AIDS INFORMATION CENTER

PROGRESS REPORT FOR THE PERIOD JANUARY-DECEMBER 1997:

PROJECT TITLE: PROVISION OF VOLUNTARY HIV COUNSELLING AND TESTING (VCT); DELIVERY OF IMPROVED SERVICES IN HEALTH (DISH) PROJECT

SUBMITTED TO: UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

AIC
P.O.BOX 10446
KAMPALA
UGANDA
TABLE OF CONTENTS

1 EXECUTIVE SUMMARY

2 PLANNED ACTIVITIES OF THE YEAR

3 ACCOMPLISHMENT OF PLANNED ACTIVITIES

4 INTEGRATED SERVICES

5 DEVELOP A TRAINING STRATEGY FOR EXPANSION OF HIV CT SERVICES BEYOND AIC CENTRES

6 DEVELOP A MODEL OF PROVISION OF HIV CT IN NON-AIC SITES

7 PUBLIC AWARENESS AND UNDERSTANDING OF HIV/AIDS

8 ON-GOING SUPPORT SERVICES

9 STRENGTHEN MIS

10 EVALUATION OF THE PROCESS, QUALITY AND IMPACT OF PROVISION OF HIV CT SERVICES IN THE MAIN BRANCHES AND DISTRICT SITES

11 PROBLEMS, CHALLENGES AND LESSONS LEARNT

12 SUMMARY AND CONCLUSION
10 EXECUTIVE SUMMARY

In 1997, AIC made progress in extending the provision of voluntary and anonymous HIV counselling and testing services to the public in some parts of the country.

A Rapid testing and same day test results protocol was introduced in all AIC centers and district sites where voluntary counselling and testing had started. The first large scale project in Africa to offer same day results. Now, for the first time, almost all clients tested actually learned their results.

A total of 39,165 clients benefitted from counselling and testing (CT) services in the year. Of these 37,694 clients (or 96%) were served from the 4 main branches of AIC Kampala, Jinja, Mbarara and Mbale. The rest of the clients (2,954 or 4%) were served with support of AIC in the districts of Masindi, Luwero, Mbarara, Rakai, Kamuli, Soroti and Tororo.

The counselling protocol was reviewed to cater for both pretest and post-test counselling in a single session.

AIC forged a collaboration with districts through signed memorandum of understanding in which districts were to contribute to the establishment of voluntary counselling and testing services.

120 district counsellors, 36 technicians and 24 data entrants were trained as CT service providers.

Approximately 60 talks/seminars were conducted in 1997. These reached about 3000 people. In addition, PTC 101 drama shows were performed and about 11,900 people were reached.

Through Post Test Club (PTC) activities, 5765 PTC members visited medical booth for medical consultation/treatment. 1575 sessions were also conducted for PTC members for ongoing support counselling.

Philly Lutaaya Initiative/People Living with HIV project also conducted 3364 reachouts. About 100,000 were reached with behavior change messages by People Living with HIV going Public.

AIC Headquarter and Kampala branch offices shifted to the newly constructed AIC building in Mengo-Kisenyi, which was commissioned by the First Lady of the United States of America, Mrs Rhodam Clinton.

A study on couples served at AIC commenced with assistance from UVRI and CDC which study was to help AIC improve services specifically for the discordant couples.

AIC received funding from USAID, UNICEF, DED, DFID, UNDP to implement planned programmes.
20 PLANNED ACTIVITIES OF THE 1997

21 AIC focused on the following broad objectives/activities to implement in the year 1997

i) Continue offering facilities for voluntary and anonymous HIV Counselling and Testing at the four main branches in Kampala, Jinja, Mbale and Mbarara

ii) Make appropriate referrals for approximately 9790 clients in need of more services

Distribute condoms to clients as follows

- Fee condoms (from the MOH) 1,020,000 pieces
- Protector Condoms 120,000

iii) Integrate STD, FP and TB services in HIV CT services

iv) Develop a training strategy for expansion of HIV CT services beyond AIC Centers

v) Develop a model for the provision of HIV CT in Non-AIC Sites

vi) Extend CT services beyond the Main AIC Sites

vii) Increase Public Awareness and Understanding of HIV/AIDS

viii) Provide on-going psychosocial and medical support to AIC clients through the Post Test Club (PTC)

ix) Strengthen the current AIC Management information system

x) Conduct evaluation of the process, quality and impact of providing HIV CT services in main branches and indirect sites

30 ACCOMPLISHMENT OF PLANNED ACTIVITIES

Implementation of work-plan activities and achievements made in the Period January - December 1997 is as explained below

31 Counselling and Testing Services

In 1997, AIC had targeted to provide voluntary and anonymous counselling and testing services to approximately 44,755 clients in all the 4 branches of Kampala, Jinja, Mbarara and Mbarara and Mbale

3
By December 1997, 39,165 clients had been served using the new rapid testing protocol with same day confirmed results. Nearly all of them received their results and post test counselling on the same day. The breakdown of clients served by branches and district sites are as below.

Table 1 Counselling and Testing 1997 Overall Branch Performance

<table>
<thead>
<tr>
<th>Branch Name</th>
<th>No of clients served</th>
<th>No of Clients Projected</th>
<th>% Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kampala</td>
<td>18,264</td>
<td>21,000</td>
<td>87%</td>
</tr>
<tr>
<td>Jinja</td>
<td>7,548</td>
<td>9,000</td>
<td>97%</td>
</tr>
<tr>
<td>Mbarara</td>
<td>7,525</td>
<td>9,000</td>
<td>84%</td>
</tr>
<tr>
<td>Mbale</td>
<td>2,874</td>
<td>5,520</td>
<td>52%</td>
</tr>
<tr>
<td>Indirect sites</td>
<td>2,954</td>
<td>17,407</td>
<td>17%</td>
</tr>
<tr>
<td>Overall Total</td>
<td>39,165</td>
<td>64,297</td>
<td>62%</td>
</tr>
</tbody>
</table>

Total number of clients served from the branches and indirect sites are 37,694 and 2,954 respectively. Compared with the set target for the year of 44,755 and 17,407 clients respectively for main branches and indirect site, it can be seen that branches achieved 78% while and indirect sites only 17%.

The overall achievement for branches was mainly affected by Mbale branch performance. Due to funding problems, Mbale branch remained closed until April 1997. Factors that affected the performance of the indirect sites will be discussed later in this report.

Furthermore, when the number of clients (37,694) served from the branches in 1997 was compared with that of 1996 (42,442), it showed a decline of 11%. This decline is a result of the decision made by AIC management to close all satellite operations in 1997 after finding it expensive and not sustainable.

3.2 1997 Seropositivity rates in branches

In order to understand more on clients served in 1997, an analysis on seropositivity rate by branch and gender below was done.
Table 2 Seropositivity Rates by Branch and Gender for 1997

<table>
<thead>
<tr>
<th>BRANCH</th>
<th>SEX</th>
<th>TOTAL</th>
<th>HIV+</th>
<th>% HIV+</th>
</tr>
</thead>
<tbody>
<tr>
<td>KAMPALA</td>
<td>MALE</td>
<td>9256</td>
<td>1254</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>FEMALE</td>
<td>9008</td>
<td>2168</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>18264</td>
<td>3422</td>
<td>19</td>
</tr>
<tr>
<td>JINJA</td>
<td>MALE</td>
<td>4846</td>
<td>615</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>FEMALE</td>
<td>3963</td>
<td>907</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>7548</td>
<td>1522</td>
<td>17</td>
</tr>
<tr>
<td>MBARARA</td>
<td>MALE</td>
<td>3993</td>
<td>637</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>FEMALE</td>
<td>3515</td>
<td>1024</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>7525</td>
<td>1661</td>
<td>22</td>
</tr>
<tr>
<td>MBALE</td>
<td>MALE</td>
<td>1677</td>
<td>193</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>FEMALE</td>
<td>1198</td>
<td>271</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>2874</td>
<td>464</td>
<td>17</td>
</tr>
<tr>
<td>TOTAL</td>
<td>MALE</td>
<td>19772</td>
<td>3028</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>FEMALE</td>
<td>17348</td>
<td>4851</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>37694</td>
<td>7879</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 2 above shows that slightly more males 19736 (53%) than female 17348 (47%) benefitted from CT services in 1997. Kampala branch served more clients in the year (42%) than other branches.

Furthermore, table 2 shows an average seropositivity in the year of 20%. Compared with previous year 1996 seropositivity rate (23%), there was a decline of 3%. It is difficult to explain causes for the decline. However, it might probably be that clients served in 1997 had a lower HIV infection risk than those of 1996.

In the table, females seropositivity rates in all branches were higher than that of males. The average was 26%, with Mbarara having the highest 29% and Jinja and Mbale having the lowest (23% each). On the side of males, the average seropositivity was 15 with Mbarara branch exhibiting the highest 16% and Mbale the lowest 12%.
3.3 **Demographic and Socio-Economic characteristics of 1997 Clients**

The demographic and socio-economic characteristics analysis of 1997 AIC clients has been carried out and presented in the pie charts and bar-graphs. The summaries of the findings are explained below.

3.3.1 **1997 Clients Age and Sex Distribution**

Chart 1 shows the percentage distribution of males and females in 1997. In this year, clients balanced by gender and with the bulk of them (52%) belonging to the age-group of 20-29. Knowledge of serostatus among the age group 20-29 is important for marriage and child bearing decisions.

3.3.2 **1997 Clients Seropositivity Rates**

The seropositivity of the males and females clients served in 1997 is shown in Chart 2. According to this graph, females had a higher seropositivity rates than males in all age groups. At lower age (20-24), it was almost 6 times that of their counterpart. Reasons causing wide differences might include biological factors, poverty and lower levels of education among females.

In terms of clients education, Chart 3 and 4 show the number of 1997 clients by educational levels. While 37% of the clients reported primary and 57% secondary and above 7% reported no education at all. This has an implications as it can be seen in Chart 4, that lower levels of education was highly associated with higher levels of HIV infection.

On marital status, Chart 5 indicates that 51% of the clients who came to AIC during 1997 were single. The seropositivity of singles and other types of marital status in the year is also shown in Chart 6. It can clearly be seen that the seropositivity for single was low (9%) when compared to those reported married, divorced/separated and windowed.

The different types of analysis and findings from 1997 clients data were shared with service providers during service improvements meetings of the year. Some presentation of the data were also made at the local and international fora.
CHART 1:
1997 CLIENTS DISTRIBUTION

GENDER

MALE
53%

FEMALE
47%

AGE

30-39
26%

15-19
11%

40+
11%

20-29
52%

37694 SERVED IN 4 CENTERS
CHART 2: 1997 SEROPOSITIVITY BY AGE-GROUPS & GENDER
CHART 3: EDUCATION STATUS
1997 AIC CLIENTS

- PRIMARY: 37%
- POST SEC: 11%
- SECONDARY: 46%
- NONE: 7%
CHART 4: HIV+ BY EDUCATION
AIC CLIENTS, 1997
CHART 5: MARITAL STATUS
AIC CLIENTS - 1997

- Single: 51%
- Married: 33%
- Div/Sep: 10%
- Widowed: 6%
CHART 6: HIV+ BY MARITAL STATUS
AIC CLIENTS -1997

- 70% ~----------------------------------------~
- 60%
- 50%
- 40%
- 30%
- 20%
- 10%
- 0%

- Single
- Married
- Div/Wid/Sep
- Widowed
3.4 Clients Referrals

The 1997 target for referrals services was 10,895 clients. Of these 5091 (47%) clients were referred for other health services. 40% of the referred clients were HIV positive and went to various TASO centers in the country. The rest either joined PTC or mobile Home-care programme like Nsambya, Kamwokya and Rubaga.

3.5 Condom Distribution

Distribution of condoms was also another activity undertaken in the year. AIC had targeted to distribute 1,020,000 pieces of condoms from the Ministry of Health. By December 1997, slightly more free condoms (1,125,509) had been distributed.

In addition to free condoms, AIC participated in the promotion and selling of protector condoms. The target for the year was to sell 120,000 pieces of condoms. Only 69,748 pieces or 58% of the targeted number was sold. Factors that affected the selling of Protector condoms included market forces (supply and demand) and the availability of free condoms all over the country.

4.0 INTEGRATE STD, FP AND TB SERVICES IN HIV CT SERVICES

One of the AIC's task of 1997 was to integrate STD, FP and TB in the counselling and testing services. During this year, service providers particularly counsellors were trained in integrated counselling. Laboratory technicians were also trained in RPR screening. 36 counsellors and 7 laboratory technician benefited from the training which led to great improvement in service delivery.

4.1 Targets for Integrated Services

44,755 clients had been targeted to receive integrated information on HIV/AIDS/STD/FP/TB in all AIC branches. Of these 1798 (4%) would receive modern FP methods from the branches. In 1997, all the 37,694 clients screened for HIV also received information on other health services of family planning, sexually transmitted diseases and TB.

On the family planning target of 1798 clients, only 812 (45%) began using FP methods.

4.2 Syphilis Screening

The 1997 target for Syphilis screening and treatment was 44,755 and 4475 clients respectively. However, only 15,455 clients were screened for syphilis. The number is smaller than targeted because there was a delay in getting the necessary equipment for syphilis screening. It is only Kampala branch that was able to start implementing RPR testing and this was not until the second quarter of 1997.
Among clients screened for syphilis, 976 (about 7%) were reactive on RPR test. 51% of these were treated at AIC. About 16% of the reactive clients had their partners treated through partner notification.

50 EXPANSION OF CT SERVICES IN THE DISTRICTS

Under this objective, the following activities were carried out in 1997.

51 Develop capacity of AIC to expand HIV CT services to districts.

In preparing for the expansion strategy, AIC started by strengthening its training department and that of the branches to be able to expand services. The Posts of Training Coordinator and Assistant Coordinator were created and filled.

Senior counsellors from each branch were selected and trained as HIV counsellor trainer/supervisors. The training was conducted with the assistance of CDC consultant.

A total of 12 counsellor trainer/supervisors were trained. These become responsible for organizing training courses for district counsellors.

52 Reviewing HIV Training Curriculum for HIV Preventive Counsellors.

Throughout the year, the trainers/supervisors for AIC continued to review the training curriculum to include integration aspects. They also attended supervisors course which was conducted with CDC consultant on HIV prevention counselling and supervision. By the end of the year, 120 district counsellors had been trained.

53 Training of District/Site Counsellors.

AIC worked in collaboration with district and site officials to select among the already existing site personnel to be trained in HIV prevention counselling knowledge, skills and attitude. Each had an average of three counsellors trained of whom one was selected and trained as supervisor.

54 Training of Laboratory Technicians and Data Entrants.

Trainers in the HIV laboratory work and CT Data processing were also selected. These worked with Districts to select and train laboratory technicians and Data entrants for districts. In the whole year, 36 laboratory technicians and 27 data entrants were trained.

The training, together with the wide consultations AIC made with district personnel and technical people particularly those in the field of HIV/AIDS and laboratory work, showed directions of expanding CT services to the districts in 1997.
DEVELOP A MODEL FOR PROVISION OF HIV CT IN NON-AIC SITES

Access to Counselling and Testing services

In order to bring services nearer to the people, AIC decided to decentralize the provision of CT services to districts. 16 districts were selected in the pilot phase.

These included Masindi, Luwero, Masaka, Kampala, Mbarara, Ntungamo, Rakai, Kasese, Kamuli, Jinja, Soroti, Kumi, Pallisa, Kapchorwa, Tororo and Mbale.

Each of these districts was to have three CT sites. Clients target to be served from all the districts sites was set at 17,407. Districts, where AIC had operated satellites before (Tororo, Soroti and Luwero) were targeted to serve higher number of clients than the "virgin" districts. The monthly target for each of the selected district sites is discussed later in this report.

AIC introduced Rapid testing and same day test result counselling protocol in these indirect sites. The same algorithm of using screening test, confirmatory test and tie-breaker was to be adopted in the district services. The VCT services were to be integrated in the already existing health services.

Location of Districts to Branches

All the for selected districts were divided among the 4 AIC branches for ease of expansion of HIV CT as shown in the table below.
Table 3 Selected districts for CT services

<table>
<thead>
<tr>
<th>Branches</th>
<th>Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kampala</td>
<td>Masindi</td>
</tr>
<tr>
<td></td>
<td>Luwero</td>
</tr>
<tr>
<td></td>
<td>Masaka</td>
</tr>
<tr>
<td></td>
<td>Kampala</td>
</tr>
<tr>
<td>Jinja</td>
<td>Kamuli</td>
</tr>
<tr>
<td></td>
<td>Jinja</td>
</tr>
<tr>
<td>Mbarara</td>
<td>Mbarara</td>
</tr>
<tr>
<td></td>
<td>Kasese</td>
</tr>
<tr>
<td></td>
<td>Ntungamo</td>
</tr>
<tr>
<td></td>
<td>Rakai</td>
</tr>
<tr>
<td>Mbale</td>
<td>Soroti</td>
</tr>
<tr>
<td></td>
<td>Tororo</td>
</tr>
<tr>
<td></td>
<td>Mbale</td>
</tr>
<tr>
<td></td>
<td>Pallisa</td>
</tr>
<tr>
<td></td>
<td>Kapchorwa</td>
</tr>
<tr>
<td></td>
<td>Kumi</td>
</tr>
</tbody>
</table>

6.2.2 Needs Assessment for CT services in Districts

In 1997, branches visited their districts and carried out CT service needs assessment. A semi-structured questionnaire with questions on CT services in the districts, availability of personnel and commitment of the districts to support such services was prepared and subjected to District leaders and service providers. The findings showed that all districts were in need of CT services. The required personnel and support from the districts also existed.
Memorandum of Understanding

In the year, AIC signed a memorandum of understanding with the following 8 districts: Masindi, Luwero, Mbarara, Rakai, Kasese, Kamuli, Jinja, Soroti and Tororo. A memorandum was drawn between the district/sites and AIC for the implementation of CT services. The memorandum spelt out specific roles (shown below) each party was to play.

<table>
<thead>
<tr>
<th>AIC Tasks</th>
<th>Districts Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with districts to create capacity for CT service provision</td>
<td>Mobilizing the public to utilize CT services</td>
</tr>
<tr>
<td>Work with districts to select CT services providers and to train them</td>
<td>Provide personnel to be trained and provide motivation to them. Provide space, consumables and basic laboratory equipment</td>
</tr>
<tr>
<td>Supply of testing kits to districts</td>
<td>Provide personnel to be trained and provide motivation to them. Provide space, consumables and basic laboratory equipment</td>
</tr>
<tr>
<td>Monitoring and supervision of the delivery of CT services in districts</td>
<td>Monitor and supervise the provision of CT services in district</td>
</tr>
<tr>
<td>Phase out support after two years</td>
<td>Take over the responsibility of managing the CT services in districts</td>
</tr>
</tbody>
</table>

Opening of CT Sites

The following sites in the table below were operational by 1999.
Table 4  Clients Served Per Month Per District CT Site in 1997

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>CT SITE</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>MASINDI</td>
<td>MASINDI HSP</td>
<td>*17</td>
<td>40</td>
<td>37</td>
<td>26</td>
<td>23</td>
<td>21</td>
<td>21</td>
<td>23</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td>KIRYANDONGO</td>
<td>*13</td>
<td>10</td>
<td>8</td>
<td>10</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>85</td>
</tr>
<tr>
<td>LUWERO</td>
<td>KASANA H C</td>
<td>*58</td>
<td>162</td>
<td>119</td>
<td>112</td>
<td>140</td>
<td>111</td>
<td>84</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>686</td>
</tr>
<tr>
<td>MBARARA</td>
<td>RUSHERE HSP</td>
<td>*14</td>
<td>7</td>
<td>18</td>
<td>24</td>
<td>13</td>
<td>12</td>
<td>12</td>
<td>12</td>
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<td>12</td>
<td>12</td>
<td>12</td>
<td>88</td>
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<tr>
<td></td>
<td>ITOJO HSP</td>
<td>*27</td>
<td>22</td>
<td>16</td>
<td>19</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>RUHOKO H C</td>
<td>*17</td>
<td>48</td>
<td>23</td>
<td>73</td>
<td>41</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
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<td>20</td>
<td>122</td>
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<tr>
<td>KAMULI</td>
<td>KAMULI HC</td>
<td>*12</td>
<td>52</td>
<td>37</td>
<td>36</td>
<td>40</td>
<td>23</td>
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<td>23</td>
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<td>23</td>
<td>23</td>
<td>23</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td>KALIRO H C</td>
<td>*3</td>
<td>22</td>
<td>22</td>
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<td></td>
<td>KIDERA H C</td>
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<td></td>
<td></td>
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<td>40</td>
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<tr>
<td>SOROTI</td>
<td>SOROTI HSP</td>
<td>*2</td>
<td>51</td>
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<td>43</td>
<td>68</td>
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<td>TORORO</td>
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<td>76</td>
<td>76</td>
<td>76</td>
<td>76</td>
<td>1011</td>
</tr>
</tbody>
</table>

Note * Marks the month that CT services were introduced at different times in each of district sites. The starting date was largely determined by the availability of trained manpower and acceptable laboratory facilities.

AIC was not able to achieve opening of all targeted medical sites as planned for a number of reasons. A number of districts failed to fulfill their commitment in equipping the laboratories with the basic laboratory equipment. In some sites, it was difficult to get personnel to train either as HIV counsellors or technicians. The process of opening a site was more elaborate and demanding than previously anticipated.
641 1997 Indirect site clients

In order to assess the performance of each of the above site in the year 1997, the total number of clients served is averaged and compared to the monthly set target shown in the table below.

Table 5 Average Clients Served Per Month in District Sites

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>CT Sites</th>
<th>No of Clients</th>
<th>No of Months</th>
<th>Average per month</th>
<th>Target per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masindi</td>
<td>Masindi HSP</td>
<td>200</td>
<td>6</td>
<td>33</td>
<td>179</td>
</tr>
<tr>
<td></td>
<td>Kiryandongo</td>
<td>85</td>
<td>6</td>
<td>14</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>HSP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bulusia</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>53</td>
</tr>
<tr>
<td>Luwero</td>
<td>Kasana</td>
<td>686</td>
<td>6</td>
<td>114</td>
<td>355</td>
</tr>
<tr>
<td>Mbarara</td>
<td>Rushere</td>
<td>88</td>
<td>6</td>
<td>15</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Itoto</td>
<td>94</td>
<td>5</td>
<td>19</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Rukoho</td>
<td>122</td>
<td>3</td>
<td>41</td>
<td>178</td>
</tr>
<tr>
<td>Kamuli</td>
<td>Kamuli</td>
<td>200</td>
<td>6</td>
<td>33</td>
<td>249</td>
</tr>
<tr>
<td></td>
<td>Kalro</td>
<td>113</td>
<td>6</td>
<td>22</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Kidera</td>
<td>40</td>
<td>6</td>
<td>6</td>
<td>53</td>
</tr>
<tr>
<td>Soroti</td>
<td>Soroti HSP</td>
<td>224</td>
<td>4</td>
<td>56</td>
<td>155</td>
</tr>
<tr>
<td></td>
<td>Lwala HC</td>
<td>91</td>
<td>4</td>
<td>22</td>
<td>53</td>
</tr>
<tr>
<td>Tororo</td>
<td>Tooro HSP</td>
<td>1011</td>
<td>6</td>
<td>169</td>
<td>400</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2954</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table shows that 2954 clients were served in the whole of 1997. Compared with the target set of 17,407 clients, it can be seen that the achievement was low (only 18%).
7 0 TO INCREASE PUBLIC AWARENESS AND UNDERSTANDING OF HIV/AIDS

7 1 Collaboration

In collaboration with other NGOs/ CBOs, AIC organized and conducted awareness talks, workshops/ seminars at least once in every month. Approximately 60 talks/seminars conducted in 1997 and these reached about 3,000 people.

In addition AIC planned to collaborate with IEC DISH component to print and distribute IEC materials in the four main branches before the end of 1997. The IEC massages were to be developed on the new protocol for rapid testing, the expansion strategy, integration of STD/FP/TB services into HIV counselling and testing.

Unfortunately material development exercise delayed and no IEC materials were distributed in 1997.

Through the year all branches disseminated HIV/AIDS and HIV CT information through 101 drama shows and a total of 11,900 people were reached.

In the year, nine (9) AIC staff presented important findings and experiences on HIV CT at various fora, nationally and internationally. This include the 3 papers presented at International AIDS conferences at Abidjan Conference and 3 papers for Tanzania Conference.

In collaboration with local radio stations, AIC has participated in monthly AIDS Awareness/Mobilization programmes. Some Counsellors carried weekly talks on Capital Radio.

7 2 PLI/PWA Project

In 1997, AIC worked closely with the Philly Lutaaya Initiative to reach-out to various target groups of people, and conduct home/hospital visits. The project was also assisted to implement Income Generating Activity for people going public.

A total of 3364 reach-outs were conducted and about 100,000 people were reached with behavior change messages by People Living with HIV going Public (PLWHA). 3364 outreaches were conducted where PLWHA shared life experiences with adolescents in schools and out of school, adults in institutions and local communities.

In an effort to increase on the number of PWA who go public, the project trained 411 PLWHA in 9 districts Mpigi, Masaka, Bushenyi, Kamuli, Mbale, Tororo, Soroti, Kumi and Lira. Of these 310 were females and 101 males. These were supported in their districts in sensitizing the public about HIV.
During this reporting period, the project conducted 2148 counselling sessions. Through this, 1408 home and hospital visits were conducted. However, during the same year, 12 PLHIV passed away. Of these, 7 were male and 5 females.

In addition, PLI/PWA assisted PLWHIV to implement 40 IGA so as to help them in improve on their welfare.

8 0 ON-GOING SUPPORT SERVICES

8 1 Training of PTC Members

Three 3 training workshops were held for 90 Peer Educators, for the branches of Jinja, Mbarara and Mbale. 20 of these were again trained as reproductive volunteers for branches.

4 training workshops for 80 promoters of Protector Condom in the SOMARC programme were also carried out in the year.

8 2 On-going Counselling

1575 sessions were conducted for PTC members for on-going support counselling in all the 4 main branches of AIC. In addition, 5765 medical consultation and treatment were provided to PTC members in the year.

8 3 Education Talks

143 educational talks/discussions/debates were organized in the year and about 5,760 PTC members benefitted in all 4 branches. Recreational opportunities through indoor games to PTC members were also made available to PTC members and 1,507 participated in these games.

8 4 1 Expansion of CT services to Masindi and Lira

In 1997, there was a plan to pilot expansion of PTC to districts of Masindi and Lira. The expansion involved sensitization of collaborating parties, establishing a PTC, training peer educators and conducting educational talks to the members. This programme did not take off because of the UNAIDS delayed to release the required funds.
90 TO STRENGTHEN THE CURRENT AIC MANAGEMENT INFORMATION SYSTEM

91 Data Collection/Process

Throughout the year the department of Evaluation, Research and data supervised the collection of CT data in AIC main branches and district sites. In order to process the collected data on time, two (2) computers and accessories were procured.

The same department carried out quarterly data analysis of the main branches and district and gave feedback to the respective branches and sites.

In the year, Evaluation, Research and Data Department, reviewed CT data collection tools for both the stand alone branches and the district sites so as to be able to tap integrated service delivery other than the traditional CT services only. The review made changes in data collection tools. Before implementing the new changes the department conducted a training on the new MIS for counsellors, Data entrants and receptionist from all branches.

92 Client Satisfaction Study

Client satisfaction questionnaire were also prepared and administered to randomly selected clients who consented to participate in the exercise. The same questionnaire sought clients' views on the 1997 cost-sharing.

The findings showed that clients waiting time was longer than the services time. Some clients especially those that come at AIC Kampala branch at mid-day, spent between 3-4 hours. To the contrary those who come to the branch in the afternoon were seen to be spending less time (about one hour and half). Some of the factors causing the difference include shortages of counselling room, counsellors lunch time and sometimes the rush made by counsellors while servicing afternoon clients. It was feared that quality of counselling clients in the afternoon is somehow compromised by the fatigue counsellors get in the morning sessions.

100 EVALUATION OF THE PROCESS, QUALITY AND IMPACT OF PROVIDING HIV CT SERVICES IN MAIN BRANCHES AND INDIRECT SITES

101 Process Evaluation

Though, there was a plan to carry out an evaluation of the process of implementing counselling and testing in the selected districts, this was not done. Instead the Evaluation, Research and Data together with branches analyzed number of clients served in district.
site and found them to be far below the set target. It was then decided to examine factors affecting CT service utilization in the selected districts.

Structured questionnaires were prepared with questions on factors affecting CT service utilization in the districts. Questionnaires were subjected to district leaders, CT service providers, local community and clients. District questionnaires were analyzed and reasons include:

1) Lack of Mobilization for CT service utilization
2) Inadequate CT personnel in the district
3) Lack of involvement of district leaders
4) CT service centers very far from the potential users
5) Low motivation among CT service providers
6) Cost-sharing
7) Lack of district support for CT services

AIC planned District workshops to discuss the above problems and to find solutions.

10.3 Quality Control

Another review done in the year is on quality control protocols. The CT quality control protocols which involves taking 5% of non-reactive sample and 10% of reactive samples selected randomly on a monthly basis to NBB continued in the year.

According to NBB results, Mbarara and Mbale branches had one false positive each and Kampala which served more clients had 7 cases of false negative. Jinja results tallied with NBB results.

At the District sites, there was no problem in reporting HIV negative and positive blood samples.

All the false samples were investigated and it was found that all of them were due to human clerical errors. Measures were put in place to minimize as much as possible human errors.
10.4 Cost per Clients study

The study to assess the impact of the new rapid test HIV protocol on cost of providing the service (cost per clients was carried out with technical assistant of Profession Deborah Macfaldand from CDC in 1997. The finding indicated that cost per clients was about $13.37. Compared with cost per clients of the old protocol, this was higher by 2 USA dollars. It was explained that if more people were mobilized to come for CT services, the cost per clients will decline beyond the level of 12 USA dollars.

10.5 Couple Study

In an effort to assess the impact of counselling and testing, AIC in collaboration with UVRI and CDC implemented study on couples seeking CT services at AIC Kampala branch. The aim of the study is to help AIC improve services offered to couples. 300 couple were to be recruited for the study.

In 1997, 197 couples were recruited for the study. Table 6 below shows the number of couples screened in the year, those that were found eligible for the study and those consented to participate.

<table>
<thead>
<tr>
<th>Screened Couples</th>
<th>Eligible Couples</th>
<th>Consented Couples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Concor-</td>
<td>Dis-</td>
</tr>
<tr>
<td></td>
<td>dant HIV+</td>
<td>dant</td>
</tr>
<tr>
<td>884</td>
<td>95</td>
<td>115</td>
</tr>
</tbody>
</table>

Of 299 eligible couples, 197 (66%) consented for the study. The distribution of consented couples in categories of the study is as shown above.

While many of the consented couples came back for the baseline interview (at 2 to 3 weeks after recruitment) and follow-up, there is a substantial number that did not come for their appointment dates.

10.6 Rifabutin TB Preventive Study

In the first quarter of 1997, the collaborative study between AIC and Case Western Reserve University TB study ended on in March 1997. During that quarter 146 clients
were tested for TB of which 82 were found reactive and referred to Mulago for further assistance. Data analysis started and AIC was promised to be provided with all the findings from the study.

11.0 PROBLEMS, CHALLENGES AND LESSONS LEARNT

11.1 Problems and challenges of the year included

i) Low utilization of CT services in the indirect sites

ii) Low utilization of STD care services

iii) Low level of involvement of district leaders in the district sites where HIV CT services had been started

iv) Data Entrants selected by the districts and trained by AIC to process CT data for districts refused to do the work for lack of motivation

v) Referrals made for clients for other health services particularly those at AIC centres were probably not recorded

vi) About 11% of the couples who come to AIC in 1997 received discordant results

vii) HIV seropositivity rates for females remained higher than for males throughout the year

viii) A number of clients recruited in the couples study were not coming back for their follow-up appointment

11.2 Lessons Learnt

The following lessons were learnt during the year

i) Decentralization of HIV VCT to district hospitals or health centers is feasible, although it requires a strong component of monitoring and supervision of both AIC and districts

ii) The change in both the counselling and testing protocol enabled same day results

iii) Clients especially those who come to AIC during lunch time wait for a longer time before being served
AIC services continued to be a model programme in the whole world. Many visitors all over the world came to AIC to learn more on the programme.

Clients with lower levels of education and those who had divorced or separated with their partners had a high seropositivity rates during the year.

Clients served in the district hospitals had a higher seropositivity rates than those at district health centers.

12.0 SUMMARY/CONCLUSION

- Over 39,000 persons were served by AIC or at the 35 AIC assisted indirect sites,
- Young people 15-29 accounted for 63% of AIC’s clients,
- Women who came for VCT were more likely to be HIV+ than men,
- Half of AIC clients were single and came mostly for pre-marital planning,
- 57% of AIC clients had more than primary education and the HIV rates declined by with higher education levels,
- VCT clients at indirect sites had higher rates of HIV infection than at AIC centers, clients who tested in hospital centers had higher rates than those at health centers,
- Cost-sharing accounted for 4% of total revenue,
- AIC received funding from clients and donors, including USAID, DFID, UNICEF, UNAIDS and the German Development Service