9	41	53.4	52	42.3	89.4	86	89.8	84	97
Average/total	28.2	36.8	35.6	37	36	83.86	76.7	71.5	78	77

On average, the case detection rate slightly improved but was still persistently very low in the districts of Bukwo, and Butaleja. This may be partly attributed to limited geographical access to diagnostic sites, the terrain and floods in the region, which even led to cholera outbreak in Butaleja.

The treatment success rate average is still lower than the target although at least 50 percent of the districts met the target. However the average TSR of 77 percent can still be improved with increased interventions bearing in mind that the national TSR is also staggering at around 73 percent currently. Budaka, Sironko, Kapchorwa and Budaka districts have been performing fairly well as far as treatment success is concerned. Bukwo had good TSR in the previous quarters but the DTLS retired from service and left a vacuum. However, STAR-E trained one for the district who has become more active and involved in the TB work and hopefully the indicators should be able to improve.

Challenges/constraints

There is still limited geographical access to the TB diagnostic centers especially in the districts of Butaleja and Bukwo. There is inadequate human resource especially the laboratory staff. A district like Butaleja has only two laboratory assistants and this makes it difficult to have more diagnostic units. Due to not fully functional implementation of the DOTS strategy in most of the districts, follow up of patients for examination of sputum at five and eight months of treatment is limited and hence the limited evaluation of cure rates as opposed to completion rates.

Way forward

STAR-E will continue supporting districts to open up more diagnostic units for Tb through capacity building, providing equipment and working with other partners to improve on the key staffing gaps.

INTERMEDIATE RESULT 2: DECENTRALIZED SERVICE DELIVERY SYSTEMS STRENGTHENED FOR IMPROVED UPTAKE OF QUALITY HIV/TB SERVICES

Intervention 1: Increased Access to Quality Clinical Care through Improved Human Resources for Health

In PY 2, Human Resource Development (HRD) as a framework for helping employees develop their personal and organizational skills, knowledge, and abilities, was employed through such opportunities as training, coaching, and mentoring. This was done in the context of HIV/AIDS services delivery.

In its proposal bid for the STAR-E project, MSH was cognizant of the fact that unfilled positions, low morale of personnel, frequent absenteeism and staff turnover inhibited effective health services delivery and expansion of HIV/AIDS services. It was further observed that well trained, productive health care providers are essential for scaling up quality services.

One key intervention planned to support human development activities was the use of the MSH tool the Work Climate Assessment tool (WCAT).

The results ensuing are expected to guide managers to use better human resource management practices and develop nonmonitory incentives to improve work climate and staff retention. Embedded in the WCAT is the need to have well trained health workers.

During PY 2, STAR-E conducted a rapid training needs assessment in line with the various technical programs. This was later followed by the development of a comprehensive Training Master Plan (TMP) The TMP was adopted as a working document in the implementation of all the capacity building activities both at the regional, district, health facility and community levels. Critical in TMP is the detail on how STAR-E strategy relates with the MOH regarding policy, guidelines and technical support for training of health workers and how the districts and MOH headquarters staff would be involved in the training activities.

Over the last four quarters, a number of health workers and community resource persons have been trained in various disciplines related to HIV/AIDS/TB care, treatment and support. To date, 707 health workers (as participants), 396 community resource persons (PHAs, youths, MARPS, etc), and 291 religious leaders, have been trained in various disciplines of HIV/AIDS and TB including comprehensive HIV/AIDS prevention, care and treatment, the Laboratory Training of Trainers (TOT) courses, pediatric HIV/AIDS and PMTCT for the facility-based services and peer educators for the community services. Other trainings were conducted as preparations for the LQAS survey, in which 268 data collectors were trained. Table below summarizes all the trainings conducted per program area.

Table 7. Training Conducted by STAR-E Project in PY 2

No.	Type of Training/Course	No. Trained	Source of Resources
Training of health workers			
1	Pediatric ART care	60	MOH—facilitators, monitoring and training
2	Ready to use Therapeutic Foods	30	MOH—facilitators, monitoring and training
3	IMAI (comprehensive ART)	56	MOH—facilitators, monitoring and training
4	IPAC/ PMTCT	29	MOH—facilitators, monitoring and training
5	TB Logistic information management	60	MOH—facilitators, monitoring and training
6	TOT for 26 laboratory staffs in rapid HIV testing	26	MOH—facilitators, monitoring and training
7	Syndromic STI management	26	MOH—facilitators, monitoring and training
8	TOT for HCWM	15	MOH—facilitators, monitoring and training
9	TOT for EID	29	MOH—Facilitators, monitoring and training
10	EID training at districts	67	MOH—Facilitators, monitoring and training
11	RCT training at 3 hospital(Bududa, Busolwe & Kapchorwa	125	MOH—Facilitators, monitoring and training
12	TB HIV co management	26	MOH—Facilitators, monitoring and training
13	Training in Health care waste management.	67	MOH, JCRC—Facilitators, monitoring and training
14	Logistic management	32	MOH—Facilitators, monitoring and training
15	Quality Improvement for all district except Bududa	36	MOH- Facilitators, monitoring and training
16	Safe Medical Male Circumcision (SMMC)	23	Rakai Health Sciences Project, MUWRAP
Trainings for Community Resource Persons			
17	Training of Commercial sex worker as peer educator	60	TASO, AIC
18	Training of peer educators on AB and other preventions	80	TASO, AIC, and Mbale RRH
19	Trained PHAs in adult treatment protocols	120	TASO, SCOTS, and MOH
20	Training of PHAs as peer educator for positive prevention	116	TASO, NACWOLA
21	Trained PHAs in IMAI	20	MOH
Training for Religious Leaders			
22	Training of religious leader in HIV/AIDS prevention skills and servicers	291	MOH, IRCU, and STAR-E
Lot Quality Assurance Sampling (LQAS)			
23	Training of data collectors in LQAs	268	STAR-E M&E staff, 2 consultants, 8 district trainers, and STAR-E LQAS team

The project has been very mindful of that in scheduling training programs and the respective DHOs were always central to the planning, selection of the suitable participants and the implementation of the various trainings. Furthermore, efforts were made to emphasize workplace based mentoring/coaching approaches as opposed to the didactic approaches wherever possible. This was achieved through various technical support supervisions, clinical mentoring sessions, and integrated support supervisions. Table below summarizes the supportive supervision visits carried out in PY 2.

Table 8. Supportive Supervision Visits Conducted in PY 2

District	Quarterly Integrated SS at HSD & LLU	Quarterly Technical Supportive Supervision
Budaka	4	7
Bududa	4	5
Butalejja	4	5
Bukwo	3	6
Busia	4	8
Sironko	4	8
Kapchorwa	3	5
Pallisa	4	7
Total	30	51

Facilitation of District Recruitment and Hiring

During the implementation of the work plan, the four districts of Sironko, Busia, Bududa, and Bukwo submitted their requests to STAR-E for support in advertising, recruitment, and induction of health workers. This process was however hampered by the late approval of the districts' wage bills by the Ministry of Finance (MOF) for the fiscal year 2010/2011, something that usually happens after the end of every fiscal year in June. The result of this was the delayed submission of their requests to STAR-E and therefore, all the requests are still pending approval for funding.

Working closely with the Capacity Project (USAID), Sironko became one of the nine districts to be prioritized for special wage approval due to its very poor staffing levels for health workers. The process is also still ongoing with full involvement of the MOH planning division and MOF.

Intervention 2: Improved Physical Environment, Including Laboratory and Furniture

A preliminary baseline assessment of the infrastructure needs of the health facilities was done by STAR-E. However, given the expected extent of intervention and the variations in the needs across districts and health facilities, it was deemed necessary to carry out a detailed and comprehensive health infrastructure assessment exercise with the assistance of a private and very experience engineer/engineering firm. This process was initiated, requests for expression of interest from qualified engineers received, and the selection is yet to be completed.

Intervention 3: Increased Access to and Uptake of Quality Laboratory Services

By the end of PY 2, a total of 45 public (i.e., 5 general hospitals, 11 HC IVs, and 29 of 85 HC IIIs) and 5 private health facilities had had been supported to have functional laboratories.

The number of functional laboratories increased because STAR-E provided an assortment of essential laboratory equipment to 26 health facilities, in eight of the nine districts. These included 10 hemoglobinometers, 18 microscopes, 75 infection control medical waste bins, and 10 refrigerators. The aim was upgrading the existing relatively functional labs to fully functional status at all levels (Appendix_1__).

Laboratory Commodities Management

In the PY 2 reporting period, a number of support activities were done to improve the quality of laboratory services in the nine districts. There have been minimal cases of stock-outs reported for HIV test kits and other essential commodities such as ZN stain. In these minor situations, reallocations from overstocked to less-well-stocked health facilities within same district and across districts were facilitated. This is an official and transparent process of ensuring that commodities are put to efficient use while minimizing wastages from expiry. This process has been supported by the commodities tracking system introduced by STAR-E to help in monitoring the flow and consumption of the key commodities. The tracer commodities under this tracking system are Determine HIV I/II test kits and ZN reagents for TB diagnosis. Centrally, the system has been computerized, and on a monthly basis the laboratory advisor receives information pertaining to what was received, sources, and how much was used. Tagged to the consumption are the monthly returns are the numbers of people tested and those used on quality control.

The improved stocking of HIV test kits in the districts is due to the strengthened ordering system, ensuring orders are made in time and delivered in time and in coordination with NMS. STAR-E has worked closely with health unit staff to accurately quantify their laboratory commodity requirements and also facilitated distribution of commodities from NMS and JMS.

Overall, 122,100 Determine HIV test kits, 12,870 Start Park HIV test kits, 7,370 Unigold test kits, and 154,230 vacutainers were supplied to all the HCT-implementing health facilities in the eight supported districts (Appendix11). These are inclusive of the STAR-E mobilized buffer stocks for reagents, test kits, and other necessary supplies for ensuring uninterrupted laboratory services.

Capacity Building and Supervision for Improved Laboratory Services

The capacity building program for strengthening laboratory services started with TOT for 26 senior laboratory personnel from all eight districts. These were oriented on the MOH integrated package for laboratory management.

Continuous supportive supervision was carried out in the five general hospitals and eleven HC IVs in the supported districts. Important to note is the approach to mentoring and coaching of the laboratory staff as part of the integrated package of laboratory management.

Findings included poor infrastructure (i.e., inadequate working space), lack of furniture, poor staffing, lack of required equipment, use of manual systems, and the need to improve on quality of results and turnaround time. All these inadequacies will be addressed next year, in PY 3. Furthermore, IQA and mentoring of staff at district hospitals, HC IVs, and HC IIIs were also done to impart practical skills to improve the quality of results. Continuous follow-up visits for performance improvement have also been supported through districts' laboratory focal persons (DLFP) and the STAR-E Laboratory Advisor.

The Laboratory Advisor at STAR-E continued to hold meetings with officials at the NMS, MOH and CPHL to strengthen the laboratory commodity supply chain system. At the NMS, delays in receiving laboratory commodities orders under the credit line were identified as resulting from a poor ordering system, lack of accountability reports from districts, districts not aware of delivery schedules, and some districts not aware that the laboratory credit line was catering for other supplies such as gloves, slides, and pipettes. These delays have been addressed through intensified coordination of the DLFPs for timely accountability and submission of bimonthly procurement requests to NMS.

Laboratory Specimen Referrals

STAR-E consistently supported the referral of laboratory specimens from all the HCT sites to the JCRC reference laboratory in Mbale. The samples were prepared predominantly from ART sites and other, non-ART sites. The total numbers of specimens per quarter are shown in Figure 6_ and Table 9

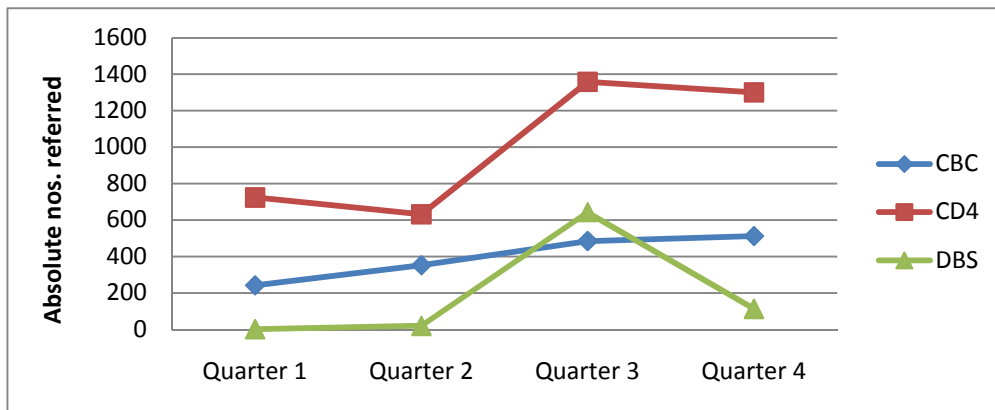


Figure 6. Laboratory referrals in PY 2, by type and quarter

Throughout PY 2, there was a marked increase in specimens referred for CD4, CBC, and DBS for DNA/PCR due to improved functionality of the referral system. New sites were set up and supported for EID alongside HCT, leading to increased DBS sample collection, as seen for Q3. Although in Q3 there was mass mobilization for EID and hence the sharp increase, also better and sustained supervision of the referral system through active involvement of community volunteers, case managers, and PHAs also resulted in a greater number of referrals than in the

previous two quarters. In Q4, CD4 samples referred remained steadily high but the growth was not as expected due to a long spell of nonfunctionality of the CD4 machine at JCRC.

Table 9. Overall Performance in Laboratory Investigations (Q1 to Q4)

Type of Test	No. Referred in Q1	No. Referred in Q2	No. Referred in Q3	No. Referred in Q4
CBC	242	352	485	512
CD4	724	632	1,359	1,301
Chemistry	6	3	5	7
CRAIG	1	0	0	0
DNA PCR	2	20	643	57
Viral load	3	0	0	0

There was a marked increase of specimens referred for CD4, CBC, and DNA PCR in Q3 onward due to the improved referral system. New sites were set up and supported for EID leading to increased DBS sample collection. There was also better supervision of the referral system this quarter.

Challenges for PY 2

Functionality of HC III public laboratories is still very low (29/85), whereas MOH policy mandates all HC IIIs to have functional labs to offer basic tests for TB, malaria, and HIV diagnosis.

Way Forward

Conclude consultation with MOH and district officials on infrastructure improvement of laboratory space and build capacity of HC III labs.

Intervention 4: To Increase Access to Quality Services Through Improved Commodities Management

STAR-E has ensured constant supply of commodities through the following activities:

- Liaising and working closely with the key stakeholders for commodity management, which are NMS, JMS, SCMS, and the district health staff. SCMS procures ARV drugs on behalf of STAR-E and ensures that they are delivered and stored at JMS.
- The signing of an MOU with the JMS to directly supply ARV drugs to each health facility providing ART. These are being received and distributed on a quarterly basis.
- Continued mentoring by the STAR-E Logistics Advisor of workers at the health facilities in the handling of commodities from NMS and JMS.
- NMS supplies testing kits, co-trimoxazole and fluconazole using MOH logistics arrangements. The staff at health facilities have been mentored to forecast, quantify, and

make orders, including keeping proper records of commodities received. Logistics standards have been incorporated into the FFSDP quality improvement tool, and the clinical mentors use these standards when they visit health facilities to ensure zero stock-outs of ARVs, medicines for the treatment and prevention of OIs, and anti-TB medicines, as well as test kits, our gold standard for systems improvement.

- Providing assistance, where possible, in timely delivery of orders to NMS and JMS and in the quick processing and delivery of commodities.

Key Achievements

Supportive Supervision

Joint support supervision by STAR-E and districts was conducted in support of a weak commodity management system, specifically on inventory records (use of stock cards, issue vouchers, dispensing log, daily consumption logs) for ARVs, test kits, laboratory reagents, and drugs for the prevention and treatment of OIs. All 13 ART sites now have an inventory tracking system for commodities, at least for what is received from suppliers (NMS, JMS, and other sources) to the user departments/service points at a facility.

A drug-monitoring tool has been developed and onsite support supervision and mentorship to health facility stores managers and health unit in-charges has been provided. Technical supportive supervision to health units, with an emphasis on the weaker sites, was done by the STAR-E technical staff and the district logistics.

Training of Health Workers

With technical support from SURE and MOH, 32 health personnel were trained centrally in logistics management as district-based teams who will train other health personnel at district level in order to streamline commodities management in all the supported districts. Jointly with the DHOs, STAR-E also supported the logistics management trainings in three districts (Butaleja, Kapchorwa, and Bududa) to health personnel in all ART sites.

Coordination of Supply Chain Management

STAR-E liaised with MOH, NMS, JMS, SCMS and the districts to ensure constant availability of HIV/AIDS commodities, which resulted in the number of health facilities with a stock-out of first- or second-line drugs being zero. To achieve this, STAR-E and the districts ensured that all 13 (100 percent) health facilities offering ART promptly made orders and reports of ARV drugs to NMS.

There has not been any stock-outs of first- and second-line ARVs due to improved quantification skills, and redistribution of ARVs from sites that had previously been overstocked.

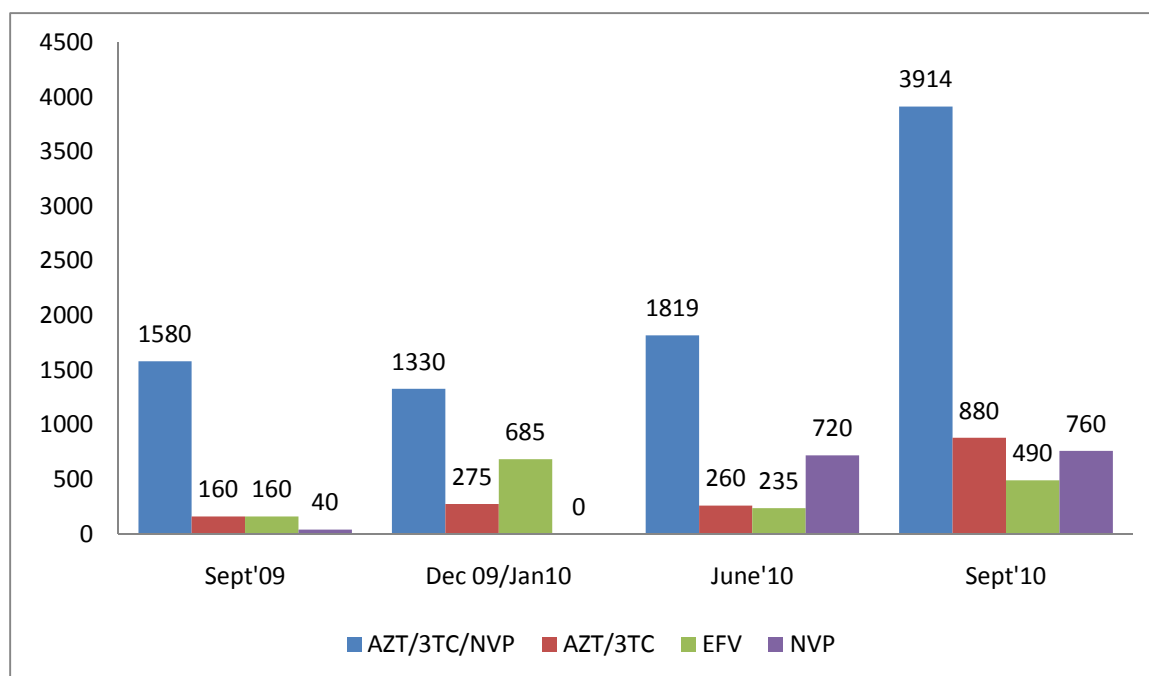
From the third to the fourth quarter, the number of ART sites that submitted orders to NMS on time increased from 7 to 13 (100 percent).

Data Verification

This exercise covered all current patients enrolled at the 13 ART sites. The findings will be used to quantify the amount of buffer stock of ARVs and co-trimoxazole required for PY 3. The STAR-E Logistics Advisor worked closely with SURE for their technical support and MOH to develop materials for logistics management tailored to meet the specific objectives of STAR-E in strengthening HIV/TB responses in eastern Uganda.

Allocations and Distribution of HIV/AIDS Commodities

STAR-E has consistently worked jointly with JMS and SCMS to allocate a number of HIV/AIDS commodities to the ART health facilities. Of special mention are the ARVs allocated and distributed to the 13 health facilities. Detailed table in appendix 111



Figur1e 7. Total ARVs commodities allocated between from September 2009 to Sept 2010

Overall, there has been a steady increase in the quantities of ARVs allocated to the ART sites. Of particular significance is the high allocation of AZT/3TC/NVP in September 2010 compared to the previous allocations.

The sudden increase has been brought about by the STAR-E scale-up efforts from the old 13 sites to a total of 23 sites. As seen in the figure above, STAR-E did not allocate as much nevirapine between September 2009 to May 2010. During this period, PEPFAR and Baylor College were very active, and therefore providing sufficient buffer stocks, even for the adults. However, with the handover of PMTCT and pediatric sites, the quantities of NVP have significantly increased in past two quarters. Pediatric allocations were last made in January 2010 only for the new sites and Kapchorwa Hospital.

Challenges

There is an inability for NMS to supply all the HIV/AIDS commodities ordered by the health units, in which case STAR-E buffer stock does not last for the intended period. For some programs, such as pediatric ART and PMTCT, many programs supply ARVs, leading accumulated stocks soon to expire (e.g., single drugs, two-drug fixed-dose combinations, and pediatric formulations). There is no clear coordination mechanism in place yet for the various IPs. Some programs that supply ARVs to health units require separate records (stock cards) for their supplies, hence creating an additional burden for the health workers.

Intervention 5: Strengthening the Districts' HMIS/M&E System

Baseline Survey

The project successfully carried out a baseline survey in the eight supported districts.

Table __: Highlights of baseline findings – Appendix 1V

HMIS Gap Analysis and Support to HMIS

A rapid assessment was done to identify the gaps that existed in the area of HMIS and how they would best be bridged. The following gaps were identified: stock-outs of data collection tools; lack of staffing to handle HMIS; too many record books by donor partners to be updated by the already-overburdened human resources; and lack of skills leading to incompleteness and inaccuracies of HMIS data that is turned in. Facilities have since been offered targeted support.

During the year, STAR-E provided all health facilities of level III and above in the districts with MOH preformatted HIV/AIDS and TB related HMIS reporting tools. The tools included antenatal, postnatal, ART, pre-ART, HCT, TB registers, and others. Throughout this period, the STAR-E project staff provided on-the-job mentoring of staff at the supported health facilities in the use of the HMIS registers.

Operations Research: Drug Adherence Baseline Study

During the reporting period, the project conducted an operations research study in the area of drug adherence, which aimed to establish adherence levels at baseline in 13 facilities that offer ART in the eight STAR-E districts of operation.

A total of 130 patients were interviewed and 325 patient records reviewed retrospectively from March to August 2009, just before STAR-E rolled out comprehensive TB/HIV/AIDS intervention.

RESULTS

In-depth interview of the results of 60 patients on ART indicate that 86 percent reported perfect adherence on self-reports (i.e., overall 95–100 percent adherence); dispensed medicine covered 91.1 percent of days in a six-month retrospective period; 15.6 percent of patients had a gap of more than 30 days in their dispensed medications; 72.8 percent of patients attended clinic on or before the date of their next appointment; 84.1 percent of patients attended within three days of their scheduled appointment. Facilities scored differently in terms of patients lost to follow-up, the lowest being 7 percent and the highest being 23 percent. The study, however, had limitations, including the inability to isolate facility-specific median indicators, as it would require more time to see variations in individual facilities. There were limitations in retrieval of data in two health facilities. Record keeping was a major challenge, as most of the patient cards did not show calculated adherence scores. The space on the card for documenting treatment and indicators was not adequate to capture all information that would be needed for this calculation. Consistency was interfered with by stock-outs of medications and patient cards.

Facility and Community Operations Research

Three operations research papers have been completed:

- *Strengthening ART Adherence Levels in Uganda: Case Study of District HIV/TB Programs (DHTP) in Eastern Uganda (STAR-E Project)*
- A community concept paper on SMMC titled *Perceptions of Acceptability of Medical Male Circumcision as HIV Prevention Measure by Different Communities Supported by STAR-E: A Situational Analysis*
- *Improving Client Enrollment on Pre-ART and ART: A Case Study in Eastern Uganda*

The adherence protocol was approved by the Uganda National Council for Science and Technology (UNCST) and is awaiting Joint Clinical Research Centre IRB approval. A third version of the SMMC paper is being circulated for review and will soon also be submitted to UNCST for approval.

Submission of HIV/AIDS Abstracts to the International AIDS Conference

The project is determined to acquire new knowledge and share its experience with the rest of implementer partners. The project submitted nine evidence-based abstracts to the International AIDS Conference (IAC), held July 2010 in Vienna, Austria, out of which five were approved. One abstract was granted a partial scholarship. Three abstracts have been published on the MSH website under the intranet page.

INTERMEDIATE RESULT 2A: ESTABLISHING A SUSTAINABLE LOT QUALITY ASSURANCE SAMPLING (LQAS) MONITORING SYSTEM IN UGANDA

STAR-E- LQAS focuses on promoting use of Lot Quality Assurance Sampling methodology at national and district levels and among USAID-funded implementing partners reporting on the SO8 indicators.

There was an initial PY 2 work plan approved by USAID which guided implementation of activities through April 2010. The strategic plan for the IR 2a (STAR-E LQAS) component was revised in March 2010. The entire report is structured along the seven strategic objectives of the revised plan, as shown Section 1 of the full report (Appendix V)

SO1: Establish and manage STAR-E LQAS

Planning

Annual and quarterly planning and review meetings were undertaken with support from the home office and LATH. The annual plan, including a project Performance Monitoring Plan (PMP) and detailed budget, were developed and submitted in time. The STAR-E Finance Department provided guidance in preparing and finalizing the annual and quarterly budgets.

Staffing

One senior staff member and three drivers were recruited during PY 2. Mr. Timothy Wakabi, coordinator for LQAS district applications, resigned from MSH at the end of July 2010, resulting in a rearrangement of staff responsibilities. The recruitment of the replacement staff was completed in September, for the recruited person to assume duties on October 1, 2010.

An additional staff position of a Specialist: District-Level LQAS, Facility Assessments, and Data Use Processes was approved and the recruitment process begun. (See Section 2.1.2 of Appendix V.

Reporting

Quarterly and annual reports were prepared and submitted in time to STAR-E CoP for incorporation into the STAR-E regional project reports. The reports highlighted the activities and results under each STAR-E LQAS strategic objective, challenges faced and achievements made.

Overall STAR-E LQAS Management

Management meetings were held weekly as part of the project monitoring process. Weekly activity plans are discussed and each staff member gives feedback on activities of the past week to foster coordination and team work. (See Section 2.1.2 of Appendix V.)

SO2: Develop LQAS Institutionalization at the Central Level

Because STAR-E LQAS is mandated to establish a national Institutional Home (IH) for LQAS, a systematic review of a number of cross-sector cutting government departments and other bodies was done to identify the most appropriate potential IH. The final decision was deferred at USAID's recommendation, awaiting additional information on the justification of the need for an LQAS IH.

Partnerships

STAR-E LQAS embarked on identifying and linking with various partners for LQAS promotion and application, carrying out the following activities:

1. An MOU was signed between MAKSPH and STAR-E LQAS in June 2010, relating to the teaching of LQAS within the institution and supporting in-service training. Another MOU was prepared covering an attachment of a fellow to STAR-E LQAS from MAKSPH.
2. Working relationships have also been established with the Civil Society Fund, MEEPP, NUMAT, Reproductive Health Uganda, SDS, STAR-SW, STRIDES, Uganda Health Marketing Group, UMEMS, and UNAIDS.
3. A presentation was made to 38 Northern Uganda USAID-funded IPs about institutionalization of LQAS as a monitoring tool and the role of STAR-E LQAS vis à vis IPs. Institutions included ACIDI/VOCA, HIPS, IRS, LEAD, NUMAT, TASO, Uganda Health Marketing Group, and Unity.

Technical Advisory Group

The STAR-E LQAS Technical Advisory Group (LTAG), representing 10 institutions, held all its scheduled meetings during the reporting period. The LTAG offers technical and strategic guidance and oversight to the implementation and sharing of results of LQAS. It provided guidance on undertaking a systematic review in search of an IH and advised on the implementation of the approved revised strategic plan. (See Section 2.1.2 of Appendix V.)

SO3: Building Capacity in LQAS Support at the National and District Levels

This strategic objective focuses on building and strengthening capacity at the national level to provide training in and apply LQAS methodology in order have more competent people available to support LQAS application and data use at the district level.

Development and Standardization of LQAS Materials and Guidelines

STAR-E LQAS developed materials that are to guide the standardized application of LQAS methodology. These materials include the following:

- HIV/AIDS, TB, and malaria survey questionnaires
- Hand tabulation guidelines
- LQAS detailed implementation plan template
- Tool for assessing partners' readiness for LQAS application

Institutional Training in LQAS

MAKSPH undertook institutional training in LQAS as part of building national capacity for LQAS application. The school incorporated LQAS into its curricula. The school has also designed short term in-service training. During the past 12 months 236 students attending various degree courses at the school have been exposed to LQAS (see Section 2.1.2 of Appendix V).

National LQAS Facilitators and Master Trainers

Twenty-eight individuals (six females and 22 males) were drawn from UBOS, district local government, ministries (Education, Health, Gender, Labour and Social Development) and private individuals for training as National LQAS Facilitators (NLF). They form the first group in a pool of expertise STAR-E LQAS is developing to support IPs and districts in applying LQAS. The five-week training program is divided into two parts: the first, two-week segment covers basic LQAS principles and the theoretical aspects of LQAS surveys; the second, three-week segment involves participation in actual district-level application of LQAS methodology.

The 28 people who undertaken the first part will complete their training as STAR-SW begins its baseline LQAS surveys in November.

NLFs become Master Trainers when they have undergone satisfactory training in the three STAR-E LQAS processes: LQAS, Facility Assessments (FAs) and Service Performance Assessment and Improvement (SPAI). (See Section 2.3.2 of Appendix V.)

SO4 Promoting Application of LQAS Methodology in the Local Governments

This strategic objective focuses on supporting districts undertake LQAS surveys. It is the centre and platform for LQAS institutionalization effort. The activity is undertaken with full involvement of the District Management Team who choose the people to be trained and who eventually carry out the surveys within their districts.

The following LQAS survey activities have been carried out:

1. STAR-E districts: In August 2010, the STAR-E LQAS component supported STAR-E project to conduct LQAS survey to collect data and report on the project population-based performance indicators in all nine supported districts. Four of these were conducting repeat LQAS surveys, following the first applications in November–December 2009. One hundred and eighty-five district staff have so far participated in LQAS surveys in STAR-E project districts (120 once, and 65 twice). Appendix V1 – Preliminary results of LQAS in all the 9 STAR-E districts.
2. STAR-EC has applied LQAS to collect baseline data in its nine project districts in collaboration with STAR-E LQAS on survey tools. Eighty-five district workers have participated in the LQAS applications (36 once, and 49 twice).
3. UNAIDS: STAR-E LQAS provided technical support to UNAIDS in its effort to establish Centers of M&E Excellence in the districts of Kasese and Kiruhura. Forty-four district persons were trained in LQAS methodology.

In addition, planning got under way for the following LQAS surveys:

1. STRIDES project: Sixteen STRIDES staff members were oriented on LQAS methodology. LQAS application in the STRIDES project region is scheduled for January 2011.
2. STAR-SW: Preparatory activities were started in supporting STAR-SW to undertake LQAS surveys. Training of project staff is scheduled for October 2010 and the surveys for November 2010.

More details on LQAS applications are given in Section 2.4 of Appendix V.

SO5: Mobilize Partners in the Application of LQAS

This objective focuses on creating demand, commitment, and involvement among partners in application and support use of LQAS.

Develop and Implement a Strategy to Advocate and Mobilize IPs for LQAS Application

Various stakeholders' meetings were attended to promote LQAS methodology. Key meetings included the US CDC–supported IPs and the meeting with USAID-funded Northern Uganda IPs mentioned under *Partnerships*.

Establish TWG to Support LQAS Application

During this period only one TWG was set up to support the selection and finalization of indicators that will guide the establishment of the national database.

Communication

STAR-E LQAS has developed and disseminated LQAS knowledge and information materials targeting various consumers at different levels. Achievements include the following:

1. A STAR-E LQAS component promotional brochure and a flier that explains the experience of conducting LQAS in four STAR-E districts were prepared and disseminated.
2. A poster describing LQAS survey methodology as applied in four districts of the STAR-E project region was produced and used during the STAR-E project launch.
3. Two LQAS abstracts were presented at the International AIDS Conference in Vienna: a poster presentation, *Knowledge of Antiretroviral Therapy and Sexual Behavior among People with HIV/AIDS in Eastern Uganda* and an electronic poster presentation, *Institutionalizing Lot Quality Assurance Sampling (LQAS) as a Simple Monitoring Method of Health Services at the District Level*.
4. An electronic information brochure, *MSH and Health Systems Strengthening in Uganda; Use of LQAS, Facility Assessment, and Service Performance Improvement in Increasing Service Coverage*, was produced for the MSH website.
5. A consultant is compiling a report on LQAS experiences in Uganda by geographical area, implementing agency, and service sector.

SO6: Establish and Manage an Information System for LQAS

This strategic objective focuses on establishing a functional LQAS information system. It involves developing and maintaining a centralized LQAS database, to which districts will transmit LQAS data sets in order to make national estimates for service performance.

Developing a Central Database and the Capacity to Maintain It

A stakeholders' meeting was held in July 2010 to review and provide guidance on the core set of the LQAS national indicators. A TWG comprised of 15 members was formed to continue supporting and guiding the review of the indicators. The final list is expected in mid-October 2010, for presentation to USAID for approval.

A database containing data from the LQAS surveys of four STAR-E districts in November–December 2009 has been established at the STAR-E LQAS project office. The database also contains data sets of previous LQAS applications from UAC and Maplay. A report for the LQAS survey process of the four districts (Busia, Butaleja, Pallisa, and Sironko) was prepared and disseminated. Analysis of the data from the four districts is ongoing.

Proving Data Management Support

STAR-E LQAS has supported UNAIDS to develop databases and data entry for the LQAS surveys in Kasese and Kiruhura districts. The support will further be extended for the analysis and dissemination of the survey findings.

SO7: Promote Facility Assessment and Innovative Use of Results

This objective focuses on ensuring that facility assessment tools are developed and used by IPs to undertake FAs to complement the community LQAS data. It aims at realizing more IPs supporting districts undertaking FAs and use of results through the SPAI process.

Continued Development and Standardization of Tools and Guidelines for FAs and Data Use

During the period, the component developed FA tools to be used by IPs providing services for HIV/AIDS, TB, and malaria, including client exit interviews, provider interviews, and a health facility checklist. These will be tested in October 2010 with the support of LATH. SPAI guidelines were developed, reviewed and revised with the involvement of MAKSPH.

Support to IPs in Application of SPAI in Districts

The SPAI process was undertaken in two districts, Bugiri and Mayuge, in the STAR-EC project region. Two teams of nine people from each district were guided through a systematic review of the survey indicators, other data collected from the districts, and in-depth assessment of the problems relating to the survey priority areas in order to come up with priority areas for improvement. At the end of the five-day process, each of the two districts had developed improvement and monitoring plans. Mayuge district was able to realize resources from another donor to implement some of the planned improvements.

Lessons Learned

1. District leadership (political, administrative) is key for effective promotion of the LQAS concept and successful implementation of project activities in the districts.
2. Districts (CAOs) need to be part of the team to convince district leaders (planners, department heads, district councils) to mobilize resources for M&E improvement processes.
3. Districts that have repeated application of LQAS are eager to conduct the LQAS survey, beyond the service areas covered in their districts
4. Repeat surveys in four districts in STAR-E project region showed that knowledge of the LQAS methodology can be retained by district workers.

Challenges

The full report in Appendix V details a number of challenges faced by STAR-E LQAS, including the following:

1. Coordinating the SO8 district-based partners implementing LQAS in the technical areas of HIV/AIDS, TB, RH/FP, education, and child survival
2. Insufficient human resources and capacities within the country in terms of the technical expertise required for leading and supporting LQAS implementation and sustainability
3. Limited budgeting and planning for M&E activities in general, and LQAS monitoring efforts, in particular, among IPs and districts

Opportunities

Despite the above challenges, the following opportunities exist:

1. A general appreciation of the need for information by the district management teams for use in performance monitoring and annual district health planning.
2. The collaborative linkages with a wider array of IPs. Throughout the year an increased number of implementing partners expressed interest in using LQAS to monitor their services.
3. The close link with MAKSPH provides expertise to support tools and guidelines development. The attachment of a MAKSPH/CDC HIV/AIDS fellow to STAR-E LQAS, currently participating in the implementation of activities, is an extension of the collaboration.

Summary of PY 3 Activities under IR 2a

1. STAR-E LQAS will work collaboratively with the IH once identified. The IH will house the national LQAS database and an MSH staff member will work closely with it.
2. STAR-E LQAS will continue working with MAKSPH for institutional training of LQAS. Other training institutions will be approached to incorporate the teaching of LQAS in their curricula.
3. Other activities will be to set up a quality assurance plan for LQAS applications, continue the development and standardization of tools and guidelines for LQAS application. The component will support STAR-SW, STRIDES, and one to two other identified IPs in undertaking community LQAS; complete develop and implement a strategy to advocate for and mobilize IPs for LQAS application; develop and finalize the LQAS database; obtain data from implementing partners that have applied LQAS; support Kasese and Kiruhura districts under UNAIDS support; analyze results; prepare reports and disseminate results; and support application of FA and SPAI in 20 STAR-E and STAR-SW districts.

INTERMEDIATE RESULT 3: QUALITY HIV/TB SERVICES DELIVERED IN ALL SUPPORTED HEALTH FACILITIES AND COMMUNITY ORGANIZATIONS AND ACTIVITIES

Evaluation of Site Team Functionality

The QOC in MOH and HCI project had trained staff of ART-accredited facilities in Quality Assurance Initiatives (QAIs) using HIV/QUAL models, but many of these staff had left the facilities and many centers were not monitoring any indicators after they had graduated. STAR-E with MOH trained the site QI teams in quarter 3 of PY 2; a total of 39 health workers were trained in the 13 accredited sites to augment the number previously trained by QOC and HCI and follow-up training has been done, with the teams being mentored on collection of data and how to use this data for continuous quality improvement, making of monthly work plans, and monitoring of MOH indicators. Site QI teams have been formed in 10 sites, awaiting accreditation and mentoring in QI principles and formal training in quarter 1 of PY 3 .

Service Provision

Service availability at the health facilities has improved and the most active clinics are now running ART clinics twice in a week.

There has been a scale-up from the original 13 ART sites to 23 active ART sites, with a plan to increase the number to a total of 32 in the operational area by end of PY 3. Provision of repeat CD4s at six months, which was at 10 percent at the baseline assessment, has improved to 45 percent at the sites offering ART services. Since STAR-E started operating, we have purchased some equipment for the facilities, specifically for the laboratories, and commodity management has been done to ensure minimal stock-outs in the health facilities, especially of ARVs and HIV testing kits; this will expand to include other essential medicines and commodities. The process of facility infrastructure assessment is ongoing and will provide a picture of the equipment and remodeling needed in the 32 health facilities.

Evaluation of Data Management at the Facilities

At the baseline assessment, HIV/ART cards and HMIS registers were not available in all the ART sites and where they were present they were not being used properly. With the continuous clinical site mentoring by STAR-E staff, data management in the health facilities has improved and there is now active use of HIV/ART cards and registers. Health facility workers have been trained in various HIV-related management packages, coupled with the clinical mentoring at the health facilities. IEC/BCC materials, to supplement MOH policy guidelines, have been provided, evidently improving the quality of service delivery. However, motivation is still a challenge coupled with profound workload. STAR-E, working with the districts, will use nonmonetary methods to reward the best-performing health workers and facilities, as well as institutionalize the Work Climate Assessment Tool in PY 3.

Challenges

Some of the health facilities are limited in their continuous QI monitoring because of the few number of staff, and some facility QI teams are reliant on one or two members of staff who if not around the data collection stalls. Meetings and CME are irregular such that as much as the data may be collected its meaning and use may be limited to the collectors. In 30 percent of the health facilities, there are still problems in having MOH registers completed on time, a shortfall that delay the flow of data from sites to districts and ultimately to the national level. Problems continue with the filing system of patients' records, meaning that patients' confidentiality is not guaranteed. Twenty percent of the sites (in the hard-to-reach areas) do not deliver their HMIS data to the districts and MOH in time, although most have summaries already compiled.

Follow-up of patients is not carried out in all health facilities; we operate in districts bordering Kenya and patients go cross the border for various reasons, some receiving ART from both sides, making their follow-up difficult.

Way Forward

STAR-E will ensure continuous quality improvement and monitoring by using the data collaborative at the supported sites. STAR-E is in the process of making facility site supervision teams functional; these will be composed of STAR-E technical staff, members of the district team, and the MOH quality improvement regional coaches. These teams will camp at health facilities and do mentoring and give prompt feedback followed by action plans for the subsequent months.

As HCI transitioned from the STAR-E project area, in February 2010, STAR-E held joint meeting with MOH, STAR-EC and URC/HCI project to plan a way forward, and the following was agreed:

- A member of STAR-E (director HSS) will be represented on the National Quality Steering committee and STAR-E progress reports to the steering committee from STAR-E will be forwarded though the national core team.
- The national core team will continue building the capacity of the regional quality teams and district quality teams and will be involved in training of health workers at the health facilities in addition to providing supportive supervision, and will involve STAR-E during these exercises.
- STAR-E will co-opt the existing MOH regional team during supportive supervision and coaching visits, and meetings of the regional coaches, previously been facilitated by HCI, will be supported by STAR-E
- Exchange visits between the STAR-E QI personnel will be facilitated to share best practices and challenges in the field.

Strengthen Clinical Mentoring Systems

During PY 2, the project was able to provide support to chronic care/ART clinic staff in the various districts to scale up the number of people accessing HIV care and treatment.

At the beginning of PY 2, chronic care and ART was being offered at five district hospitals and eight HC IVs, and a total of 159 new patients had been started on ARVs in the project area. As of the end of PY 2, the project has facilitated an additional nine facilities to become functional ART sites (Kaproron HC IV, Buwasa HC IV, Chesower HC III, Kaderuna HC III, Ikiiki HC III, Nabiganda HC III, Budumba HC III, Lumino HC III, and Bukigai HC III). The extension of ART services has been possible through training of district staff and above all through the regular support of the four district clinical mentors employed by the project. Through site visits and phone consultations, the clinical mentors have been able to build the confidence of clinic staff to initiate and look after patients on ARVs.

As of the end of PY 2, a total of 10,031 HIV-positive patients were receiving chronic care, and 3,354 were receiving ART in the original eight districts covered by the project.

The clinical mentors have also been able to make an impact on the quality of care being offered, especially in the area of HIV/TB co-management.

All ART sites now show evidence of all HIV-positive patients being screened for TB at each visit, as well as all TB patients being offered HIV counseling and testing. This, however, is not the case at non-ART sites.

An observation has been that during the course of PY 2, the ART facilities used the clinical mentors largely as clinicians offering direct patient care alongside them and as consultants for difficult cases. To a lesser extent the clinical mentors have been able to identify clinic staff to mentor and nurture them to mentor staff at lower-level facilities. In one or two cases, these mentees have been used in supporting the newer sites being prepared for ART accreditation. In order to make more time for the mentoring process as well as document the process more effectively, the project ended PY 2 by reviewing and changing the mentoring strategy. In addition, our entire team of clinical mentors and district health advisors spent a week's placement at the JCRC facilities in Kampala in a bid to benchmark and improve our mentoring practice. Going into PY 3, the new approach will hinge on fewer visits to each site but with a larger team (the field-based team) spending two to three days per site visit, with a more structured and documented approach to the five key components of a site visit.

Planned Activities for Next Quarter

- To identify, together with the district leadership, those clinic staff who have shown great promise as potential mentors. These will then be placed in a structured program working together with our mentors so that they can in turn be prepared to mentor other health workers within the district.
- To fully and effectively implement the field-based team model to carry out mentoring at site visits using the STAR-E clinical mentors and the other technical advisors within the project.

Success story: GETTING THE EXPERTISE TO WHERE IT MAKES A DIFFERENCE.

Shamim is a single mother of two currently on management of HIV/TB co-infection. She first fell sick in July 2009 when she was diagnosed as HIV positive. She was admitted at Mulago National referral hospital for two months and was treated for bacterial pneumonia without improvement. A family member later requested that she be transferred back to her home district hospital (Bududa) – since it was proving too expensive for the relatives to look after her and they had given up hope of her recovery or survival.

Bedridden Shamim in hospital.



Bududa district hospital is one of the facilities supported by the STAR-E project and the responsible **Clinical mentor** is **Dr Damalie Bajunga**. Damalie first met Shamim in November 2009 after she had been admitted at Bududa hospital for two months with high grade fevers, severe anaemia, chronic cough and severe wasting. After reviewing her history, clinical picture and Chest X-rays; a diagnosis of Pulmonary TB was made and treatment started. She was discharged after two weeks – feeling better, to continue her treatment as an outpatient. She is presently doing well on both Anti-TB drugs and ARVs and has been able to get back to work and support her children.



INTERMEDIATE RESULTS 4: NETWORKS, LINKAGES AND REFERRAL SYSTEMS ESTABLISHED OR STRENGTHENED

4.1 Participating in Networks at the National/International Level

During the course of PY 2, the project has been responsive to ACP/MOH-led activities and has actively participated in TWGs in areas such as the National Quality Assurance Steering Committee, HCT, PMTCT, and EID.

This has added value to the districts covered by the project in that dissemination of new national guidelines has been facilitated by the project down to the facility level.

The project also contributed to the body of knowledge in the provision of HIV services by preparing nine abstracts for the International HIV/AIDS Conference held in July 2010 in Vienna, Austria. Five of these were accepted as poster presentations and the rest as electronic presentations. The project also facilitated all nine DHOs and ART facility in-charges to attend the National Pediatric HIV Conference held in September 2010. In addition to helping district personnel access new developments in the practice of pediatric HIV care, this also served as a positive motivation factor for their work.

The project also worked closely with several development partners, including participating in a PEPFAR coordinating office review exercise in June 2010. The project has had to work closely with PREFA and Baylor-Uganda as they transition out of the districts now supported by STAR-E to ensure that services are not disrupted. The project has also involved the new Strengthening Decentralized Systems (SDS) project in its work planning as well as other USG-funded projects such as STAR-EC, NUMAT, SURE, STRIDES, HCP, MUWRP, and HCI to mention a few.

4.2 Participating in Networks at the Regional and District Levels

Through the funding support provided by the project to the districts, all districts have held and recorded at least two quarterly DHMT meetings, at least two quarterly HIV/TB review meetings and monthly support supervision activities carried out by HSDs to lower level facilities. However, only two districts were able to hold a documented DAC meeting in the course of PY 2.

The project also actively supported the National TB and Leprosy Program by facilitating district personnel to attend the quarterly zonal meetings as well as taking part in one review exercise.

4.3 Participating in Networks at the Community Level

Case Managers have been the key link between health facilities and the communities. These are PHAs who have been trained to assist health workers with some of the clinic activities as well as following up of HIV-positive patients in the community. The project has worked with 42 case managers to date.

The other strategy has been to continually grow the number of PHA support groups formed and trained/orientated. Bukwo district is an example of progress made. The district had high levels of stigma and by the end of PY 1, there was only 1 PHA support group in the whole district, found in one subcounty (Suam). As of the end of PY 2, each of the five subcounties in Bukwo has an active PHA support group, each with at least 25 members. In the course of the last quarter, a campaign to accelerate access to pediatric HIV services was held around selected facilities, including Chesower HC III in Bukwo. A total of 1,574 children (between 6 weeks and 17 years) were brought forward for testing by their parents/guardians following the week-long campaign—again, representing good progress in an area previously deemed to have high levels of stigma against people with HIV/AIDS.

Success story: THE LONG WALK TO PHA NETWORKS IN BUKWO DISTRICT- A SUCCESS STORY

Unlike other STAR-E supported districts, Bukwo district had not had any major HIV/AIDS projects with a focus on PHA support networks. The PHAs were subdued with fear and apprehension arising from stigma in their own communities. Many would trek into the neighboring Anderson Hospital on the Kenyan side of the border to receive their treatment, care and support services due to stigma. There was no Post Test Club, no single PHA group, and no PHA leadership. In the absence of a social support network, there was little, if any, tracking of lost clients, which was majorly done by the overwhelmed health workers. Consequently, every one of the PHAs melted back into their own homes, leaving psycho-social support and sense of belonging, to fate.

Together with the DHO, STAR-E sought to strengthen social support for PHAs in the district. The DHO identified Hellen Chemaswet, a single mother, and HIV/AIDS widow the first person living with the HIV virus to come out openly and declare her HIV status in the district to coordinate fellow PHAs. STAR-E mentored her as a case manager and placed her at Bukwo HC IV as a motivator to other clients to accept their HIV status and live positively.

Together with another lady Hellen mobilized fellow PHAs to form Swam PHA network. The Swam PHA network now has 110 active members who associate regularly and discuss topical issues affecting their lives. Hellen and her pioneer friend have supported PHAs to form three other PHA groups of Bukwo town council Bukwo Town Council Kabe and Chesower. Many of the PHA members have been trained as peer educators. These are empowered enough to sensitize their communities on and mobilize them for various HIV/AIDS services.



Ice breaker; The first meeting ever with PHAs in Suam sub-county. Embracing PHA networks amid stigma in Bukwo district

The individuals in the various community networks, such as case managers and other volunteers, are provided with adequate supplies of referral books, pens, registers, and condoms. They keep records of referred clients and what services clients have received. In PY 2, 2000 referral books and 1,000 referral registers were distributed to promote the community health unit referral of community members for various services.

INTERMEDIATE RESULT 5: INCREASED DEMAND FOR COMPREHENSIVE HIV/TB PREVENTION, CARE, AND TREATMENT SERVICES

The project has worked with different structures in the community in the nine districts to increase awareness on available services for HIV/AIDS and TB and also to sensitize the communities to demand for those services.

In all districts PHAs have been engaged to be change agents in disseminating knowledge to the wider community on the available services for PMTC, HCT, pediatric, HIV/TB, and HIV prevention services. .

Other methods used to mobilize the communities to demand, seek, and utilize health services included video shows and film shows. These activities were implemented by respective districts, through health workers at places negotiated and agreed upon with communities.

The video shows and films to mobilize communities to demand, seek and take up services were adapted from MOH, JCRC, AIC, NACWOLA, and Uganda HIV/AIDS Alliance. Health workers and PLWHA who facilitated these shows answered questions coming from the audience to the extent that the shows were interactive and informative. Brochures from MOH on specific services such as TB, PMTCT, and HCT were distributed at these shows. Condoms were also distributed to those who needed them.

EID Services

According to the WHO, HIV-exposed infants should be tested for HIV as early as six weeks in order to have them access care, and treatment. According to the new guidelines by Government of Uganda all children below 24 months who test positive for HIV should be started on treatment.

One of the challenges the project and health facilities face is that a proportion women prefer to deliver outside the health facilities, and loss to follow up for babies delivered in health facilities is high. The project worked with the districts of Busia, Bukwa, Butaleja and Budaka to mobilize communities in the catchment areas of Lumino, Budumba, Chesoweri and Ikiki health facilities to bring children for DNA PCR and rapid testing. The communities responded and over 1000 children were brought to have a DBS or Rapid test based on the different age groups as per guidelines of Ministry of Health. The case managers deployed by STAR-E at health facilities and community based volunteers trained from the PHAs will help in tracking children who test positive for HIV for the children to be enrolled into care ,treatment and support.

TB Services

The project is promoting two of “3 Is” for TB: **I**nfection control, **I**ntensified case finding and piloting INH prophylaxis at a few sites. The challenge has been lack of awareness on TB/HIV issues leading to a low suspicion index for potential TB cases.

Film shows have been conducted with Ministry of health in the districts of Kapchorwa, Sironko and Busia to raise awareness on indicative signs and symptoms for TB and also demonstrate to the public the link between HIV and TB. The district health educators were present at these film shows to answer questions raised by the audience. People were informed of the available outlets for TB diagnosis and treatment. Similarly Drama shows were held in Pallisa and Budaka to increase awareness on TB and HIV and to direct people to HCT outlets and TB management centers. Radio talk shows were supported by Sironko and Kapchorwa Health services on TB and HIV and people called in and were directed to Health facilities where HCT and TB services could be accessed.

SMMC Services

Bugisu and Sebei regions are traditional circumcising area. This is part of the culture, however it is done under unhygienic conditions and the ceremonies associated with the rituals increase the risk for HIV Infection. This year we organized youth camps that attracted a lot of sexually active youths, who were given advice and information on where to get safe medical circumcision. Four Health facilities have been prepared to conduct safe male circumcision among them, Busolwe, Masafu, Busia HCIV and Pallisa hospital. The youth have shown enthusiasm in taking up male medical circumcision.

Adherence Counseling

The project has engaged PHAs through the PHA networks to encourage HIV-positive people to seek for services. The main barrier to seek for services has been stigma, lack of awareness and fear of being charged for services. However, the drama shows and live testimonies given out by PHA groups has reduces stigma, and effectively encourages PHAs who have been shunning for services to seek for health care. Those on medication for TB on co-trimoxazole prophylaxis and on ART have been encouraged to stick to the treatment protocols by peers and encourage to go for refill and medical check- up in case of side effects but not to abandon treatment.

Condom Use Promotion

Based on the discussion the STAR-E team has had with commercial sex workers in Busia and Kadama would accept unprotected sex if a customer is willing to pay higher price. Knowledge on the relationship between STIs and HIV has also been found to be low. The STAR-E team has engaged CSW to increase awareness on available services for STI at Busia HC IV and Budaka HC IV, respectively. Again, the peer educators from among the CSW were encouraged to pick condoms for distribution to their peers.

STAR – E PROJECT: FINANCE, ADMINISTRATION, AND GRANTS

Year ending September 30, 2010

Total Project Budget including LQAS	USD 33,701,157
USAID Plug in	USD 30,000,000
Cost share	USD 9,555,173
Obligated Funds	USD 11,257,110
Total Project Budget	USD 73,256,330

Overview

The Annual activities were conducted according to the contract and a few success stories were outlined as below:

Project Management and Contract

Incremental funding from USD 3,800,000 to USD 5,800,000 was received. Procurement of 19 motorcycles and 17 motor vehicles was completed. Staff recruitment level reached 100 percent. Verification of USAID NXP was successfully conducted by USAID representative. Subrecipient monitoring audit letters sent and feedback received from all MSH partners. STAR-E work plan and budgets for PY 3 were done and submitted to USAID.

Performance-Based Grants and MOUs

1. The grants management cycle (Figure 7) was successfully carried out, and we are now at approval stage before award. Out of 122 organizations that applied, only 28 organizations qualified and 10 were successful.

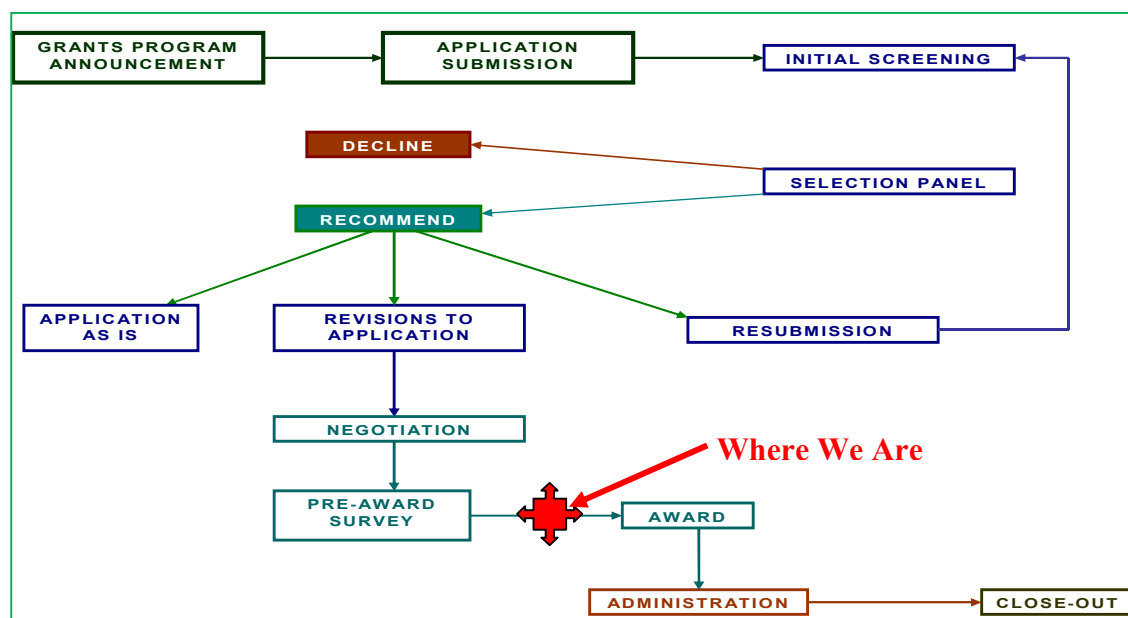


Figure 7.

PLANNED ACTIVITIES FOR NEXT QUARTER

- Award PBGs to the ten organizations that have been successfully evaluated.
- Disburse funds to successful PBGs.
- Train PBF awardees in financial management and donor regulations.
- Develop a database of grantees' needs, resources, and best practices, including templates and reporting formats.
- Develop, complete and submit a capacity building plan for the subgrantees and district carry out routine quarterly support (compliance) visits to the districts and subgrantees on the required reporting guidelines and compliance checks.