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OPERATIONAL MANUAL FOR IMPLEMENTING MOBILE HIV COUNSELING AND TESTING SERVICES IN ETHIOPIA



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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government

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ACRONYMS AND DEFINITIONS

ART	Antiretroviral Therapy
EQA	External Quality Assurance
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FSW	Female Sex Worker
HAPCO	HIV/AIDS Prevention and Control Office
HCT	HIV Counseling and Testing
IEC	Information, Education, and Communication
MOU	Memorandum of Understanding
NGO	Nongovernmental Organization
PLHIV	Person/people Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
PSP-E	Private Sector Partnerships for TB and HIV-Ethiopia
RFP	Request for Proposal
RHB	Regional Health Bureau
STD	Sexually Transmitted Disease
TB	Tuberculosis
USAID	United States Agency for International Development
WoHO	Woreda Health Office

Ethiopia is divided into the following political and administrative subdivisions:

- **Region:** Ethiopia is divided into nine ethnically based regional states and two Federal City Administrations (Addis Ababa and Dire Dawa), each with its own government directly accountable to the Federal Government.
- **Zone:** Zones are subdivisions of regions with varying political and legal recognition as well as authorities.
- **Woreda:** Zones are further divided into woredas, an administrative division managed by a local government, equivalent to a district. Woredas are important political and administrative units with legal recognition and authority in their territories including delivery of services such as education and health, budget allocation, and management.
- **City Administrations:** The larger cities in each of the regions have city administrations, each directly accountable to their respective regional governments.
- **Subcity Administration:** The larger city administrations have subcities, the urban equivalent of a woreda. Addis Ababa, for instance, is divided into 10 subcities.

- **Towns:** Towns, mostly capitals of the woreda administrations, have their own local government.
- **Kebele:** The kebele is the smallest unit of local government in Ethiopia (urban and rural), equivalent to a neighborhood association. Kebeles are accountable to the woreda or city or subcity administrations.

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I. INTRODUCTION

I.1 OVERVIEW

HIV/AIDS presents serious demographic, social, economic, and developmental challenges in Ethiopia. HIV prevalence among adults age 15–49 is estimated to be 2.1 percent (Federal Ministry of Health [FMOH] and Federal HIV/AIDS Prevention and Control Office [HAPCO] 2007). Knowledge of HIV status is relatively low – 3.8 percent of adult women (ages 15-49) and 4.9 percent of adult men have ever received an HIV test result (Central Statistical Agency [Ethiopia] and Macro International, Inc. 2006). HIV counseling and testing (HCT) is the entry point for helping HIV-negative individuals make specific decisions to reduce risk and increase safer sex practices, and provide HIV-positive clients access to care and support services, to take action to protect their sexual partners, to plan for the future, and to prevent mother-to-child transmission.

The United States Agency for International Development (USAID) in Ethiopia has identified the following as priority at-risk populations for HIV/AIDS interventions: sex workers, females involved in cross-generational and/or transactional sex, males engaged in transactional sex including male clients of sex workers, young men having multiple sexual partners, highly mobile workers, separated/divorced individuals, and pregnant women. According to the Joint United Nations Programme on AIDS (UNAIDS), the key populations at higher risk of HIV exposure (referred to hereafter as key populations) are important in terms of the dynamics of HIV transmission in a setting as well as essential partners for an effective response to the epidemic.

The Private Sector Program for TB and HIV-Ethiopia (PSP-E), funded by the USAID through the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and led by Abt Associates Inc., conducted three rounds of assessments to inform the design of mobile HCT services. Data from these assessments indicate that these key populations do not utilize facility-based HCT services due to barriers related to access and confidentiality. The hours of operation and location of health facilities are often not convenient for key populations. Clients also perceive a lack of confidentiality and privacy at health facilities – they fear being recognized by the counselor or other clients when seeking services. At times, existing HCT sites cannot provide services due to shortages in staff and necessary testing supplies. In addition, the travel time and transport costs required to visit clinics pose a barrier to clients wanting to access HCT. As a result, the July 2007 national HCT guidelines clearly indicated the need for outreach and mobile HCT service delivery.

Mobile HCT services is an important strategy for increasing accessibility to HCT services for key populations and people living in hard-to-reach areas. The principle behind mobile HCT services is to bring HCT out of health facilities and into the community. There are different approaches to providing mobile HCT services: A team of providers may offer the services to the general population, defined groups such as a church congregation, attendees at cultural and sports events, employees of a company, or hard-to-reach groups such as injection drug users, sex workers, truck drivers, street boys, or those with no fixed address (Family Health International 2005). The temporary services site may be a tent, or existing community locations such as churches, schools, and administrative offices. In some cases, bicycles and motorcycles are used. A more expensive model involves the use of a mobile van, often equipped with video units. Providers counsel and test clients inside the van, which remains in a designated location or drives to different locations to attract clients. Finally, HCT may be offered to clients within their homes (home-based HCT), with services providers going door-to-door to offer the service.

PSP-E often offers services in tents set up in a central location chosen by the community, with trained counselors providing counseling, testing, and same-day results using minimal laboratory infrastructure.

The services are coupled with community mobilization activities to inform the community about the services, create acceptance and demand for the services, and reduce stigma.

It is important for mobile HCT services to establish referral linkages with private and public institutions to provide additional post-testing care and support. Clients identified as HIV positive, with their consent, should be referred to other care and support services or for further diagnosis and treatment.

I.2 PSP-E'S EXPERIENCE IN IMPLEMENTING MOBILE HCT

PSP-E began conducting mobile HCT services in Oromia region in July 2007. Since then, PSP-E has implemented mobile HCT services in 40 towns in Oromia, Amhara, and Afar regions. The goal of the activity is to serve key populations with confidential HCT and refer 100 percent of HIV-positive clients to health care professionals for further care and support. The mobile HCT service established referral networks with public and private sector health services such as antiretroviral therapy (ART), tuberculosis (TB) diagnosis and treatment, and other care and support programs.

Based on this implementation experience, this manual describes the process to conduct mobile HCT services targeting key populations. The approach outlined can be tailored to meet the specific needs and address the challenges unique to particular regions and subregions. The approach emphasizes careful community assessment and collaboration, monitoring and evaluation, and multilevel community mobilization, and requires close and collaborative relationships of all actors involved.

I.3 PURPOSE OF THE MANUAL

The purpose of this manual is to outline the process and procedures recommended to implement mobile HCT services, based on PSP-E's implementation experience. In the process described, PSP-E served as the "coordinating partner." However, this manual can be used as a reference guide by other organizations seeking to coordinate the implementation of mobile HCT services. The manual includes tools developed by PSP-E that others can adapt.

I.4 TARGET AUDIENCE

The intended audience of this manual includes program managers, regional health bureaus (RHBs) and HIV prevention and control offices (HAPCOs), Federal Ministry of Health (FMOH) officials, policymakers, program planners, development partners, and other key stakeholders who will be directly or indirectly involved in the implementation of mobile HCT activities.

2. STRATEGIC APPROACH

PSP-E uses interlinked strategies to deliver quality mobile HCT service to key populations.

PSP-E collaborates closely with the RHBs, local health officials, and community stakeholders to design, plan, and implement mobile HCT services in each region. Following initial discussions with the RHB, PSP-E and the RHB sign a memorandum of understanding (MOU) agreeing to collaborate in implementing mobile HCT services. PSP-E and the RHB jointly coordinate a consensus-building meeting with stakeholders at a regional and/or subregional level to secure community support and agree on the roles and responsibilities of community actors during planning and implementation of the mobile HCT services.

PSP-E's mobile HCT services are designed to reach at-risk key populations. The activities to date have been implemented in urban and peri-urban areas along four major transportation corridors that link Ethiopia to Kenya, Djibouti, Eritrea, and Sudan. PSP-E conducts rapid assessments in targeted towns to identify the key populations in each town, and determine the distribution, estimated population, and specific locations of these groups as well as behaviors related to HCT service utilization and condom use, identify and document the health facilities and organizations providing HIV/AIDS services in each town, and collect other information to design and plan mobile HCT services for each town. These targeted towns are initially selected based on discussion with RHB staff and review of data pertaining to HIV.

To build local capacity, PSP-E (Abt Associates) subcontracts out the HCT services to experienced, highly qualified local health service providers. To date, the project has contracted out services to four local subcontractors for the provision of services in Oromia, Amhara, and Afar regions. The subcontracted organizations are responsible for conducting HIV counseling and rapid testing in full compliance with national guidelines and standards, in addition to providing condom demonstrations and appropriate client referrals.

PSP-E uses flexible service scheduling to ensure maximum uptake of services by key populations. The mobile HCT services are offered for five continuous days (Wednesday to Sunday, using weekend services as an opportunity to reach workers and particularly day laborers) and may be repeated for multiple weeks in a given town depending on the population size and anticipated demand. Providing the service over several days gives clients flexibility to attend services at a day and time convenient to them. In some towns, "moonlight" services are provided during evening hours to increase uptake among clients who prefer the evening hours or in areas where temperatures are very high during the day.

It is important to note that mobile HCT should not be a one-time service. PSP-E conducts at least two rounds of service in each town. If the visits are spaced approximately three months apart, clients in the window period can be re-tested. This is also an opportunity to reach partners of clients who were tested in the previous round.

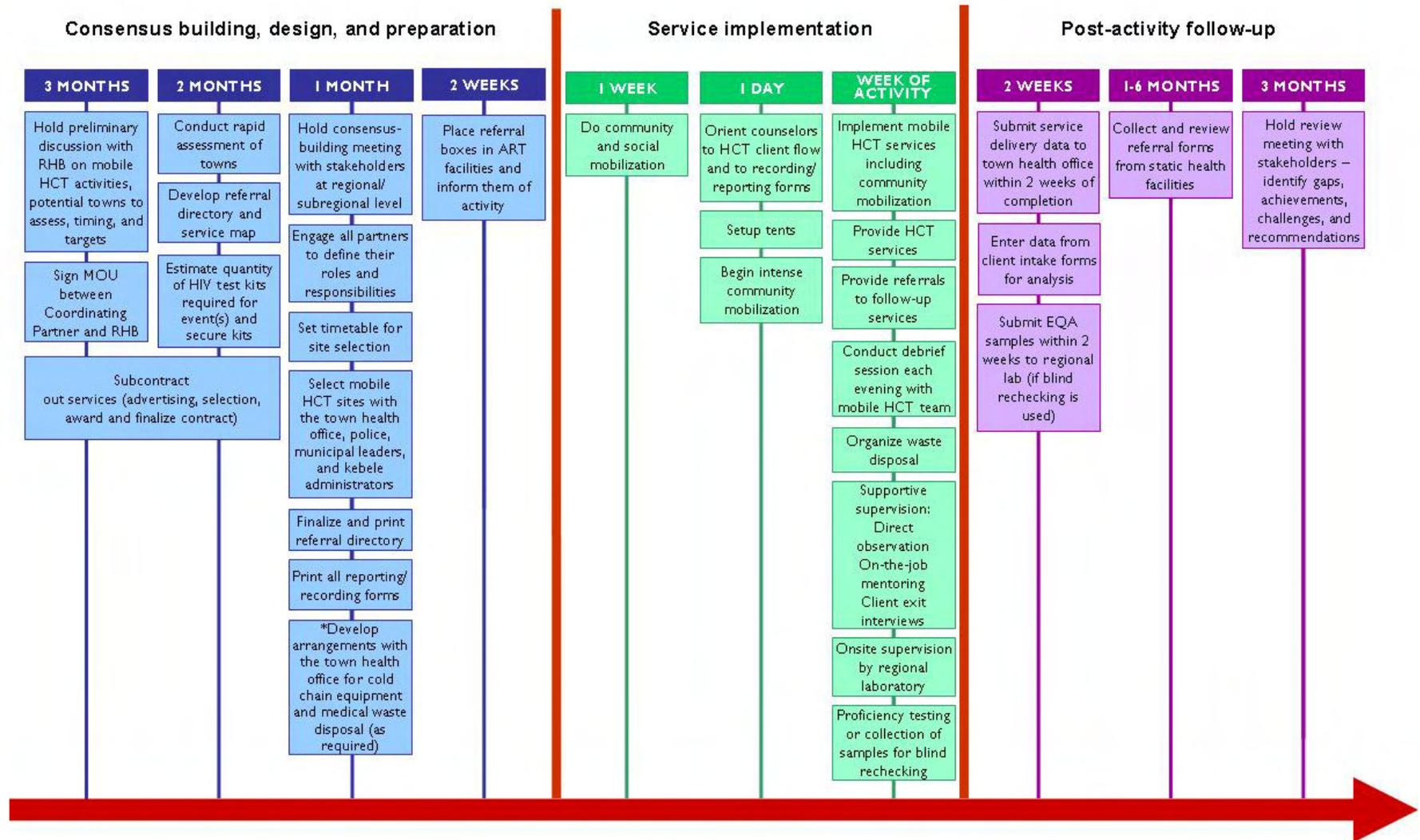
PSP-E supports intensive community mobilization as a strategy to ensure good uptake of the mobile HCT services, particularly by key populations. Population Services International (PSI), a PSP-E partner, implements a variety of community mobilization strategies to create demand for and increase uptake of both mobile and static HCT services. The mobilization activities are implemented in collaboration with key stakeholders, including town health offices, women's associations, and anti-AIDS clubs.

PSP-E works in partnership with the Supply Chain Management System, which supplies rapid HIV test kits, and with the RHBs, regional laboratory, and woreda health offices (WoHOs), which provide

supportive supervision and external quality assurance (EQA) for the testing service. In addition, a PSP-E HCT supervisor is present during the mobile HCT activities to monitor and supervise service quality on a continuous basis. In addition to supportive supervision, PSP-E collaborates with town health offices and public health facilities to provide access to cold chain equipment and waste disposal facilities.

As part of the mobile HCT services, PSP-E provides referrals to HIV-positive clients to private and public institutions for follow-on care and support services or for further diagnosis and treatment. As part of the rapid assessment, PSP-E maps HIV/AIDS-related services in a town and compiles the information into a referral directory to facilitate appropriate referrals. PSP-E and the RHB also informs the ART sites in target towns of the mobile HCT activities to prepare them for incoming referrals.

FIGURE 1: STEPS AND TIMELINE TO IMPLEMENT MOBILE HCT



* A recent change in the national HIV testing algorithm utilizes test kits that do not require refrigeration (KHB followed by Statpak as confirmation for positive tests, with Unigold as the tie-breaker). In addition, if the finger-prick method is used, EQA is conducted onsite through proficiency testing and onsite supervision (described in Section 8.3), eliminating the need to store and transport samples for blind rechecking.

Coordinating Partner

For smooth planning and implementation, there should be a lead organization serving as a coordinating partner. PSP-E served in this role in the mobile HCT services referenced in this manual. Following are suggested roles and responsibilities of the coordinating partner:

- Provide overall coordination of mobile HCT implementation, which includes engaging a subcontractor for service delivery, organizing the rapid assessment of sites and site identification, convening consensus-building meetings, and leading community mobilization.
- Lead all interactions that involve government officials such as the FMOH, and regional and woreda HAPCOs, and coordinate with the subcontractor to bring any challenges to the relevant government bodies.
- Develop a referral directory to be used by mobile HCT counselors to refer HIV-positive clients to follow-up care and support services.
- Provide supervision and troubleshooting support. PSP-E HCT supervisors are present in each town continuously for the first several weeks of testing and provide daily oversight and problem solving support. During the subsequent rounds, supervisors visit each site for a minimum of two days per week.
- Work in partnership with RHBs and the respective town health offices to conduct regular supportive supervision and provide technical support for the mobile teams.
- Supply the rapid test kits to the mobile HCT providers.
- Provide basic furniture for use in mobile HCT sites. PSP-E's experience has been with two teams per town, each with the following equipment: 5-6 counseling tents, one reception tent, and one lab tent¹ as well as chairs, tables and stools for the tents.
- Establish a partnership with the RHB and the WoHO to provide the mobile HCT subcontractor with access to cold chain equipment such as cold boxes, vaccine carriers, and chilled ice packs (when required by the testing algorithm).
- Establish a partnership with the regional laboratory for EQA for HIV testing (including onsite supervision, proficiency testing and/or blind rechecking)
- Arrange access to an incinerator for waste disposal with the town health office or private health facilities equipped with an incinerator.
- Compile and analyze data to develop weekly and monthly reports for submission to the RHB and WoHO.
- Conduct monthly progress meetings with the subcontractor to discuss achievements and problems encountered.

¹ With the recent change in the testing algorithm from venipuncture to finger-prick testing, a laboratory tent is no longer required. The laboratory technician is available onsite, however, to provide technical support to the counselors in HIV testing as needed.

3. CONSENSUS BUILDING AND DESIGN

3.1 PRELIMINARY DISCUSSION WITH THE RHB

The coordinating partner should schedule a meeting with the appropriate RHB approximately three months before the proposed mobile HCT activity. The purpose of this meeting is to:

- Provide an overview of the mobile HCT strategy and approach
- Discuss the general process for planning and implementing mobile HCT
- Agree on roles and responsibilities between the coordinating partner and the RHB
- Identify towns to assess for possible implementation
- Define timeline and next steps

Participants at the meeting include PSP-E project leaders, HCT technical staff, social mobilization coordinator, and RHB and HAPCO staff (head of the Communicable Diseases Division and the focal person for HCT or HIV/AIDS services).

The meeting should result in a clear agreement of the next steps and timeline for planning and implementation of mobile HCT services.

3.2 MOU BETWEEN THE RHB AND PSP-E

Once consensus on the approach has been reached, a MOU between the coordinating partner and the respective RHB should be developed. The MOU establishes a formal relationship between the RHB and coordinating partner and clearly articulates the roles and responsibilities of both partners. Table 1 lists suggested roles and responsibilities for each partner to be included in the MOU.

The MOU should be signed by both parties in advance of the next planning activities. A copy of the MOU used to establish RHB and PSP-E roles and responsibilities is presented in **Annex A: Sample Memorandum of Understanding**.

TABLE I. ROLES AND RESPONSIBILITIES OF RHBS AND COORDINATING PARTNERS

Regional Health Bureau	Coordinating Partner
<ul style="list-style-type: none"> • Mobilize support from the woreda and town health and local officials • Provide technical support for mobile HCT rapid assessments • Support program implementation, supervision, and follow-up. • Provide the necessary support to maintain cold chain system (if required by the testing algorithm used) • Provide space at health facilities for temporary collection of waste products and access to an incinerator • Conduct supportive supervision during mobile HCT activities • Provide laboratory EQA through the regional laboratory, either through proficiency testing or rechecking of samples (depending on whether testing relies on venipuncture of finger-prick) • Provide technical support in development of mobile HCT promotional materials • Monitor, evaluate, and serve as steward for the mobile HCT activities • Prepare health facilities to receive mobile HCT clients referred for care and treatment services 	<ul style="list-style-type: none"> • Develop a program implementation plan with the RHB • Conduct a preliminary assessment in towns selected in collaboration with the RHB • Conduct a service mapping exercise to develop referral directory for use by mobile HCT providers and distribute referral boxes to service providers • Identify and engage (through a subcontract) an organization to implement the mobile HCT services using trained counselors • Organize and conduct the consensus-building meeting for key stakeholders, including the RHB, town health offices, municipality or town administration, and local civic organizations. • Provide HIV test kits in support of activities • Oversee all logistics for activities • Conduct community mobilization to create demand for mobile HCT services • Advertise the mobile HCT services through banners and posters • Ensure the quality of services through supportive supervision, client exit interviews, and preparing samples for EQA or coordinating onsite proficiency testing for counselors • Collect dry and liquid waste and transfer to public facilities for appropriate disposal • Provide monitoring, reporting, and referral forms • Submit an activity report with service statistics to each town health office within 15 days of activity

3.3 RAPID ASSESSMENT TO INFORM DESIGN

As mentioned earlier, the RHB identifies potential towns for mobile HCT and then PSP-E conducts a rapid assessment. The purpose of the rapid assessment is to collect and analyze data from towns in order to design effective mobile HCT services that target key populations in each town. The specific objectives of the assessment are to:

- Identify the key populations in each town, and determine the distribution, estimated population size, and specific locations of the key population subgroups
- Identify and document the health facilities and organizations providing both facility-based and community HIV/AIDS treatment and support services in each town to establish a referral network for mobile HCT follow-up.
- Identify the behaviors of key populations with regard to HCT service utilization and condom use.
- Collect information to design and plan mobile HCT services for each town, including acceptability of the service by target populations and local stakeholders, recommended hours and locations, and potential partners to assist with implementation

The coordinating partner is responsible for obtaining official concurrence and buy-in from the RHB and the HAPCO prior to data collection. The RHB facilitates data collection by issuing a letter to request collaboration from WoHOs, HAPCOs, and local government officials (**Annex B: Collaboration Request Letter from PSP-E to the RHB** and **Annex C: Request Letter from RHB to Key Local Actors for Assessment**). The RHB may participate in some data collection activities depending on their availability.

PSP-E identifies a consultant with experience conducting assessments to serve as the principle investigator and lead the study (**Annex D: Terms of Reference for Assessment**). The principle investigator recruits data collectors to conduct the assessment who have a minimum qualification of the first degree in health or social sciences, as well as experience with quantitative and qualitative studies. Prior to deployment to the field, the data collectors attend a two-day orientation on the study purpose, methodology, data collection instruments, and data collection procedures. This orientation includes one day of field work to familiarize the data collectors with the study instruments. The data collectors work in teams of two persons, and each team includes at least one person who knows the culture and language of the study population. The coordinating partner conducts the data collectors' training, designs the questionnaire, and provides direct field level supervision during data collection. The coordinating partner also obtains approval of all data collection tools from the RHB.

The data collectors work closely with relevant government authorities throughout the data collection process. Data collectors request and obtain written consent from all interviews using a standard consent form. All communications with participants are conducted in the local language. Data are collected using the following methods:

- **Key informant interviews:** One-to-one interviews are conducted in each town using a structured interview guide with representatives from the RHB, HAPCO, nongovernmental organizations (NGOs) and faith-based organizations providing HIV/AIDS-related services, support groups for people living with HIV (PLHIV), *iddirs* and other community-based groups, the Office of Education, the Office of Social Affairs, and the Office of Women's Affairs (**Annex E: In-depth Interview Guide with Key Informants**). The interviewers gather perceptions of key informants regarding the general health problems in the community, sexual activity, presence of key populations at risk (including location, numbers, and risk behaviors) knowledge of HIV/AIDS, and availability of activities and programs targeting key populations.
- **In-depth interviews:** Interviews are conducted with female sex workers (FSWs) to discuss their perceptions of HIV/AIDS in the community, availability and effectiveness of programs targeting FSWs, knowledge of HCT, and recommendation for improving HIV/AIDS programs, particularly HCT (**Annex F: FSW Interview Guide**).
- **Focus group discussions (FGDs):** FGDs are held with community members such as in- and out-of-school youth and daily laborers using a discussion guide (**Annex G: Focus Group Discussion Guide**). The FGD focuses on general perceptions of HIV/AIDS, availability and effectiveness of interventions, convenience of HCT and other services for target groups, recommendations to improve accessibility of HIV/AIDS services, and the acceptability of mobile HCT. Specific groups targeted for FGDs are determined in part by the definition of key populations (i.e., assumed risk groups) and in part by information from key informants on who the key populations are in each town.

The information collected from the assessment is distilled into a report on the region assessed, with details on each target town (**Annex H: Outline of Rapid Assessment Report**) (Habte 2008a, 2008b, 2008c).

In addition, interviewers collect information to complete a referral using the **Service Mapping Assessment Tool (Annex I)**. The town health offices provide information to the rapid assessment team on the key service providers to include in the service mapping. Data collectors obtain information on the services provided, working hours, and contact details of each organization by interviewing the service providers directly. This information is compiled into a referral directory (discussed in Section 4 and illustrated in Annex K: Referral Directory). The coordinating partner should also use the assessment as an opportunity to review data on HCT and ART services, visit health facilities to identify potential waste disposal sites, as well as laboratories for storage of EQA samples and facilities to assist with cold chain management, and transport and storage of EQA samples from the mobile sites (if needed).

3.4 CONSENSUS-BUILDING MEETING WITH KEY STAKEHOLDERS

Approximately one month before the planned mobile HCT activity, the coordinating partner, in collaboration with the RHB, convenes a meeting with key stakeholders to inform them about the mobile HCT activities. The following key stakeholders are invited to the meeting:

- RHB staff
- WoHO staff
- Town health office staff
- Local government representatives (towns, woredas, and kebeles)
- Representatives of the police force
- Community organizations (women's associations, PLHIV groups, anti-AIDS clubs, etc.)
- NGOs with HIV/AIDS prevention, care, and support programs
- Public and private sector health care providers

PSP-E, as the coordinating partner, takes the lead in developing the agenda, organizing meeting facilities, and assisting the RHB to prepare invitations for stakeholders. A sample agenda, core presentations, and workshop report for the consensus-building meeting is attached (Annex J). The meeting serves as a forum to thoroughly explain the mobile HCT approach, targets, and timeline for implementation services. Topics such as logistics, supervision, reporting, and community mobilization should be addressed. The following topics are covered in the meeting:

- Overview of PSP-E program
- Elements of the mobile HCT approach
- Key findings from the rapid assessment
- Referrals from the mobile HCT sites to public health facilities and care and support services
- Criteria for selection of mobile HCT sites, proposed composition of the site selection team, and timetable for site selection (within each town)
- Support for social mobilization and mobile HCT activities (security, water and electricity, community mobilization, etc.)
- Proposed roles and responsibilities for stakeholders, coordinating partner, and mobile HCT subcontractor are discussed to reach consensus
- Timeline for social mobilization and mobile HCT activities
- External quality control and supportive supervision
- Disposal of dry and liquid waste

Ideally, the roles and responsibilities of each partner will be clearly defined during the meeting and an informal committee established to assist with coordination of mobile HCT services. Table 2 lists suggested roles and responsibilities for stakeholders other than the coordinating partner, mobile HCT subcontractor, and RHB, which are described in other sections.

TABLE 2. KEY STAKEHOLDERS* IN MOBILE HCT ACTIVITIES

Stakeholder	Activity
HAPCO	<ul style="list-style-type: none"> • Depending on the regional structure, provides support for planning, social mobilization, and sensitization workshops
Woreda and/or town health offices	<ul style="list-style-type: none"> • Communicates with the town's police department and local government prior to social mobilization and mobile HCT services to ensure their engagement in activities • Reviews and approves social mobilization and mobile HCT service delivery schedule • Provides rapid test kits (from RHB and other partner organizations) to public health facilities to effectively respond to the demand created by social mobilization activities • Participates in supervision of the mobile HCT activities • Coordinate with health facilities to provide support for cold chain and waste disposal • Chair an ad-hoc committee established for mobile HCT site selection
Health facilities	<ul style="list-style-type: none"> • Serve as temporary site for storage of EQA samples (if needed). Laboratory technicians transport EQA samples from mobile sites and store them for EQA to be conducted by regional laboratory • Permit the use of incinerator and allow facility staff to support mobile HCT team, especially sanitarian and cleaners • Provide vaccine carrier and cold box for storage of rapid testing kits and EQA specimens (if required) • Accept referrals from mobile HCT sites and deposit referral feedback forms into the referral boxes provided by coordinating partner
Police and town committees	<ul style="list-style-type: none"> • Provide security for the mobile HCT sites and social mobilization activities • Help develop and implement strategy to involve the town's women's affairs offices, women's associations, and anti-AIDS clubs to increase HCT uptake • Participate in site selection for mobile HCT services
Women's association and anti-AIDS clubs	<ul style="list-style-type: none"> • Assist with identification of women to serve as mobile HCT promoters to mobilize women and other vulnerable groups to attend mobile HCT services • Encourage their members to be tested
Community and social mobilization partner	<ul style="list-style-type: none"> • Provide mobile video show focused on HIV/AIDS and HCT for the community and compile data on the type and number of attendees • Recruit and train female promoters to contact women and disseminate informational leaflets and coupons that promise women will receive priority in the queue for HCT service • Verify that the target groups are mobilized by female promoters by collecting and counting coupons each day • Provide announcements in appropriate places and in local language using loudspeakers mounted on cars • Disseminate brochures, hang banners, and place "where and when" posters in appropriate, strategic locations in the town to create awareness of ongoing mobile HCT activities • Lead the orientation session of women promoters and provide technical support

* Table does not include the role of the coordinating partner, mobile HCT subcontractor, and RHB, described in other sections.

Additionally, meeting participants should establish a site selection committee for each town to select appropriate mobile HCT sites. The site selection committee includes representatives from the mobile HCT subcontractor, coordinating partner, HAPCO, town health offices, town police force, local government, women's associations, and kebele administration. The site selection committee is responsible for identifying suitable locations within the town for provision of mobile HCT services (using tents or possibly schools and kebele halls in case of rainy season).

4. ESTABLISHING A REFERRAL SYSTEM

Counseling and testing services are an entry point to the HIV/AIDS continuity of care. Clients who are identified as HIV positive require access to a variety of services to meet their needs, including their physical health, psychosocial well-being, food resources, economic security, and spiritual needs. An effective referral network will link clients to organizations and facilities providing HIV/AIDS-related services, as well as link the organizations to each other, to provide continuity of care for PLHIV. Full cooperation and coordination by the public and private sectors allows for referral and feedback and provides appropriate follow-up and monitoring.

So that HCT counselors make appropriate referrals for HIV-positive clients, the coordinating partner develops a directory of services that provides a listing of all community-based organizations, NGOs, and government and private health facilities that deliver HIV-related services for PLHIV and their families within a geographic catchment area (**Annex K: Sample Referral Directory**). During the rapid assessment, data collectors collect information on each organization providing HIV/AIDS-related services, including the name of the organization, services provided, fees, location and contact information, and hours of service to compile into a referral directory.

Referral forms must also be developed or adapted to document referral information for HCT clients to pre-ART, ART, and opportunistic infection services, as well as care and support programs (**Annex L: Sample Referral Form**). During post-test counseling, the counselor will discuss the follow-up care and support with the client and give the client a referral form to direct him/her to the service needed. The form serves as an introduction for the client to the organization/facility that will fulfill the referral, identifies the organization and person initiating the referral, and specifies the services for which the person is being referred.

The bottom of the referral form includes a tear-off section to be completed by the receiving organization (e.g., ART site). PSP-E provides referral boxes to health facilities providing ART services and requests that they store the referral tear-off slips in the collection box. From one to six months after the services, PSP-E periodically collects the referral forms to determine the effectiveness of the ART referral system (i.e., to confirm whether the client access ART services). Organizations implementing mobile HCT may want to follow-up with other referral services in addition to ART services, to monitor the effectiveness of the referrals.

5. SUBCONTRACTING SERVICES

Approximately 3-4 months before the planned mobile HCT services, the coordinating partner will need to begin to identify a subcontractor, using a competitive process. The following steps are required:

- **Bidding:** The coordinating partners will advertise to request bids in national newspapers. Interested parties are sent a Request for Proposals (RFP) that outlines the full scope of work, deadline, budget template and timeline for HCT activities (**Annex M: Sample Request for Proposals**).
- **Evaluation of proposals:** The coordinating partner will form a technical review committee to evaluate bid responses based on selection criteria that are defined for bidders in the RFP. Suggested criteria include personnel, capabilities (prior experience with HCT and references), business qualifications (availability of office space, documented financial systems, business registration, license to provide HCT), and analysis of cost proposal (**Annex N: Sample Score Sheet for Mobile HCT Subcontractor**).

Organizations are contracted to provide mobile HCT services over a 12-30 week period in the key towns of the regions selected. Testing is provided five days of the week for at least eight hours per day. The terms of reference (**Annex O: Subcontractor Statement of Work and Deliverables**) of the subcontracted mobile HCT service provider includes:

- Providing two complete mobile HCT teams. Each team consists of 5-6 counselors, one health educator, one laboratory technician, one receptionist, three guards (one for the day and two for the night), and one cleaner.
- Each counselor is expected to test 15-20 clients per day. Therefore, a counseling team of five counselors should provide HCT services to approximately 375-400 clients over five days.
- Recruit guards and cleaners in each town where mobile HCT is provided to build relations with the local community.
- Coordinate closely with community mobilization efforts in order to respond effectively to the demand created by those efforts. The coordinating partner will lead implementation of community mobilization activities to increase the demand for mobile and static HCT services.
- Conduct two rounds of services in each town. The mobile team will move through the target towns in sequence providing 5-10 days of counseling in each town, resting for two days after every five days of service.
- The time between the first and second rounds of mobile HCT service will be determined in consultation with the RHB; it should be sufficiently long to allow for re-testing after the window period.
- In the event that the rainy season interferes excessively with service delivery, the coordinating partner and the subcontractor will negotiate to determine any necessary changes.

The subcontractor's detailed implementation responsibilities include the following:

Planning

- Participate in identification of specific mobile sites in each of the target town by working in collaboration with the coordinating partner and local officials. The coordinating partner will organize the site selection team. The contractor is only obliged to participate as a member of the team.

Logistics

- Transport the full mobile HCT team to and from the work site at the beginning and end of each week of testing. The contractor or its team members must also arrange for transportation to the testing site in the morning and evening and for lunch on each day of testing.
- Ensure that all tents, furniture, equipment, and signage are appropriately arranged and installed before service is scheduled to begin. Disassemble and pack the tents at the end of each week and transport the tents and furniture between towns.
- Move the testing site (tents, furniture, equipment, and supplies) as necessary within each town if demand diminishes in order to ensure strong continuous uptake of services.
- Establish and maintain appropriate cold chain equipment and supplies in each town by collecting vaccine carriers each week and chilled ice packs each day from the WoHo (if testing algorithm requires refrigerated storage of kits).
- Ensure that HIV rapid test kits are stored in accordance with the national guidelines.
- Provide all the supplies necessary for HCT except for the rapid test kits. Supplies include such items as sharps disposal containers (safety boxes), vacutainer and needle systems or capillary tubes and lancets, alcohol, cotton, disposable gloves, micropipette tips, and nunc tubes for sample storage (depending on testing algorithm used).
- Provide condoms for condom demonstrations and for distribution. To calculate the quantity of condoms required, estimate one condom per client for demonstration and assume that 30 percent of clients will accept 10 condoms each.
- Provide a TV set and DVD player for use in the reception. The coordinating partner will provide HIV information, education, and communication (IEC) materials for the DVD player.

Implementation

- Conduct HCT in full compliance with national guidelines, protocols, and standards.
- Provide HCT services for eight hours per day. The hours of testing may be varied from day to day in order to reach target groups (e.g., 9 am to 5 pm on one day, and noon to 8 pm on another day). Mobile HCT subcontractors must be willing to be flexible in providing testing during these changing hours in consultation with the coordinating partner HCT supervisor. Test days may even be split between morning and evening hours in order to accommodate the schedules of agricultural workers (e.g., offer testing from 6 am to 10 am and resume from 4 pm to 8 pm).
- Provide appropriate referrals for treatment, care, and support services based upon the referral directory developed by the coordinating partner. Assist in refining the referral network based on local knowledge if appropriate.
- Collect dry and liquid medical waste at the end of each day and transport it to health facilities identified by the coordinating partner for incineration and disposal.
- Collect and transport test samples for EQA to a local health facility for storage in accordance with the national guideline (100 percent of the positive tests and 10 percent of the negative tests). If proficiency testing is used instead, facilitate counselors participation in proficiency testing.

- Train personnel to use the standardized registering and reporting formats and maintain quality of data. The coordinating partner will supply recording formats for client registration, counseling registers, lab registers, client intake forms, and daily and weekly summary forms as well as other forms for monitoring client flow.
- Manage the entire process, including client experience from the reception tent to the counseling tent, and wait time (total waiting time and amount of time spent in pre-test and post-test counseling).
- Collaborate with coordinating partner and local health officials to conduct direct observation of several counseling sessions per week to provide feedback to counselors: at least two pre-test and post-test counseling sessions observed per day per town.
- Ensure that all staff participate in a debriefing session every evening with a PSP-E supervisor to provide feedback on service delivery.
- Submit daily and weekly reports and individual client intake records for each MCT client encounter. The subcontractor must ensure that all forms are correctly and consistently used by all mobile HCT personnel. At the end of each week or two of service, the subcontractor sends the original daily and weekend summary forms and all client intake forms to the coordinating partner for data entry and analysis.

6. SERVICE PROMOTION AND COMMUNITY MOBILIZATION

Publicizing the mobile HCT services and mobilizing the community to make the services acceptable and create demand is a critical component of the mobile HCT strategy. First, because mobile HCT services are short-term and offered in new locations, mobilization is required to motivate people to attend the services during the period of implementation in the targeted location. People may know about static sites, but mobile HCT services are temporary so the community needs to be informed about their availability. In addition, the mobile HCT aims to increase access to HCT services for populations that are less likely to attend static services. Targeted messages and strategies are required to create demand within these groups to access the services. The messages and materials should be tailored to each region, taking into account cultural, linguistic, and education levels of the community. The findings from the HCT rapid assessment and input from local stakeholders are used to develop targeted messages and mobilization strategies for each town and region.

The coordinating partner works closely with local stakeholders to gain support for mobile HCT and to promote the activities throughout their community. Mobile HCT services are actively promoted in the community between one day and one week before the service is provided. There is intensified mobilization the day before the service starts. Community mobilization continues during implementation of services. Leaflets, posters, and banners promoting the services (complete with the dates, times and locations) are used to advertise the services. During the service provision, large banners are clearly positioned to direct people to the mobile HCT services.

PSI leads the community mobilization for the PSP-E team. Several communication strategies help to reach key populations and to specifically target women, who have higher rates of HIV but initially accounted for only about 20 percent of clients at mobile sites. The following social mobilization approaches are used to promote and create demand for mobile HCT services:

- **Car announcements:** A vehicle equipped with a loudspeaker advertises mobile HCT (service times and locations) along with messages on the importance of being tested, interspersed with music to attract attention. The vehicle drives through busy areas and deep into residential and business areas that were identified through the assessment as places to reach key populations. Car announcements should be used a few days before the event (days and evenings) as well as during the mobile HCT services as a source of information about the services for the community. Posters with information on the service can also be attached to the car.



- **Roadside shows with question and answer session:** Professional artists provide messages on HIV transmission, the need for early testing, and reducing stigma and discrimination through entertaining music and drama shows. These shows are conducted in busy areas and attract a large audience, including potential mobile HCT clients. There is a question-and-answer component to these shows and prizes are awarded to audience members for active participation. PSP-E discontinued the roadside shows due to high cost (of experienced artists from Addis Ababa) coupled with low uptake of services directly attributable to the shows.
- **Mobile video units with question-and-answer session:** The day before and during the mobile HCT services (depending on interest), a mobile video show (using an LCD projector and screen) is organized in a town square, plaza or other gathering place in the evening. A short film (approximately 30 minutes) is shown to provide information to the audience on HIV/AIDS and HCT issues in an entertaining way. Following the show, a facilitator generates a short discussion, holds a question-and-answer session, and awards prizes for participation.
- **Women promoters:** A group of women, identified with the assistance of the women's association, the kebele, and anti-AIDS clubs, is engaged to educate women on the importance of



HCT at the household level and distribute “coupons” that enable women to receive priority service at the HCT site. The promoters that are selected are influential members of their neighborhoods who are knowledgeable about the needs of their community. FSWs are often engaged as women promoters as a strategy to reach their peers. The women are trained by the coordinating partner and offered a small stipend for their time. Women promoters go door-to-door in residential areas to contact women in their homes, inform them of HCT services, and encourage them with coupons that promise that women will be served first at the MCT site.

- **Coffee ceremonies:** In coordination with the women promoters, traditional coffee ceremonies are organized to stimulate discussion and education on HIV/AIDS issues. Coffee ceremonies are an opportunity for women to share their personal experiences, discuss barriers, respond to questions and concerns, and promote HCT services.
- **Workplace promotion:** In towns where there are large companies and factories, the coordinating partner may meet with company management and arrange for distribution of IEC materials and display of mobile HCT posters or banners.
- **IEC materials:** Materials with information on HCT services, referral sites, and education targeting women are produced by the coordinating partner and distributed by women promoters and at other community mobilization events (**Annex P, Photos of IEC Materials**). These include:
 - **Posters:** Colorful posters providing information on the services (date, time, location) are posted in 40-50 places that key populations frequent in each town (streets, hotels, bars, traditional drinking houses, bus stations, shops, etc.)
 - **Banners:** Five to 10 banners advertising the service are posted in busy areas throughout the town. In addition, separate branded banners are posted on the mobile HCT tents.

- *HCT brochure*: This provides information on HCT, in particular on mobile HCT services, advantages of being tested, and targeted information for specific population groups.
- *Referral brochure*: This brochure has information on maintaining HIV-negative status as well as living positively. It lists the organizations in the town/region that provide follow-up HIV/AIDS care and support services.
- *Women-focused brochure*: Targeting women, the brochure includes testimonials from women who have been tested and describes the benefits of being tested.
- *Coupons for women*: Women promoters distribute a small card to women interested in accessing mobile HCT services. This coupon allows women to be prioritized for service once they arrive at a mobile HCT site.

7. SERVICE DELIVERY

7.1 TIMING OF SERVICES

At the start of implementation, PSP-E provided mobile HCT services from Tuesday to Saturday. However, at the request of stakeholders, the services were shifted to Wednesday through Sunday. Provision of services over both weekend days increases access for employed clients who work or attend school from Monday to Friday. This includes key population groups such as factory workers, daily laborers, and in-school youth.

Services are provided for eight hours a day. However, the hours are varied from day to day in order to reach target groups (e.g., 9 am to 5 pm on one day and noon to 8 pm on another) depending on the local context. The services also may be split between morning and evening hours to accommodate the schedules of agricultural workers (e.g., offer testing from 6 am to 10 am and resume from 4 pm to 8 pm).

PSP-E has also offered moonlight services from 6:00 pm to 10:00 pm. In some areas, this strategy was used to avoid extreme mid-day heat while, in other areas, it was used to increase uptake by clients who are unable to attend services during the day (including weekends). Moonlight services increased participation of women – reasons cited by women clients include being busy with household activities during the day and having more privacy at night.

PSP-E has also implemented mobile HCT for women only on specific days. Female-only HCT days provide an opportunity for women who are hesitant to be seen by men in the community at the mobile HCT site. This was in response to rapid assessment findings that indicate that FSWs are afraid of using facility-based services for fear of being seen by their clients.

7.2 FURNITURE/EQUIPMENT AND CONSUMABLES

Annex Q (List of Furniture, Equipment, and Supplies for Mobile HCT) includes a complete list of furniture (tents, tables, chairs, stools), equipment, and supplies (laboratory, monitoring and evaluation forms, HIV test kits, etc.) required for the mobile HCT activities.

The coordinating partner is responsible for obtaining sufficient numbers of HIV test kits through the Supply Chain Management System. Arrangements for procurement should begin approximately one full quarter before the event. Below is general guidance to calculate the number of test kits required for MCT:

- *Screening test kit:* # of counselors X 15 to 20 clients/day X # of days
- *Confirmatory test kit:* # of counselors X 15 clients/day X # of days X HIV prevalence among VCT clients (estimated to be 7 percent in PSP-E's experience)
- *Tie-breaker test kit:* # of confirmatory tests X discordant rate (estimated to be 3 percent of positives)

Furniture Requirements for MCT

Reception Tent: 1
Group Education Tent: 1
Counseling Tents: 5-6 (1 per counselor)
Laboratory Tent: 1 (if required based on testing algorithm used)
Chairs: 3 per counseling tent, 1 each for reception, laboratory, and group counseling
Tables: 2 per counseling tent, 1 each for reception, laboratory, and group counseling tents
Stools: 30 for reception tent

Staff Requirements for Mobile HCT

1 site coordinator
5-6 counselors (nurses)
1 health educator
1 laboratory technician
1 receptionist
3 guards (1 for the day and 2 for the night)
1 cleaner

PSP-E recommends adding a 10 percent margin to each total to account for wastage. The coordinating partner must also make arrangements for proper storage of these test kits, including obtaining access to refrigeration if required.

The coordinating partner or mobile HCT subcontractor may need to arrange for a generator for electricity backup for laboratory equipment (if venipuncture samples must be centrifuged) and during moonlight services. Solar lamps are also an option. These additional needs should be identified with local stakeholders and incorporated into implementation plans.

7.3 ORIENTATION FOR COUNSELORS

Prior to the mobile HCT service, the coordinating partner will conduct a one-day orientation session for all counselors who are part of the mobile team (**Annex R: Agenda for Counselor Orientation**). The orientation, led by an experienced HCT site supervisor, will review the target populations in the area of service, numbers the activity aims to reach, client flow and logistics, quality issues, proper use of recording formats, and the importance of referrals. The importance of ethical considerations, including confidentiality issues, is discussed during this orientation. The supervisors will also check the credentials of each counselor to ensure that they have received standard national training for HCT.

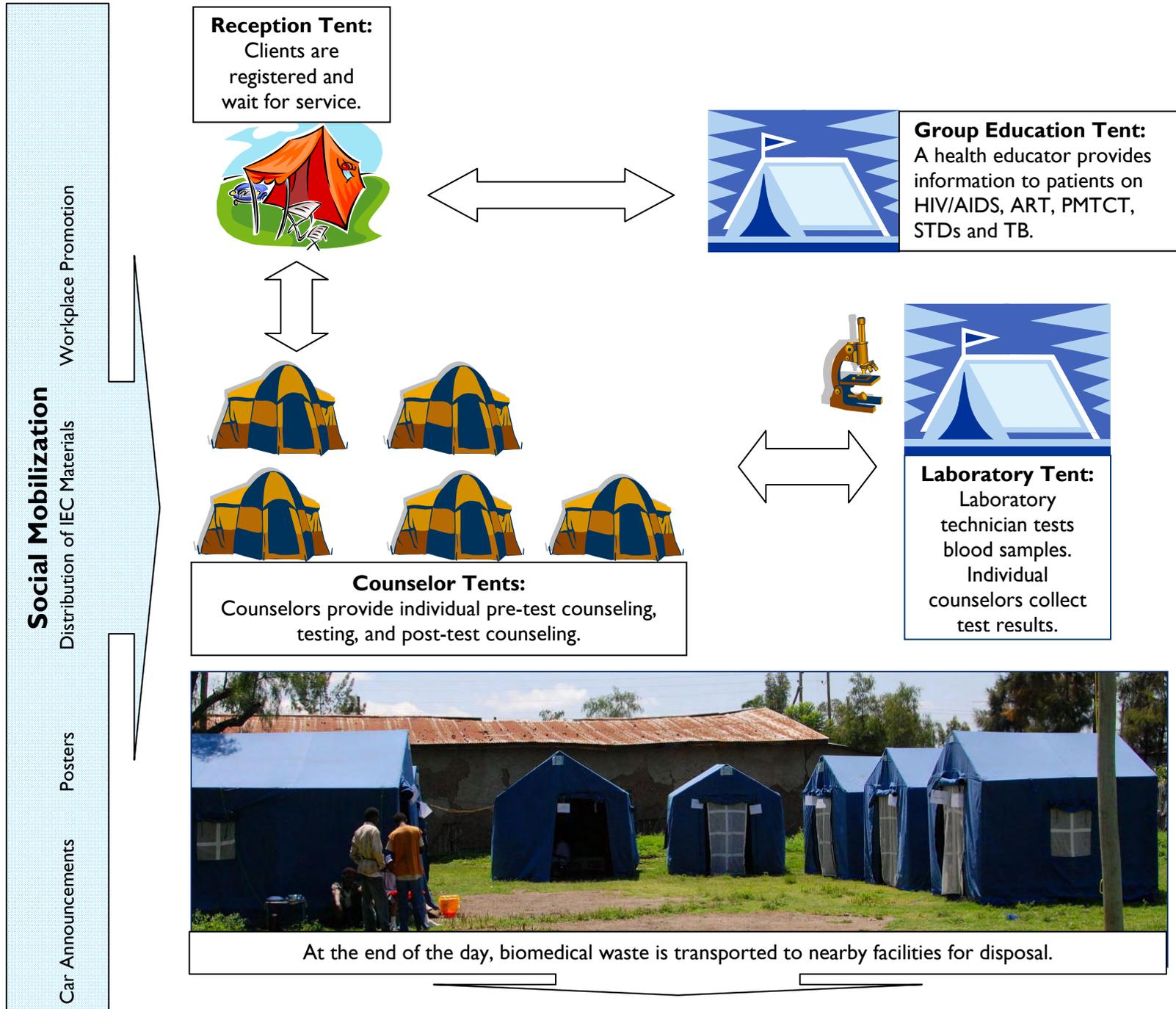
7.4 ARRANGEMENT OF THE SERVICE AREA

The service area arrangement used by PSP-E (Figure 2) includes a total of eight tents at each service site: a large reception tent, a medium-size group education tent, 5-6 small tents for individual counseling and testing, and a laboratory tent (if required by the testing algorithm used). The **reception tent** is about 5m X 4m X 2m in size and serves as both the client registration and waiting areas. A health educator provides information on HIV/AIDS, prevention of mother-to-child transmission (PMTCT), TB, sexually transmitted diseases (STDs), and family planning to 5-8 clients at the same time in the **group education tent** (4m X 3m X 2m).

Each **counseling tent** is about 2.7m X 2.5m X 2m in size and has the counselor's unique ID number posted outside the tents, for easy reference by clients being served. There are usually 5-6 counselor tents, one tent per counselor. Each counselor counsels approximately 15-20 clients per day, so using this set-up, approximately 75-90 clients will be served per team per day. The tents are erected to ensure confidential counseling and testing sessions, away from the reception and laboratory tents. All counseling and the collection of blood samples is conducted in these tents. If the finger-prick method is used, the counselor performs the HIV test in the counseling tent using a separate table to perform the test and await the result. If not, then the counselors label test tubes with patient ID codes and take them to the laboratory tent. In either situation, the patient will return to the reception tent to await test results and return to the same counseling tent for post-test counseling.

A **laboratory tent** is set up if venous blood samples are taken that require testing by a trained laboratory technician. The counselor takes the blood sample and brings it with a lab request slip (bearing the pre-printed client code and counselor ID code) to the laboratory tent for rapid testing by a lab technician. The lab technician records the result in a log book and on the lab request slip, inserts it into the client folder, and places the folder in a tray or envelope marked with the counselor's ID code located in the laboratory tent. The counselor picks up all results from his/her coded counselor folder when bringing new samples to be tested to the laboratory tent. Only authorized staff are allowed in the laboratory tent area. If the finger-prick method is used, a laboratory tent is not required. However, a laboratory technician remains onsite to assist counselors as needed and to provide internal quality assurance .

FIGURE 2



7.5 SITE SUPERVISION AND COORDINATION

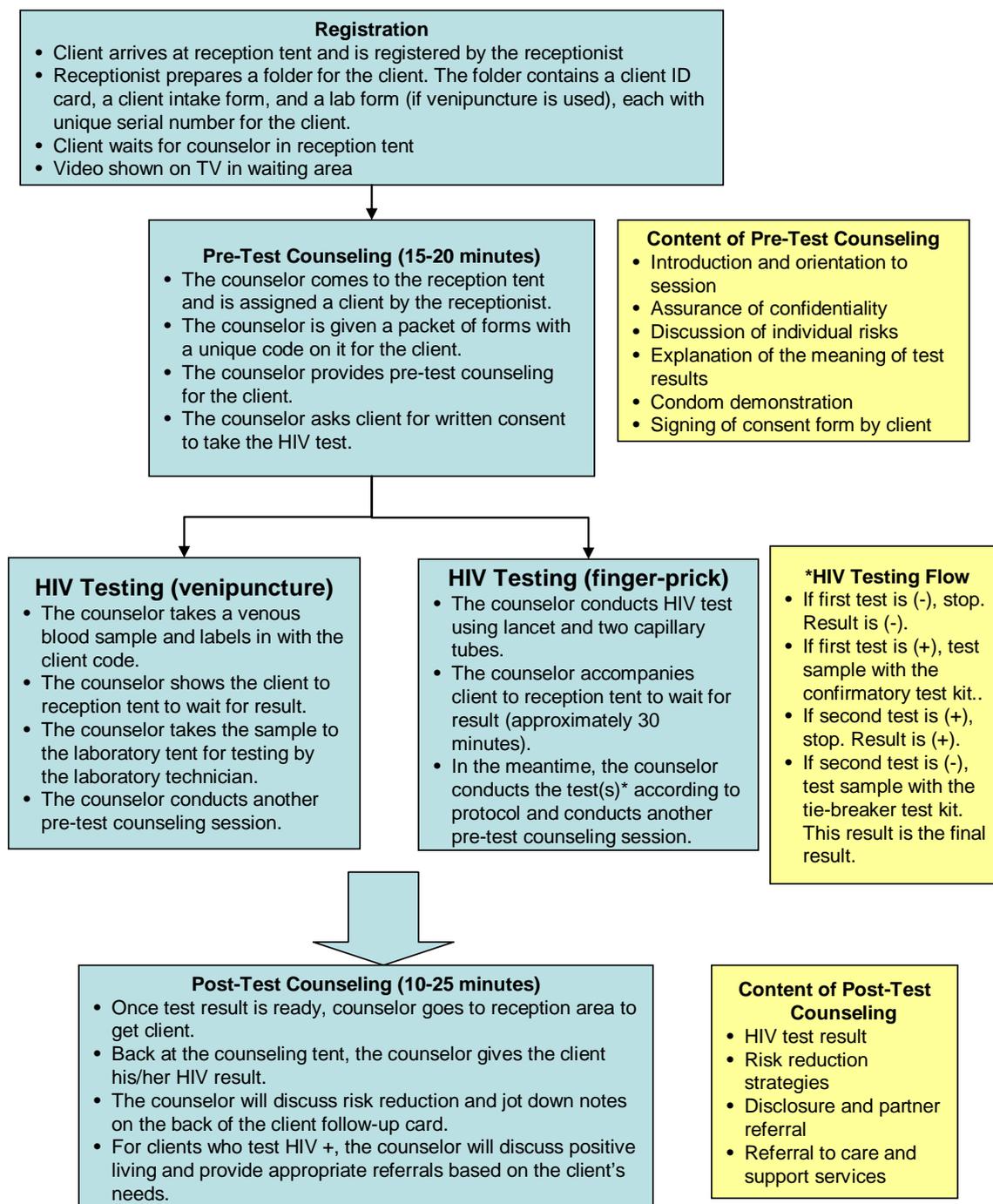
The coordinating partner identifies and assigns a staff member (or trained consultant) to supervise the HCT activities at each mobile HCT site. These HCT site supervisors are responsible for overseeing the quality of services at mobile HCT sites. The HCT site supervisor leads the orientation for all counselors and laboratory technicians (Section 7.3), participates in orientations of women's promoters, serves as a resource person during community mobilization activities, and provides onsite troubleshooting assistance. The HCT site supervisor oversees and/or implements quality improvement and quality assurance activities including client exit interviews, direct observation, daily debrief sessions with counselors, and reviews counselor self-reflection forms and joint supervision with the RHB (Section 8.2). The HCT site supervisor is responsible for compiling a report on each mobile HVC activity using a standard reporting format (described in Section 8.1). The HCT site supervisor also organizes the review meeting with stakeholders a few weeks after the mobile HCT activities are implemented (Section 8.3).

The mobile HCT subcontractor hires a site coordinator for each mobile HCT team or town (i.e., one site coordinator for two sites). The site coordinator (also known as a program facilitator) oversees the logistics of mobile HCT, including set-up and breakdown of tents, secures all property, arranges for waste disposal, coordinates the cold chain (if required by testing algorithm), hires guards/cleaners, and attends to all obstacles related to service implementation. The site coordinator consults with the HCT site supervisor on technical issues, such as identifying an alternate site due to low client flow. The site coordinator also collects reports and compiles for submission to the coordinating partner.

7.6 COUNSELING FLOW

Figure 3 outlines the counseling flow, from registration to pre-test counseling, HIV testing, and post-test counseling. The HCT services are provided by nurses who are trained as HIV counselors. Each counselor sees approximately 15-20 clients per day. **Annex S: HCT Session Guide Cue Cards** provides detailed information on the content of the pre- and post-test counseling sessions.

FIGURE 3. COUNSELING FLOW



7.7 WASTE DISPOSAL

The coordinating partner collaborates with the town health offices, and public or private health centers to arrange for disposal of medical waste. As described earlier, safety boxes are provided to the counselors and laboratory technician for disposal of needles and lancets with support from the Making Medical Injections Safer Project. These boxes must be transported to a facility with an incinerator for disposal.

Counselors dispose of blood-stained cotton balls, used test kits, capillary tubes, vacutainers, and other waste materials in a waste basket lined with a plastic trash bag. These trash bags are transported to health facilities and incinerated.

8. MONITORING AND EVALUATION

8.1 RECORDING AND REPORTING

The recording and reporting formats used for mobile HCT are adapted from forms included in the national HCT guidelines. Prior to use of these forms, mobile HCT teams (counselors, lab technicians, receptionists, and site coordinators) are oriented to each tool.

At the site, there is a structured flow of the client's record from the reception to testing, counseling, and service completion. Accurate and complete recording and reporting is expected from each member of the mobile HCT team. Table 3 provides detailed information on each recording and reporting format and register. Each of the forms/registers described are included in **Annex T: Recording and Reporting Formats**.

RECORDING AND REPORTING FORMATS

#	Form/Register	Use of Form/Register	User
1	Daily Client Tally Sheet Size A4 (book, printed on both sides)	This is a registry book used to register clients upon arrival at the reception tent. The tally sheet collects the following information: unique client code or couple code, gender, age, and counselor code. The unique client code is carried forward on forms 4, 5, 6, 7, 8, 11	Receptionist
2	Coupon 7×10cm (business card size)	Women's promoters distribute this small card to women interested in accessing mobile HCT services. The card allows women to be prioritized for service once they arrive at a mobile HCT site. The card also provides data on the number of referrals made by each woman's promoter during their community mobilization activities.	Women's Promoters, Clients
3	Appointment Card 7×10cm (business card size)	This card is given to a client when the client flow is high and the client would prefer to make an appointment during the day or week of the mobile HCT activity.	Receptionist
4	Client ID Card (Coded format) 7×10cm (business card size)	The client ID card is a small, pink card that is given to the client as soon as he/she is registered. The card includes the unique client code, date, and counselor code. The client keeps this card throughout the MCT visit. The counselor matches the client ID card to the serial numbered client intake record at the beginning of the pre- and post-test sessions. Both the counselor and the client verify that the client ID card matches with the client intake form and the lab result form or number written on the HIV test kit to avoid any mistakes. This procedure ensures that the client receives the correct test results while the client remains completely anonymous.	Receptionist
5	Client Flow Card (time card), 7×10cm (business card size)	This card is used to collect information on the amount of time required to provide the service for each client. The receptionist records the time the client registered at reception. The counselor records the time pre-test counseling is conducted as well as when test results are given with post-test counseling. This card is pre-printed with the unique client code.	Receptionist, Counselor, Laboratory Technician (if he/she conducts test)
6	Client Intake Form (Coded format) Size A4	The client intake form is used to collect information on the client (socio-demographic, risk behaviors, reason for seeking service and post-test counseling), to obtain written consent from the client agreeing to an HIV test, and for HIV test result and referral	Counselor

#	Form/Register	Use of Form/Register	User
		information. The data from this intake form is routinely analyzed to guide the program.	
7	HIV Test Lab Request/Result Form (Coded format) Size A5	The counselor uses this form to order a blood test for HIV. Once the test is conducted, the laboratory technician records the test result on this form and returns to the counselor for post-test counseling. This form is only used if the algorithm requires testing venous blood.	Counselor, Laboratory Technician (if he/she conducts test)
8	Risk Reduction Form (Coded format) Size A4	The counselor develops a risk reduction plan with the client during post-test counseling after the test result is given. The form includes the client code and is retained by PSP-E.	Counselor, Client
9	Lab HIV Registration Log Book (100 pages) A3 size	This log book is used to record the client's age, sex, client code, and HIV test results (for each test used).	Laboratory Technician (if he/she conducts test)
10	VCT Registration Log Book (100 pages) A3 size	This log book is used to record the client's age, sex, client code, residence, marital status, education level, pre- and post- test, HIV test result, and referral information. The counselor can complete the HIV test result information based on conducting the HIV test themselves or from the information on Form 5, HIV Test Request/Result Form.	Counselor
11	Client Referral Form (with feedback slip) Size A4	Using the referral directory, the counselor and client select referral sites appropriate to the client's needs. The referral form is used to refer clients to another organization or facility for follow-on care and support services. The bottom part (feedback slip) is retained by the receiving organization for collection by the coordinating partner (to assess effectiveness of referral).	Counselor
12	Referral Registration Log Book (50 pages) Size A4	For each client referred, the counselor records the client's code, date of referral, and facility/organization and service referred to. The collected feedback slips are compared with the data in this log book to calculate the percentage of completed referrals.	Counselor
13	Group Education Log Book Size A4	The group education logbook is completed by the health educator conducting the group education session. The logbook collects information on the number of clients educated during each session by gender as well as the length of each session.	Health Educator
14	Daily VCT Reporting Format Size A4	The mobile HCT site coordinator summarizes the daily client intake for the whole site, by age group, gender, test result, and referrals.	MCT Site Coordinator
15	Weekly Summary Report	The weekly summary report format is provided by the RHB. The PSP-E team completes this report at the end of the mobile HCT and submits this to the town health office, accompanied by a cover letter.	MCT Site Coordinator HCT Site Supervisor

The coordinating partner is responsible for reproduction of these forms and providing copies to the subcontractor. The mobile HCT subcontractor organizes the forms in preparation for service implementation (including batching forms with the unique client code into plastic folders).

The subcontractor is obliged to ensure that all forms are correctly and consistently used by all mobile HCT personnel. At the end of each week or two of service, the subcontractor sends the original daily and weekly summary forms and all individual client intake forms to the coordinating partner for data entry and analysis.

The data collected from these recording and reporting formats are routinely analyzed to improve program implementation (**Annex U: Sample Data Analysis Report**). For example, analysis of the first round of client intake data revealed that only 20 percent of clients were women. The intake data also revealed that HIV prevalence among female clients was double that of male clients. With this

information, PSP-E implemented activities to increase uptake of mobile HCT services by women, including use of women promoters and distribution of coupons to provide women with priority service. PSP-E reviews data on the community mobilization activities to identify approaches that are more effective than others. Data indicated that few clients were motivated to access services from the roadside shows. As a result, PSP-E discontinued this community mobilization approach. PSP-E will continue to analyze the data collected to refine and improve mobile HCT services in future rounds.

8.2 QUALITY ASSURANCE AND SUPERVISION

The coordinating partner must also put in place quality assurance system to ensure that counseling and testing services are being implemented as per national guidelines. The system is also used to provide feedback and support to counselors with the goal of enhancing each counselor's skills in delivering service.

The following quality assurance and improvement mechanisms are important for continuous quality monitoring and supervision:

- *HCT session guide cue cards*: Each counselor has a set of cue cards to assist him/her in providing consistent and effective counseling and testing to each client. The cue cards guide counselors through pre-test counseling (introduction, risk assessment and reduction, preparation for HIV test) and post-test counseling. There are cue cards tailored to delivering results to HIV-positive and to HIV-negative clients. (**Annex S: HCT Cue Cards**).
- *Daily debrief sessions*: The PSP-E supervisor convenes a meeting each evening with the mobile HCT team to review the day's activities and discuss preparations for the next day. During this short meeting (30-60 minutes), counselors share any challenging or interesting cases that they encountered during the day and discuss how they handled these situations. The PSP-E supervisor and other counselors have an opportunity to provide input and feedback, and counselors are able to learn from each other's experiences.
- *Counselor self-reflection*: After the 7th and 15th client, each counselor completes a self-reflection form (**Annex V: Counselor Self-Reflection**). This helps the counselor to reflect on a client session and assess if he/she provided services according to their training and the protocol. This form is collected and reviewed by PSP-E supervisors.
- *Client exit interview*: Site supervisors or the receptionist conducts client exit interviews using a pre-determined, random sampling strategy. Counselors will not know if their client will be interviewed and clients should be selected without knowing their HIV status. The client exit interview assesses the client's satisfaction with the services, the knowledge gained, and whether the counselor provided services based on specific standards. Approximately 10 percent of clients are interviewed using the client exit interview (**Annex W: Client Exit Interview**).
- *Mobile HCT direct observation checklist*: Another mobile HCT counselor or a site supervisor observes each counselor at least twice per week in a counseling session and completes the direct observation tool to assess the counseling skills of the individual counselors. The tool is based on the national guideline and protocol. Before the observer sits in, the client is informed about the observation and its purpose. Assurance of confidentiality must also be given. Client consent is required before proceeding with the observation. The supervisor or peer is as unobtrusive as possible and does not disrupt the counseling session (**Annex X: Mobile HCT Peer Supervision Checklist**). Feedback is given to counselors by HCT supervisor or peer counselor after each direct observation. The HCT supervisors also include key observations in their field reports.

- *Limiting counselors to 15 clients per day:* Counselors are limited to counseling and testing up to 15 clients per day. The national HCT guidelines state that counselors should see a maximum of 15-20 clients per day to prevent fatigue and burn-out. PSP-E has experimented with setting the threshold at 15-20 and is currently using a limit of 15. The service providers felt that 15 clients per day was the maximum that permitted quality counseling.

In addition to these quality assurance strategies, site supervisors continuously monitor and supervise services at the mobile HCT sites. The RHB, HAPCO, and/or WoHO also provide onsite supervision in coordination with the site supervisor.

8.3 REVIEW MEETING

PSP-E and the RHB jointly coordinate a review meeting that is held approximately three months after MCT activities in each region. Participants from the zonal health department, town health offices, WoHOs, HAPCO, local government, police, anti-AIDS clubs, and other stakeholders involved in the mobile HCT activities are invited to discuss the programmatic success, challenges, lessons learned, and best practices in implementing mobile HCT in the region and to provide on the activity. In addition, the review meeting provides an opportunity to introduce stakeholders to upcoming mobile HCT activities in the region. **Annex Y: Review Meeting Report** includes a summary of a review meeting, including the agenda, objectives and participants.

8.4 EQA FOR LABORATORY

According to the World Health Organization (2004), EQA is an important component of overall quality assurance. PSP-E has arranged for quality assurance support from the regional laboratories through the RHBs. Results are communicated to the coordinating partner, mobile HCT subcontractor, and RHB.

Laboratory quality assurance activities are conducted using the following complementary approaches:

- **Blind rechecking**

At the start of mobile HCT, the following test kits were being used for HIV testing (before the change of the national HIV testing algorithm): Determine (screening test), Capillus (confirmatory test), and Unigold (tie-breaker test). The counselor collected venous blood from the client using a syringe and collection tube (vacutainer). The sample was then passed to a laboratory technician who separated the serum from the blood using a centrifuge. For EQA, the laboratory technician prepared and numbered nunc tubes with specimens from 10 percent of all negative tests and 100 percent of all positive tests for “blind rechecking” by the regional laboratory.

These samples were stored in a nearby health facility under refrigeration and transported to the regional laboratory for re-testing. Without knowing the test result at the mobile HCT site, the laboratory retests each sample and then compares the result with the mobile HCT site. A report is provided with information on the percentage and number of samples yielding discordant results (Annex Z: Sample EQA Reports).



When this method was used, the coordinating partner arranged for vaccine carriers and frozen ice packs to transport refrigerated specimens, and for temporary storage in refrigerators at health facilities until the samples could be transported to the regional laboratory. EQA samples were stored separate from other facility samples with appropriate labels, including individual client codes for each sample. Hard copies of test results from the mobile HCT sites are also kept at the facilities where EQA samples were stored.

- **Proficiency testing**

Due to a change in the national testing algorithm, HIV testing is being conducted using KHB (screening test), Statpack (confirmatory test), and Unigold (tie-breaker test). The counselors (all nurses) collect a whole blood specimen using a lancet to prick the fingertip and two capillary tubes to collect the blood specimen. The first tube can be used for the screening and confirmatory test. The second tube is only used if a tie-breaker test is required.

Using this method, specimens cannot be saved for blind rechecking. Instead, the regional laboratory conducts proficiency testing for EQA. Each counselor is provided with small panels of 6-10 well-characterized blood samples for testing. Counselors perform HIV tests on these samples following the testing algorithm. The percentage of discordant results is calculated as an estimation of the quality of the testing services (Annex Z: Sample EQA Reports). Proficiency testing serves as a “spot-check” rather than continuous retrospective quality assurance provided by the blind rechecking approach. However, the simplicity and accuracy of rapid test kits and the finger-prick method minimizes the risk of errors.

- **Supportive supervision**

Onsite audits are used to confirm adherence to standard operating procedure, review record-keeping, and observe staff performance. This is also an opportunity to administer a proficiency test directly to each individual who performs testing. The regional laboratory and RHB conducts onsite audits and provides feedback to the coordinating partner and MCT subcontractor. Standard checklists and evaluation methods allow for the collection and comparison of consistent information from multiple sites.

9. LESSONS LEARNED

- **Strong partnership with stakeholders to allow for effective resource mobilization and networking to support service delivery:** PSP-E partnered with health facilities to use existing infrastructure to support cold chain and waste disposal, the regional laboratory to support EQA, obtained safety boxes from the USAID-funded Making Medical Injections Safer project and engaged local volunteers from women associations and anti-AIDS clubs for community mobilization.
- **Building capacity locally to deliver mobile HCT services:** By outsourcing service delivery to local service providers, PSP-E has strengthened the skills of these service providers to provide quality mobile HCT services.
- **Using data and evidence from rapid HCT assessments to design services targeting key populations:** PSP-E utilized the findings and recommendations from stakeholders and key populations to provide confidential, accessible, and acceptable mobile HCT services. For example, key informants recommended using counselors who did not reside in mobile HCT towns to ensure confidentiality and privacy of clients. Female-only HCT days and moonlight services were provided at the suggestion of FSWs interviewed during the rapid assessments.
- **Using flexible and innovative approaches to address barriers that limit uptake of services:** As PSP-E implemented mobile HCT services, service delivery was tailored to address challenges and issues that arose and to meet the needs of each local area. For example, due to the low attendance of women during initial rounds of mobile HCT, PSP-E engaged women promoters and introduced coupons that allowed women referred by the promoters to get priority during mobile HCT service hours. PSP-E also shifted the timing of mobile HCT from Tuesday through Saturday to Wednesday through Sunday to increase access for daily laborers, other workers, and in-school youth. Service hours were also made flexible to accommodate the needs of each town. In some areas, services were offered during early morning and early evening to fit the schedules of agricultural workers. In other areas, services were offered in the evenings, including weekend evenings, to avoid extreme mid-day heat or to increase uptake by clients who were unable to attend services during the daytime. Moonlight services increased participation of women – reasons cited by women clients include being busy with household activities during the day and having more privacy at night.
- **Referral and follow-up of HIV-positive clients:** As part of the mobile HCT services, PSP-E established and/or strengthened the referral system to provide follow-up care and treatment services for all HIV-positive clients. Initial data collected from referral slips indicates that in the last round of mobile CT in Oromia, 59 percent of HIV-positive referred clients visited a health facility within one month of testing (i.e. the facility to which they were referred).
- **Implementing a system to maintain the quality of services:** As described in the manual, PSP-E has instituted a system to ensure the quality of both HIV counseling and testing. This is critical to establish a high standard of service that builds clients' and local officials' confidence in the mobile HCT services. Exit interviews indicate that clients are satisfied with the mobile HCT services and many refer their friends and family for HCT. EQA for the laboratory component indicates a high level of testing quality, with discordant results occurring in less than 0.5 percent of tests conducted.

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ANNEXES

- Annex A: Memorandum of Understanding (RHB and PSP-E)
- Annex B: Collaboration Request Letter from PSP-E to RHB
- Annex C: Request Letter from RHB to Key Local Actors for Assessment
- Annex D: Terms of Reference for Assessment
- Annex E: In-depth Interview Guide with Key Informants
- Annex F: FSW Interview Guide
- Annex G: Focus Group Discussion Guide
- Annex H: Outline of Rapid Assessment Report
- Annex I: Service Mapping Assessment Tool
- Annex J: Consensus Building Meeting Agenda, Core Presentations and Report
- Annex K: Referral Directory
- Annex L: Referral Form
- Annex M: Request for Proposals for Mobile HCT Subcontractor
- Annex N: Score Sheet for Mobile HCT Subcontractor
- Annex O: Subcontractor Statement of Work and Deliverables
- Annex P: Photos of IEC Materials (Banners, Posters, Brochures)
- Annex Q: List of Furniture, Equipment and Supplies for Mobile HCT
- Annex R: Agenda for Counselor Orientation
- Annex S: HCT Session Guide Cue Cards
- Annex T: Recording and Reporting Formats
- Annex U: Data Analysis Report
- Annex V: Counselor Self-Reflection
- Annex W: Client Exit Interview
- Annex X: Mobile HCT Peer Supervision Checklist
- Annex Y: Review Meeting Report
- Annex Z: External Quality Control Reports