



USAID
FROM THE AMERICAN PEOPLE



AIDSTAR-ONE SOUTH-TO-SOUTH TECHNICAL ASSISTANCE TO SWAZILAND:

HOME-BASED HIV TESTING AND COUNSELING
JULY 8-30, 2010



AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

NOVEMBER 2010

This publication was produced by the AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector I, Task Order I, USAID Contract # GHH-I-00-07-00059-00, funded January 31, 2008.

AIDSTAR-ONE SOUTH-TO- SOUTH TECHNICAL ASSISTANCE TO SWAZILAND:

**HOME-BASED HIV TESTING AND
COUNSELING JULY 8-30, 2010**

AIDS Support and Technical Assistance Resources Project

The AIDS Support and Technical Assistance Resources (AIDSTAR-One) project is funded by the U.S. Agency for International Development under contract no. GHH-I-00-07-00059-00, funded January 31, 2008. AIDSTAR-One is implemented by John Snow, Inc., in collaboration with Broad Reach Healthcare, Encompass, LLC, International Center for Research on Women, MAP International, Mothers 2 Mothers, Social and Scientific Systems, Inc., University of Alabama at Birmingham, the White Ribbon Alliance for Safe Motherhood, and World Education. The project provides technical assistance services to the Office of HIV/AIDS and USG country teams in PEPFAR non-focus countries in knowledge management, technical leadership, program sustainability, strategic planning and program implementation support.

Recommended Citation

Chimulwa, Teddy, Annie Mpiima, Kenneth Mugisha, and Maria Claudia Escobar. 2010.
AIDSTAR-One South-to-South Technical Assistance to Swaziland: Home-based HIV Testing and Counseling July 8-30, 2010.
Arlington, Va.: USAID | AIDSTAR-One Project, Task Order 1, 2010.

Acknowledgments

AIDSTAR-One would like to extend appreciation and thanks for the support and contributions from Vincent Wong and Kirk Lazell (USAID Washington Office of HIV/AIDS); Jennifer Albertini (USAID Swaziland); Peter Ehrenkranz (PEPFAR Swaziland); Phumzile Mndzebele (SNAP/MOH); and the HTC Core Group in Swaziland; in particular, Victoria Masuku, Khosi Dlamini, and Lenhle Dhube. AIDSTAR-One would like to especially recognize TASO for the superb team they kindly provided which made this south-to-south work possible.

Cover photo: The photo was taken by Teddy Chimulwa in Swaziland in July 2010. This photo captures the training participants and AIDSTAR-One trainers from TASO before they embark on their first field experience of home-based HIV testing and counseling in the community.

AIDSTAR-One

John Snow, Inc.
1616 Fort Myer Drive, 11th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
E-mail: info@aidstar-one.com
Internet: aidstar-one.com

CONTENTS

Acronyms

Trip Report and HBHTC Strategic Recommendations

Annex A: Scope of Work

Annex B: Schedule of Activities

Annex C: Summary of Meetings

Annex D: Attendance List

HBHTC Technical Assistance Reports and Deliverables

Summary Evaluation of Swaziland HBHTC Training

Swaziland HBHTC Training Strategy

Summary Comments on HBHTC Field Practicum and Trial Run

Summary Recommendations for HBHTC Data Collection Tools

Summary Comments on HBHTC Training Participant Manual

Mentoring Plan and Follow-up Activities

Checklist for Minimum Package of HBHTC Services-Cue Card

Assessment of HBHTC Quality of Services with Tracked Changes (available as a separate file only)

National HTC SBCC Strategy Revised with Tracked Changes (available as a separate file only)

Revised HBHTC Training Participant's Manual with Tracked Changes [contains revised HBHTC Standard Operating Procedures (SOPs)] (available as a separate file only)

ACRONYMS

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral (drug)
BRHC	BroadReach Healthcare
CCT	Couples Counseling and Testing
CDC	Centers for Disease Control and Prevention
DBS	dried blood spot
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	early infant diagnosis
GBV	gender-based violence
HBHTC	home-based HIV testing and counseling
HIV	human immunodeficiency virus
HMIS	health management information systems
HTC	HIV testing and counseling
ICRW	International Center for Research on Women
MC	male circumcision
MCP	multiple and concurrent partners
M&E	monitoring and evaluation
MMC	male medical circumcision
MOH	Ministry of Health
MSF	Médecins Sans Frontières
m2m	mothers2mothers
MTCT	mother-to-child transmission
NMS	National Medical Stores
NRL	National Reference Laboratory
NERCHA	National Emergency Response Council for HIV and AIDS
OIs	opportunistic infections
OPD	outpatient department

PCR	polymerase chain reaction
PEP	postexposure prophylaxis
PEPFAR	The President's Emergency Plan For AIDS Relief
PLWH	people living with HIV
PLWHA	people living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PITC	Provider-Initiated Testing and Counseling
PSI	Population Services International
PWD	people with disabilities
QA	quality assurance
RHM	Rural Health Motivators
SBCC	Social and Behavioral Change Communication
SDHS	Social and Demographic Health Survey
SNAP	Swaziland National Aids Program
SOP	Standard Operating Procedures
SSS	Social & Scientific Systems, Inc.
S2S	south-to-south
S2STA	South-to South Technical Assistance
SWANNEPHA	Swaziland National Network of People living with HIV/AIDS
TA	technical assistance
TASO	The AIDS Support Organization (in Uganda)
TB	tuberculosis
TOR	terms of reference
TOT	training of trainers
UAB	University of Alabama at Birmingham
UNAIDS	The Joint United Nations Programme on HIV/AIDS
URC	University Research Company
VCT	voluntary counseling and testing
WEI	World Education, Inc.
WHO	World Health Organization
WRA	The White Ribbon Alliance for Safe Motherhood

**AIDSTAR-ONE TRIP REPORT
ON SOUTH-TO-SOUTH
TECHNICAL ASSISTANCE TO
SWAZILAND:
HOME-BASED HIV TESTING
AND COUNSELING
JULY 8–30, 2010**

AIDSTAR-One Trip Report on South-to-South Technical Assistance to Swaziland: Home-Based HIV Testing and Counseling July 8–30, 2010

Destination Mbabane, Swaziland

Dates July 8–30, 2010

Traveler HBHTC South-to-South Technical Assistance Consultants:
Teddy Chimulwa, The AIDS Support Organisation (TASO)
Kenneth Mugisha, TASO
Annie Mpiima, TASO

AIDSTAR-One Counseling and Testing Advisor:
Maria Claudia Escobar

Purpose

Provide technical assistance (TA) to Swaziland in home-based HIV testing and counseling (HBHTC) training and implementation.

Background

With 26 percent of its adult population living with HIV, Swaziland faces the highest HIV prevalence in the world. In 2007, an estimated 191,000 people living with HIV (PLWH) were in Swaziland, of whom approximately 62,000 were in need of antiretroviral therapy (ART). By December 2008, 35,000 PLWH were already on ART. Although Swaziland is a small country with ethnic homogeneity, there is some heterogeneity in HIV prevalence across specific subpopulations, as evident in the following table.

Low HIV Prevalence	High HIV Prevalence
Males aged 15–30 years	Females aged 15–30 years
Females aged 35–60 years	Males aged 35–60 years
Men and women who live in rural areas	Men and women who live in urban areas
Less wealthy men and women	Wealthier men and women
Unemployed men and women	Employed men and women
Men and women who spend no time away from home each year	Men and women who spend more than one month away from home each year
Never-married men who have had sex	Never-married women who have had sex

HIV Testing and Counseling in Swaziland

HIV testing and counseling (HTC) is a critical entry point to prevention, treatment, care, and support. In addition, PLWH can receive support toward adopting positive prevention strategies (e.g., behavior change, adoption of early ART, management of opportunistic infections, and adherence to recommended ART regimens). HTC scale-up is advocated as one way to normalize HIV testing and destigmatize HIV; this could in turn reduce social barriers to HTC for persons seeking to know their HIV status.

In Swaziland, the HTC models that have been used to enable people to know their HIV status include, the client-initiated approach, voluntary counseling and testing (VCT), and, to a lesser extent, provider-initiated testing and counseling. HIV testing uptake in Swaziland remains low. According to the most recent Social and Demographic Health Survey (2007), only 27 percent of the population had ever taken an HIV test and received their results. Such figures are a testament to the fact that the majority of people do not currently know their HIV status and that many opportunities are being missed to counsel and test individuals for HIV.

Home-Based HIV Testing and Counseling

Swaziland is working toward improving its low rates of HIV testing. According to the *National Strategic Framework 2009*, Swaziland's target is to increase the proportion of people knowing their HIV status from 22 percent to 50 percent for women and from 9 percent to 40 percent for men by 2014. In an effort to expand HTC approaches and to increase testing uptake, Population Services International (PSI)/Swaziland, in collaboration with Swaziland's Ministry of Health (MOH), the National Emergency Response Council for HIV and AIDS (NERCHA), and development partners, piloted a national HBHTC campaign in 2009. The campaign demonstrated encouraging results of high acceptability of HBHTC and leadership by the local health management team (Swaziland HBHTC Concept Paper 2009). HBHTC has also been implemented in Swaziland by using the index client approach.

To further evaluate the feasibility and acceptability of HBHTC, the Swaziland HTC Core Group is conducting a six-month pilot project of door-to-door HIV testing in Swaziland.

Response

In November 2009, AIDSTAR-One coordinated a successful HBHTC Technical Consultation Meeting in Nairobi, Kenya, during which implementers shared experiences and lessons learned in HBHTC implementation. Subsequently, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) HTC Technical Working Group (TWG) and the U.S. Agency for International Development (USAID) requested that AIDSTAR-One facilitate the provision of south-to-south (S2S) TA in support of Swaziland's efforts to pilot HBHTC.

In July 2010, AIDSTAR-One facilitated the S2S exchange of TA, which is seen as an innovative model that shares expertise and practical training between developing countries. The PEPFAR HTC TWG and USAID, after consulting with USAID/Uganda, selected The AIDS Support

Organization (TASO), to be the TA provider on the basis of TASO's experience and reputation. Meetings with TASO confirmed the required level of expertise and skill set for this S2S TA activity. AIDSTAR-One facilitated S2S TA by recruiting expert consultants from TASO to provide the TA to the Swaziland HTC Core Group. The HTC Core Group is a unique, collaborative team consisting of the following members: Swaziland National AIDS Programme (SNAP), the World Health Organization/the Joint U.N. Programme on HIV/AIDS, PEPFAR, PSI, Médecins Sans Frontières (MSF), Baylor College of Medicine, and University Research Company (URC). The S2S TA was to support the launch of a six-month pilot project focusing on the feasibility and acceptability of door-to-door HIV testing in Swaziland. Following evaluation of the pilot, which was launched in August 2010, the HTC Core Group will consider a scaled-up HBHTC plan for the country. The details of the scope of work are presented in Appendix A.

AIDSTAR-One coordinated and facilitated the following S2S TA activities: 1) HBHTC training; 2) a trial run of HBHTC; 3) a review of and recommendations for behavior change communication strategy, training strategy, and quality assurance (QA); and 4) a review of HBHTC resources. AIDSTAR-One is also providing ongoing technical support and mentoring. The following documents are the products of the TA provided:

1. Trip Report and HBHTC Strategic Recommendations
 - Appendix A: Scope of Work
 - Appendix B: Schedule of Activities
 - Appendix C: Summary of Meetings
 - Appendix D: Attendance List
2. HBHTC TA Reports and Deliverables
 - *Summary Evaluation of Swaziland HBHTC Training*
 - *Swaziland HBHTC Training Strategy*
 - *Summary Comments on HBHTC Field Practicum and Trial Run*
 - *Summary Recommendations for HBHTC Data Collection Tools*
 - *Summary Comments on HBHTC Training Participant Manual*
 - *Mentoring Plan and Follow-up Activities*
 - *Checklist for Minimum Package of HBHTC Services—Cue Card*
 - *Assessment of HBHTC Quality of Services with Tracked Changes* (available as electronic document only)
 - *National HTC Social and Behavioral Change Communication (SBCC) Strategy Revised with Tracked Changes* (available as electronic document only)
 - *Revised HBHTC Training Participant's Manual with Tracked Changes (contains revised HBHTC Standard Operating Procedures [SOPs])* (available as electronic document only)
 - *Revised HBHTC Implementation Plan and QA Guidelines*¹

Activities and Recommendations

AIDSTAR-One coordinated and facilitated a number of activities in collaboration with the HTC

¹This deliverable was produced with and delivered to the HTC Core Group while in-country.

Core Group. This report provides a summary of the TA activities, the issues raised, and recommendations, which are presented in the following order:

- Strategic Recommendations for Swaziland’s HBHTC Program
- HBHTC Training and Trial Run
- Revision of HBHTC Resources and Tools
- Laboratory QA
- SBCC Strategy

Strategic Recommendation for Swaziland’s HBHTC Program

AIDSTAR-One and the S2S Consultants, in collaboration with the HTC Core group, HBHTC trainees, and HBHTC stakeholders, propose the following strategic recommendations to ensure a successful HBHTC pilot program and potential scale-up in Swaziland.

Program Design

Multipronged Mobilization Strategy

A need exists to ensure sensitization of leaders at the following levels: 1) influential leaders; and 2) the broader community. Specifically, political, cultural, and religious leaders and the Royal Family will need to be engaged to obtain their support. In addition, efforts to mobilize community leaders can build on mobilization with influential leaders.

Utilization of various forms of media, including mass media, some of which could be targeted to the pilot sites, would help to clarify facts about the HBHTC intervention taking place. Mobilization should be carried out prior to and during HBHTC implementation.

Mapping Strategy

A realistic mapping strategy is needed to both facilitate needed follow-up activities and avoid visiting households more than once where no follow-up is necessary. A zoning strategy, where counselors are assigned a specific geographical area and must ensure that all households are covered, may be considered. Online sources maps (e.g., Google Maps) could be used to map areas for visitation.

Human Capacity

Home-based HIV Testing and Counseling Human Resources

If HBHTC is to be scaled up in Swaziland, sufficient numbers of the following groups in each region will need to be specially trained in this model of HTC: HTC counselors, HTC counselor supervisors, laboratory supervisors, data entry staff members, and overall program managers. Leveraging current HTC resources may be necessary to provide adequate coverage for the HBHTC program.

Home-based HIV Testing and Counseling Counselors

HBHTC human resources require adequate training in HBHTC methodologies and skills. However, counselors must have prior training in HTC. In Swaziland, only 37 HTC trained lay

counselors are currently available who are not working in another capacity and who can implement HBHTC. A training strategy is necessary to increase the number of HTC counselors, including lay counselors, before HBHTC scale-up begins. A cascade training approach can be adopted using a training of trainers (TOT) model whereby the trainers from the TOT would build capacity at the regional level. Details can be found in the *Proposed HBHTC Training Strategy*.

Specific Home-based HIV Testing and Counseling Skills Required

Ideally, HBHTC counselors (both lay and nurse counselors) should have proven knowledge and skills in key content areas relevant to home-based approaches such as child and adolescent counseling, couples counseling, prevention of mother-to-child transmission (PMTCT), and counseling for ART. As HBHTC pilot implementation proceeds and is scaled-up, rapid needs assessments with respect to training should be conducted on an annual basis, and refresher trainings, based on those findings, should be organized to help update and augment the HBHTC providers' skills.

Motivation for Home-based HIV Testing and Counseling Counselors

Working as an HBHTC counselor can be demanding, and burnout is a potential problem. Various strategies can be used to help motivate HBHTC counselors. Such strategies include the following:

- Providing appropriate and adequate equipment (e.g., durable backpacks, umbrellas, rain boots, plastic aprons, adequate disposable gloves, brightly colored jackets or aprons, which helps identify counselors in the field)
- Providing transportation strategy to reduce walking distances (e.g., bicycles)
- Providing lunch
- Providing moderate allowances.

Logistics

Supplies

An efficient procurement and supply chain management system should be instituted to ensure adequate, regular, and consistent supply of HBHTC commodities. Accurate forecasting of required quantities for all HBHTC supplies is critical. The team might consider having buffer stocks for emergencies to avoid stockouts. Additionally, counselor field kits need to include durable supplies such as backpacks and coolers.

Transport

Given the long distances between households, a cost-effective and sustainable mode of transport should be identified and evaluated before adoption of a HBHTC program. Options include using motorbikes or taking a group of counselors in one vehicle and dropping them at one central place for a specific mapped area from which they will visit the households.

Laboratory Quality Assurance and Quality Control

Quality Control of HIV Tests Conducted in the Field

The current Swaziland guidelines emphasize proficiency testing for test kits for quality control (QC). However, to ensure correct test results in the field, retesting of every 10th client by each

counselor (irrespective of the test result) is proposed through the use of a dried blood spot (DBS) sample that is to be sent to the National Reference Laboratory (NRL) for confirmation. The counselors in HBHTC training for the pilot project were trained in DBS sample collection. Additionally, feedback from the NRL on the data collected is important so that programs can learn if discordant results were identified and how to address this and other QA issues that may arise.

Dried Blood Spot Sample Collection

HBHTC providers need to be trained on collecting and transporting DBS samples and should be provided with adequate supplies (e.g., glassine paper) to properly package each sample and avoid contaminating samples. A proposed strategy for transporting samples may include having counselors call the HBHTC hotline (once established) when a DBS sample is ready for pickup; the sample would be taken to and stored at the laboratory in the clinic located within the project site.

Certification in HIV Rapid Testing

HBHTC providers need to be certified in HIV rapid testing and QA methods by the NRL. Although willing and interested in determining how best to provide support to the HBHTC pilot project, the Swaziland NRL is currently operating under significant resource constraints. The HTC Core Group, along with the NRL, should determine a feasible schedule by which a laboratory supervisor can visit the pilot sites for supportive supervision of HBHTC counselors and can determine the process for HIV rapid testing certification.

Laboratory Infrastructure

Deoxyribonucleic acid (DNA) polymerase chain reaction (PCR) testing will be needed to 1) resolve repeated or continually inconclusive HIV tests and 2) provide early infant diagnosis (EID). At present, DNA PCR tests are sent to South Africa. The Swazi HTC Core Group should explore in-country options of PCR testing, which may include collaborating with international or regional groups, such as Baylor College of Medicine, which can help accelerate HIV testing for infants and children in Swaziland.

Referral and Linkages

Approaches to Strengthening the Referral System

Strengthening the referral system from the HBTC intervention onward is necessary to ensure that those diagnosed at home receive appropriate care and treatment. The clinics within the pilot sites are not currently initiating patients on ART. Clients who need ART must be referred to the Mbabane Government hospital, which further complicates the linkage and access to care and treatment.

Although it was agreed that the HBHTC counselors will have a referral guide with them in the field, additional strategies may include instituting follow-up systems (e.g., by expert clients or community-based care workers); decentralizing HIV care, particularly ART initiation; distributing information flyers about where to seek care; forming local PLWH support groups; and assisting patients with transportation costs to ensure referral is completed.

Decentralization of Antiretroviral Therapy

As HBHTC identifies more clients living with HIV in need of treatment, it is important to consider the need to decongest the main referral hospital and to decentralize ART provision to peripheral and lower-level health units. Task-shifting, especially for initiating clients onto ART, might be considered to help reduce the human resource gaps currently experienced at health facilities nationwide.

Waste Disposal and Management

Home-based HIV Testing and Counseling Waste

In the field, counselors are equipped with sharps containers and bags for waste that is to be collected and deposited at the supporting health facilities. It is critical that all biomedical waste generated from the HBHTC program is disposed of safely according to recommended universal practices. Swaziland may consider building incinerators at the health facilities to handle the waste disposal from the HBHTC program.

Supportive Supervision

Supportive Supervision

If one is to ensure quality service delivery in the homes, supportive supervision needs to be instituted for the HBHTC counselors. One option is to have both a counseling supervisor and a laboratory supervisor (technically competent) at each pilot site. Another option is a telephone hotline that counselors can call to assist with troubleshooting while in the field.

Ways to Ensure Security

If one is to minimize risks, especially for the female counselors, it is recommended that the HBHTC counselors work in pairs. Working in pairs will encourage teamwork, especially when faced with challenging situations.

Prevention of Counselor Burnout

Given the high prevalence of HIV in Swaziland, HBHTC counselors will likely face stress and burnout. SNAP may consider actively engaging the Swazi Wellness Unit to provide “care for the care-giver (health workers)” package to prevent counselor burnout. Daily debriefing sessions using standardized criteria and group therapy by a counseling psychologist are recommended. However, setting realistic daily HBHTC targets for the counselors will also help prevent burnout.

Monitoring and Evaluation

Home-based HIV Testing and Counseling Monitoring and Evaluation

Establishing a strong monitoring and evaluation (M&E) system that effectively tracks HBHTC services from the community level to the national level is needed. The M&E system will assist with tracking progress made, as well as with program planning, budgeting, and forecasting human and financial resources. A few illustrative M&E indicators for HBHTC include the following:

- Number of individuals tested, disaggregated by gender
- Percentage of persons who test as living with HIV

- Number of couples tested (this needs to be defined carefully, given the prevalence of polygamy)
- Percentage of discordant couples among those tested
- Number of repeat testers
- Number of referrals made for various services (disaggregated)
- Number of completed referrals

Counselor Performance

How a counselor's performance will be measured should be considered in the M&E and supervision design. The field trials showed, for example, that several households received education on HIV but refused testing. The HTC Core Group may consider using the following measures of counselor performance: the number of households visited per day, the number of people educated about HIV, or the number of people counseled and tested.

Clear Reporting Strategy

A clearly defined reporting strategy should be developed to ensure completeness of records, adequate storage of data, and retrieval and timely reporting of HBHTC data. An HBHTC focal person who is based at the clinic in the pilot sites can be charged with the responsibility of ensuring completeness of data from the field and in data entry.

Documentation of Different Home-based HIV Testing and Counseling Experiences

Because the pilot HBHTC project will be implemented in two unique communities, clear and specific documentation of the experiences and the lessons learned from each community is essential. Documenting the experiences and lessons learned will be critical to determining scale-up in various settings in Swaziland. Consequently, different variations or adaptations of HBHTC might be adopted for different communities across the country.

Involvement of People Living with HIV

It is essential to strengthen the involvement of PLWH in the planning, implementing (including in community mobilizations), and monitoring of HBHTC activities in order to help challenge stigma and discrimination and in advocating for universal access to HTC, care, treatment, and impact mitigation. PLWH can provide invaluable services as expert clients and can assist with treatment adherence, community mobilization, and support groups, to name just a few examples.

Partnerships

Expanding Home-based HIV Testing and Counseling Support

If HBHTC expands and is scaled-up in Swaziland, more partners should be identified and trained. Potential partners may include traditional leaders, religious leaders, youth groups, PLWH support groups, and civil society organizations.

Financial Aspects

Home-based HIV Testing and Counseling Costs

It is essential to monitor the costs of HBHTC through the pilot and calculate inputs. To

determine feasibility of national scale-up, one must consider cost-effectiveness. The HTC Core Group will need to consider how this expense shall be defined (e.g., as cost per person living with HIV identified, or by cost per person tested).

Use of Forecasting

If one uses the pilot project experience, forecasting of the financial requirements for scale-up of HBHTC nationally will be possible.

Resource Mobilization

Funding sources will need to be identified to help sustain HBHTC and to ensure links to care and treatment.

Home-Based HIV Testing and Counseling Training and Trial Run

For the Swaziland HBHTC pilot project to be launched, the HTC Core Group required a team of qualified trainers to provide the necessary training of counselors. In preparation for the HBHTC training, AIDSTAR-One and the S2S Consultants met on July 9, 2010, with the HTC Core Group and two USAID/Washington representatives (see Appendix D for a complete list of participants). During the meeting, the following activities were accomplished:

- Consensus was reached on the contents of the HBHTC training manual, and the training agenda was revised to ensure that all priority topics were included.
- The following documents were revised: counseling cue cards, data collection, QA tools, and the HBHTC SOP for the HBHTC pilot program.

On July 12–19, 2010, the S2S Consultants conducted HBHTC training at the request of the HTC Core Group in preparation for the HBHTC pilot project. The training, conducted in Ezulweni, Swaziland, consisted of five days of classroom training and two days of practicum in the field, as follows:

- A total of 34 trainees (all former VCT counselors; 3 males and 31 females) participated in the training. This number included 14 nurse counselors who work in health units where the HBHTC pilot project will take place and 20 counselors who will participate in the HBHTC pilot project.
- Although all of the trainees participated in the classroom portion, only the 20 pilot project counselors participated in the practicum. A detailed summary of the training can be found in *Summary Evaluation of Swaziland HBHTC Training*.

Home-based HIV Testing and Counseling Training Recommendations

Recommendations from AIDSTAR-One and the S2S Consultants (the training team) stemming from the HBHTC training experience include the following:

- *Address HIV knowledge gaps:* So participants can address the significant gaps in basic HIV knowledge identified during the training course, a refresher course should be conducted for the HBHTC counselors in the following key areas:

- Basic knowledge of HIV
 - Counseling for ART
 - PMTCT
 - Nutrition for PLWH
 - Family planning.
- *Provide additional counseling skills:* HBHTC counselors will require further training on counseling children and adolescents for HIV testing, because those populations constitute a large percentage of household members, and child counseling is a new area for most counselors.
 - *Develop a HBHTC trainer's manual for Swaziland:* Once the HBHTC participant manual has been revised, the HBHTC trainer's manual must be developed and must include training tools and teaching aids.
 - *Conduct HBHTC training of master trainers:* If the HBHTC pilot project is successful and if HBHTC is deemed an appropriate strategy for scale-up in Swaziland, a training of master trainers on HBHTC will need to be conducted. A full discussion of this approach can be found in *Swaziland HBHTC Training Strategy*.

Home-based HIV Testing and Counseling Field Practicum and Trial Run

As a part of the HBHTC training, a field practicum was conducted at two different sites: Mahwalala in Mbabane East Inkundhla (peri-urban community) and Sigangeni in Motshane Inkundhla (rural community), two communities that will participate in the HBHTC pilot project. The purpose of selecting two communities was to compare the feasibility and applicability of HBHTC principles between rural and peri-urban settings. Subsequently, a one-day trial run of actual HBHTC implementation of the pilot project was conducted on July 20, 2010, at Sigangeni. Detailed findings from the field practicum can be found in the document titled *Summary Comments on HBHTC Field Practicum and Trial Run*.

Strategies for Optimizing Home-based HIV Testing and Counseling Implementation

Based on the HBHTC field trials, AIDSTAR-One and the S2S consultants met with the HTC Core Group to discuss strategies for streamlining HBHTC implementation issues that arose from the practicum and trial run. The issues and follow-up actions listed below were identified:

- *Consolidation of HBHTC tools:* The HTC Core Group will revise and consolidate data collection tools to reduce the paperwork used by counselors while in households.
- *Orientation of HBHTC counselors:* A one-day orientation workshop was conducted by the AIDSTAR-One consultants for HBHTC counselors to address gaps identified during the trial run. The orientation included DBS sample collection, tuberculosis (TB) screening, infection control, and care for the counselors. Counselors were also briefed about allocation of pilot sites to each counselor.

- *Operationalization visits to clinics:* The HTC Core Group and the S2S consultants made program operationalization visits to the Sigangeni and Motshane clinics. The team met with clinic staff members, expert clients, adherence counselors, and rural health motivators (RHMs) and discussed key issues including clarifying the HBHTC program, the role of each stakeholder, client flow, waste management plans, and overall implementation plans.
- *HBHTC sensitization:* The S2S consultants sensitized RHMs, clinic staff members, and expert clients at the Sigangeni and Motshane clinics about the HBHTC pilot program and the expected roles of RHMs.
- *Counseling cue cards:* Cards were laminated and fastened together to make them easier for counselors to use. Also, the list of supplies and requirements for the HBHTC field visit was attached to the cue cards as a reminder for counselors.
- *HBHTC implementation concept paper:* Revisions were made to the concept paper on the basis of issues identified during the field trials.

Recommendations for Home-based HIV Testing and Counseling Resources and Tools

Swaziland HBHTC tools were revised on the basis of the field experiences to ensure relevance and applicability and to reduce the number of tools a counselor must complete. Swaziland has decided that it will incorporate HBHTC into the national HTC data tools instead of creating new HBHTC forms. The tools reviewed included the following:

1. Swaziland HTC client intake form
2. HBHTC reporting form
3. Referral form
4. TB screening form
5. Household profile for HBHTC
6. Swaziland HBHTC session QA guide for supervisors
7. Assessment of HBHTC quality of services.

Detailed recommendations on each tool may be found in *Summary Recommendations for HBHTC Data Collection Tools*.

The HBHTC training curriculum was revised on the basis of issues identified during the HBHTC pilot training and field practicum. The recommendations and revisions made can be found in *Summary Comments on HBHTC Training Participant Manual*.

Revisions were made to the HBHTC SOPs to include QA and child counseling guidelines, and the revisions were provided to the HTC Core Group. (The revised SOPs can be found in the *Revised HBHTC Training Participant's Manual with Tracked Changes*.)

Laboratory Quality Assurance

Various issues regarding QA, particularly regarding HIV testing, were raised both before and after the HBHTC field trials. Two separate meetings were held on July 13 and July 21 with AIDSTAR-One, the S2S consultants, the NRL, and HTC Core Group to identify issues and solutions. An attendance list can be found in Appendix D.

Current laboratory QA issues include the following:

- QA and QC issues are currently being discussed nationally; SOPs and protocols are not finalized.
- Proficiency testing is not feasible because of human resource constraints; however, conducting proficiency testing two times per year is being considered.
- How blood samples are drawn for rapid test varies across the country (some sites draw whole blood while others draw venous blood).
- Supervision by the NRL is not currently feasible because of gaps in NRL human resources.
- Swaziland needs to develop an HIV rapid testing operating procedure and QA strategy. AIDSTAR-One obtained those documents from Uganda and provided the documents to Phumzile Mndzebele, HTC Coordinator, SNAP/MOH, for adaptation and use in HBHTC roll-out.

The NRL, in light of the significant human resource constraints, agreed that the following QA measures could be guaranteed for the sites implementing the HBHTC pilot:

1. Daily internal controls for each batch of rapid test kits before used by counselors in field
2. Taking DBS samples and retesting at NRL.

From those discussions, a schedule specifying responsible individuals was developed to guarantee timely resolution before the HBHTC launch. The following necessary actions were identified:

- Ensure that the DBS samples do not get contaminated in the field.
- Ensure logistics are in place to ensure a constant supply of rapid test kits and DBS sample collection.
- Ensure that the counselors have adequate training and skills to collect blood samples by using a DBS, and ensure infection control.
- Ensure that quality test kits focus on transportation, storage, expiry date, lot numbers, and manufacturing instructions.
- Ensure counselor supervision of both quality counseling and testing.
- Ensure that field logistics include portable sharps containers and work surfaces (e.g., flat boards) to enhance proper disposal of waste and prevent contamination.
- Include the list of minimum field requirements for supplies on the laminated HBHTC cue cards for use by the counselors.
- Finalize the mapping strategy, including allocating counselors to specific geographical areas, and provide them with online sourced maps (Google Maps) to assist in the selection of households.

Behavior Change Communication Strategy

AIDSTAR-One and the S2S consultants reviewed the Swaziland National HTC SBCC strategy. This careful review focused on the logical flow of the document, its consistency with other existing Swaziland documentation, its completeness, the key components or variables to be addressed in a SBCC strategy, and the quality of messages proposed for the various audiences. A meeting to share the comments and recommendations was conducted with the SBCC TWG, which included Victoria Masuku (PSI), Phumzile Mndzebele (SNAP), Zandile Lenhle (Elizabeth Glaser Pediatric AIDS Foundation), Lenhle Dube (SNAP), Scelile Zwane (NERCHA), Philile Twala (Swaziland National Network of People Living with HIV/AIDS [SWANNEPHA]), AIDSTAR-One, and the S2S consultants. Suggestions and comments were made within the body of the document, which can be found in *National HTC SBCC Strategy Revised with Track Changes*. A summary of the comments and recommendations for the SBCC strategy is as follows:

Strengths of Social and Behavioral Change Communication Strategy Document

- The background information is well researched and is premised largely on available Swaziland national statistics about HIV.
- The HTC SBCC strategy is consistent with the national HTC guidelines and the HIV strategic plan.
- The SBCC strategy identifies the different audiences that the communication messages should target for the greatest effect.

Recommendations for Social and Behavioral Change Communication Strategy Document

Improvement of flow and consistency: To ensure a logical flow and consistency throughout the document, the following format is suggested:

- Overview of the HIV epidemic in Swaziland
- Background to HTC and rationale
- The communication strategy process
- Theoretical framework
- Behavioral aspects of HTC
- Objectives of HTC
- Objectives of the HTC SBCC strategy
- Conceptual framework
- Identification of audiences
- Audience analyses
- Communication strategies for the different audiences
- Implementation arrangements
- Performance monitoring plan for the HTC SBCC strategy
- References
- Appendices.

Broad Objectives for the SBCC Strategy

The SBCC strategy needs broad goals and objectives. This document outlines the goals and objectives of the HTC program and specific objectives for each phase of the communication strategy. Consider answering this question: “What is the purpose of the SBCC strategy?”

Priorities and Opportunities

In the section where “HTC priorities” are listed, consider including a separate section discussing opportunities. This section could help clarify the priorities and opportunities, which currently are grouped together and create confusion.

Positive Prevention

Positive prevention is important as new HIV infections arise from PLWH. PLWH must play a central role in HTC behavior change communication implementation. Positive prevention should be more thoroughly addressed in this SBCC strategy. Examples of meaningful involvement of PLWH include actively participating in HIV prevention campaigns and peer education and counseling, challenging stigma and discrimination, advocating for the rights of PLWH, and monitoring implementation of responses to HIV.

Prevention of Mother-to-Child HIV Transmission

PMTCT needs to be highlighted to reflect the renewed effort to virtually eliminate this type of HIV transmission. Family planning should also be included as a prevention effort.

Stigma and Discrimination

The efforts being made to address HIV-related stigma and discrimination need to be highlighted. Stigma and discrimination represent a critical barrier to HTC, care, and treatment. Ways to fight stigma and discrimination may include 1) providing opportunities for PLWH to give personal testimonies; 2) promoting public disclosure of serostatus; 3) establishing music, dance, and drama groups for PLWH to educate communities about HIV; 4) providing care and treatment to maintain the well-being of PLWH; and 5) advocating for work-based health rights for PLWH.

Male Involvement

According to the *Draft SBCC Strategy*, the *National HIV Counseling and Testing Policy (2005)*, and the *National HIV Strategic Framework (2009–2014)*, male uptake of HTC services remains very low. Consider exploring strategies that foster male involvement, including couples counseling, weekend and moonlight testing for the working population, male-friendly services, and workplace and mobile testing.

Demand Creation

Efforts to create demand for HTC should not be tied to availability of services. With the high prevalence of HIV in Swaziland, it is critical to roll-out services while simultaneously strengthening the health systems.

Traditional and Cultural Leaders

Involvement of traditional and cultural leaders and religious leaders is not explicitly elaborated in this document. Consider the influence that the Royal Family and chiefdoms wield in their communities. Explore how those leaders can be involved, such as engaging them in SBCC

activities in the community, having leaders participate publicly in HTC, or having leaders participate in messaging that encourages HBHTC.

National Policymakers versus Influential Leaders

When one targets SBCC efforts, national policymakers and influential leaders should be disaggregated as their constituencies and interests may differ. Another recommendation is to develop a comprehensive strategy involving high-level government commitment and a diverse spectrum of community-based participation, including greater involvement by PLWH.

Traditional Healers

Consider what roles traditional healers can play in increasing HTC uptake and SBCC. Traditional healers can be trained to identify cases of HIV and TB and to make appropriate referrals to increase community mobilization for HTC uptake and to provide complementary and alternative therapies for chronic HIV management.

Media

It is important to use various forms of media to deliver continuous and sustained HTC SBCC messages. Effective media strategies should be tailored to the target community and may include radio, theater, billboards, text messaging, print, and community or marketing events with sponsorship (i.e., cell phone company–sponsored event).

Ways to Tailor Messages to Each Audience

An audience analysis should be included. An audience analysis is a description of a targeted audience in terms of 1) demographic profile, social characteristics, and desired and actual behaviors; 2) benefits of the actual and desired behaviors; 3) barriers to attaining the desired behaviors; and 4) key constraints and benefits. Every audience needs its own communication objectives, desired action response, support points/networks, key messages, and communication channels and approaches (see *Draft SBCC Document with Comments* for an illustrative example).

Pediatric Testing

Scaling up of pediatric HIV prevention, care, and treatment was not mentioned in the SBCC strategy. The strategy should clearly spell out how access to and uptake of EID services will be implemented. Consider establishing and equipping laboratories to conduct DNA PCR tests, to mobilize and sensitize pregnant mothers during antenatal care on PMTCT and safer infant feeding, and to publicize the importance of EID.

Confidentiality

Facilitating client-centered care does not necessarily mean that clients' names need to be used for records. Using codes allows for unique client identifiers and helps preserve confidentiality.

Next Steps

As explained in the scope of work, the AIDSTAR-One team is to produce the requested deliverables, which are featured here: 1) trip report and recommendations and 2) HBHTC TA Reports and Deliverables. Once approved by USAID/Washington, the deliverables will be sent to the HTC Core Group and TASO team.

Principal Contacts

Phumzile Mndzebele and Lenhle Dube, SNAP/MOH
Khosi Dlamini, Victoria Masaku, and Landiwe Hlophe, PSI
Jennifer Albertini, USAID Swaziland
Peter Ehrenkranz, PEPFAR Swaziland
Dr. Samson Haumba, Lindiwe Mkhatswa, Sifundo Mkandhla, and Simangaliso Chitunhu, URC

Distribution

Phumzile Mndzebele, Promise Dlamini, and Lenhle Dube, SNAP/MOH (phumtswa@gmail.com, prodlamini@yahoo.com, lenhle@yahoo.com)
Victoria Masaku and Khosi Dlamini, PSI (Victoria@psi.sz, khosi@psi.sz)
Jennifer Albertini, USAID Swaziland (AlbertiniJM@state.gov)
Peter Ehrenkranz, PEPFAR (EhrenkranzPD@state.gov)
Dr. Haumba Samson, Lindiwe Mkhatswa, Sifundo Mkandhla, and Simangaliso Chitunhu, URC (haumbas@urc-sa.com, lindiwem@urc-sa.com, simangalisoc@urc-sa.com, sifundom@urc-sa.com)
Makhosazana Makhanya, CDC /PEPFAR Laboratory Specialist, (MakhanyaMGL@state.gov)
C. Kirk Lazell, Bethany Haberer, Vincent Wong, and Shyami DeSilva, USAID (klazell@usaid.gov, bhaberer@usaid.gov, vwong@usaid.gov, SDeSilva@usaid.gov)
Ed Scholl, Bisola Ojikutu, and Maria Claudia Escobar, AIDSTAR-One (edward_scholl@jsi.com, bisola_ojikutu@jsi.com, mescobar@jsi.com)

References

Central Statistical Office and MEASURE DHS (Macro International). 2007. *Swaziland Demographic and Health Survey 2006-07, Preliminary Report*. Mbabane, Swaziland and Calverton, MD, USA.

Swaziland HBHTC Concept Paper. 2009. (*Internal document*).

Appendix A: Scope of Work

AIDSTAR-One Technical Assistance to Swaziland South-to-South Exchange Home-Based HIV Testing and Counseling Scope of Work June 2, 2010

Background

AIDSTAR-One is a global U.S. Agency for International Development (USAID) contract awarded in 2008 to John Snow, Inc., and partner organizations, including BroadReach Healthcare; EnCompass LLC; GMMB, Inc.; International Center for Research on Women; MAP International; mothers2mothers; Social & Scientific Systems, Inc.; the University of Alabama at Birmingham; The White Ribbon Alliance for Safe Motherhood; and World Education, Inc.

The project's focus is to provide high-quality technical assistance (TA) services to the Office of HIV/AIDS and U.S. Government (USG) country teams. Specifically, AIDSTAR-One will do the following:

- Synthesize, expand, and disseminate a knowledge base of effective program approaches to prevent, provide care for, and treat people living with HIV (PLWH).
- Provide short- and long-term TA to support the implementation of USG-funded HIV programs and activities.
- Increase use of good and promising practices in HIV prevention, care, and treatment among program implementers.
- Improve the quality and sustainability of HIV prevention, care, and treatment programs.

Description

HIV testing and counseling (HTC) is the gateway for clients to access prevention, care and support, and treatment services. As access to treatment has increased, HTC services have expanded in an effort to get more people tested and into needed services. To increase uptake of HTC, different models of delivering HTC services have emerged. Home-based HIV testing and counseling (HBHTC) is an emerging HTC model wherein HTC providers offer counseling and testing services at the client's home. The HBHTC model has been shown to overcome some barriers to HTC and to increase HTC acceptance and the likelihood of receiving HIV test results in resource-constrained settings.

Following a successful HBHTC Technical Consultation Meeting held in Nairobi, Kenya, and organized by AIDSTAR-One in November 2009, at which implementers shared experiences and lessons learned in HBHTC implementation, USAID has requested that AIDSTAR-One facilitate the exchange of TA in support of Swaziland's efforts to pilot HBHTC. This TA will emphasize

south-to-south (S2S) exchange as a mechanism for sharing of expertise and hands-on practical training in HBHTC. Experienced HBHTC partners in Uganda are well placed to provide TA in the start-up and roll-out of Swaziland's HBHTC pilot scheduled to begin in 2010.

Swaziland Home-based HIV Testing and Counseling Pilot Project

The interagency Swaziland HTC Core Group (composed of the Swaziland National AIDS Programme [SNAP], the World Health Organization [WHO]/the Joint U.N. Programme on HIV/AIDS, the U.S. President's Emergency Plan for AIDS Relief/the Centers for Disease Control and Prevention, Population Services International [PSI], Médecins Sans Frontières, Baylor College of Medicine, and University Research Company [URC]) will lead the implementation of a six-month pilot project to determine acceptability and feasibility of HBHTC. The HBHTC project has two components, as follows:

1. **The intervention component.** Following community mobilization and demand creation, trained counselors will visit members of households in two communities and will offer household members HTC services. Two approaches shall be used:
 - a. *Door-to-door HBHTC:* Counselors will visit all the homes in the two communities.
 - b. *Index client HBHTC:* Counselors will visit the homes of PLWH who are receiving care and treatment and will offer HBHTC services to the whole family, by using the index patient as an entry point.

The first phase of the intervention will last for approximately three months, after which the HBHTC team will revisit the same households that received HTC and offer to retest them. This phase will last another three months.

2. **The research component.** The research will be used to determine the feasibility and acceptability of HBHTC service provision in Swaziland and to make strategic recommendations for rolling out HBHTC services in the country. A questionnaire with both closed and semistructured open-ended questions will be administered to members of households to assess their views and perceptions on HBHTC service delivery and to learn about their experiences with HBHTC. HBHTC program implementers will also be interviewed to understand their experiences in offering the services.

Technical Assistance from AIDSTAR-One

The AIDSTAR-One HTC team will facilitate the S2S exchange by using HBHTC experts from The AIDS Support Organisation (TASO)/Uganda to provide TA to SNAP for the implementation of the HBHTC pilot program. The activities to be provided are as follows.

HBHTC Training and Supporting Activities

With guidance from SNAP and USAID, AIDSTAR-One will support HBHTC experts from TASO/Uganda who have extensive experience in implementing HIV prevention, care, and treatment services. AIDSTAR-One will support the cost for travel and TA services of three counselor trainers from TASO to visit Swaziland.

The trainers will provide support for the following activities:

1. Develop a HBHTC training strategy for Swaziland to ensure its in-country capacity.
2. Adapt and revise the HBHTC training curriculum.
The Swaziland HIV CT Core Group has already developed a curriculum based on the TASO curriculum that incorporates the Swazi context.
3. Conduct a pilot HBHTC training for 30 participants.
All participants are previously experienced in voluntary counseling and testing (VCT) and are able to participate in English-language training.
4. Using the lessons learned from the pilot, revise the Swaziland HBHTC training curriculum.
5. Review HTC national social and behavioral communication (mobilization) strategy and provide recommendations.
6. Review data collection tools and provide recommendations.
Research TA is not in the scope of work of AIDSTAR-One and, therefore, will not be a part of this assignment. Recommendations will be provided by the consultants after review of the tools. USAID has provided the Swazi team with the necessary contacts at Project Search if additional assistance with the research protocols and tools is needed.
7. Assist the HBHTC team to prepare for implementation of the pilot HBHTC project, including a trial run of HBHTC service provision in the field and the incorporation of quality assurance (QA) measures.
QA for both the laboratory and counseling must be included in the implementation plan along with involvement of respective in-country counterparts (i.e., Swazi Ministry of Health [MOH] coordinator of laboratory QA).
8. Provide ongoing support and mentoring.

On completion of this training, an informal evaluation will be conducted by the AIDSTAR-One HTC team in collaboration with participants and recipients of the TA to determine whether additional training TA can be provided.

Throughout the assignment, the HBHTC TASO experts are expected to work with the AIDSTAR-ONE HTC team to ensure proper delivery of TA and deliverables that meet the needs of SNAP as well as the terms of reference from AIDSTAR-One.

In accordance with USAID regulations, the TASO consultants must take an authorized leave to complete this consultancy. AIDSTAR-One will require written proof from members of TASO management confirming their agreement to this arrangement with the names of the identified consultants.

Qualifications

The consultants must demonstrate the following:

- Certified HBHTC trainer and master level for training of trainers
- Sound technical knowledge of and experience with HBHTC programs, particularly in the African context
- Knowledge and experience with HTC issues and approaches
- Strong organizational, communication, and interpersonal skills
- Ability to establish and maintain excellent relationships with AIDSTAR-One, consultants and counterparts, training participants, SNAP, and MOH officials
- Ability to work well independently and as part of a team, with limited supervision
- Experience in producing deliverables for USAID
- Fluency in English; capacity to train in English and produce high-quality deliverables in English
- Ability to demonstrate professional and courteous demeanor at all times.

Deliverables

A trip report should be provided that summarizes activities conducted in Swaziland; it should include the following:

- Schedule of activities and visits conducted per day of the visit
- Outcomes of the activities (i.e., revised standard operating procedures; revised HBHTC training curriculum)
- Completion of HBHTC training and summary of training evaluation
- Revised and completed Swazi HBHTC training strategy
- Revised Swazi HBHTC training curriculum
- Recommendations for Swazi national social and behavioral communication (mobilization) strategy
- Recommendations for data collection tools
- Summary comments on HBHTC implementation trial run
- Mentoring plan and suggested follow-up activities with timeline
- List of strategic recommendations for Swaziland's HBHTC program.

Level of Effort Not to exceed 25 days

Timeline

Phase	Activity	Venue	Number of working days	Suggested timeline
Phase 1 Prepilot HBHTC training activities	Provide TA to adapt the HBHTC training resources to Swaziland context			
	○ <i>Activity 1: Review of Swaziland national HIV documents</i>	Kampala	1	June 2010
	○ <i>Activity 2: Conduct technical review of the Swaziland HBHTC training curriculum and teaching aids</i>	Kampala	2	June 2010
	○ <i>Activity 3: Meeting to discuss Swazi context and build consensus on adapted materials</i>	Swaziland	1.5	June 2010
	○ <i>Activity 4: Review and provide recommendations to the Swaziland HTC SBCC (mobilization) strategy</i>	Swaziland	2	June 2010
	○ <i>Activity 5: Develop the Swaziland HBHTC training and scale-up strategy</i>	Swaziland	2	June 2010
Phase 2 Pilot HBHTC training	Conduct pilot HBHTC training in Swaziland for 30 HTC counselors	Swaziland	7	June 2010

Phase 3 Post-training activities	Provide mentorship and coaching to trainees during trial run of HBHTC in field	Swaziland	2.5	July 2010
Phase 4 Reporting	Draft trip report and deliverables (submitted to AIDSTAR-One HTC advisor)	Kampala	2	July 2010
	Final trip report with revisions incorporated (submitted to AIDSTAR-One HTC advisor)	Kampala	1 to 2 days	July 2010
	Provide ongoing support and mentoring <i>Total of three days up to three months following training activity</i>	Kampala	3 days	June– September 2010
	Total days		25 days	

Budgeted Costs

PSI and URC in Swaziland will cover all in-country training costs, including the following:

- Materials, supplies, and photocopying services related to the training
- Training venue and meals provided during the training (lunch/tea)
- Transportation of participants to training venue
- Any per diem paid to participants of the training
- Equipment needed for training (e.g., projector, flipcharts)
- Rapid tests and reagents needed for training and trial run of implementation
- Transport and logistics for field work/trial run of implementation
- Work venue for consultant.

AIDSTAR-One will cover the following costs:

- All international travel costs for consultants for one trip to Swaziland
- Accommodations for consultants
- Per diem for consultants
- In-country travel expenses for consultants
- Medical evacuation insurance for consultants
- Internet and photocopying expenses for consultants
- Consultants' salary as agreed to in contract.

Appendix B: Schedule of Activities

Schedule of Activities and Visits Conducted by AIDSTAR-One Consultants July 8–30, 2010

	Date of Visit	Activity Conducted	Participants Involved
1	July 8	Travel to Swaziland	N/A
2	July 9	Core Group meeting to finalize training manual, itinerary, and training agenda at Population Services International (PSI) offices	Swaziland HIC testing and counseling (HTC) Core Group members, U.S. Agency for International Development (USAID) representatives (Washington), a Centers for Disease Control and Prevention representative, and AIDSTAR-One consultants
3	July 10	Preparation for home-based HIV testing and counseling (HBHTC) pilot training	Consultants and AIDSTAR-One HTC advisor
4	July 11	Introducing HBHTC training and welcoming participants	HTC Core Group, AIDSTAR-One consultants, and HTC advisor
5	July 12	A) HBHTC training B) Courtesy meeting with the Swaziland National Aids Programme (SNAP) program manager	A) AIDSTAR-One consultants; USAID (Washington) representatives B) AIDSTAR-One consultant and HTC advisor; HTC national technical officer
6	July 13	A) HBHTC training B) Courtesy meeting with SNAP quality assurance (QA) coordinator C) Courtesy meeting with the Ministry of Health (MOH) Deputy Director for Public Health D) Meeting with the HTC National Reference Laboratory coordinator on laboratory QA issues for HBHTC	A) AIDSTAR-One consultants B) AIDSTAR-One consultants C) HTC national technical officer, SNAP QA coordinator, PSI director for HTC, AIDSTAR-One consultant and HTC advisor D) AIDSTAR-One consultant and HTC advisor, SNAP QA coordinator, PSI HTC

		E) HBHTC trainer's meeting	director, University Research Company (URC) laboratory personnel E) AIDSTAR-One consultants and HTC advisor, U.S. President's Emergency Plan for AIDS Relief (PEPFAR) coordinator in Swaziland and HTC Core Group members
7	July 14	HBHTC training	AIDSTAR-One consultants
8	July 15	HBHTC training	AIDSTAR-One consultants
9	July 16	A) HBHTC training B) Planning for field practicum	A) AIDSTAR-One consultants B) AIDSTAR-One consultants and HTC advisor; HTC Core Group
10	July 17	HBHTC field practicum, day 1	HTC Core Team, AIDSTAR-One consultants and HTC advisor, HBHTC training participants
11	July 19	Field practicum debriefing HBHTC Field practicum, day 2	AIDSTAR-One consultants, HTC Core Group members, HBHTC trainees
12	July 20	A) HBHTC training official closing B) HBHTC trial run C) Trial run debrief	A and B) SNAP program manager, HTC national coordinator, PSI HTC manager, AIDSTAR-One consultants, HTC Core Group members, HBHTC trainees C) AIDSTAR-One consultants, Core Group members, HBHTC trainees
13	July 21	A) HBHTC update meeting and sharing experiences of the trial run at Elizabeth Glaser Pediatric AIDS Foundation offices B) A meeting to discuss HBHTC quality assurance issues	A) HTC Core Group members, AIDSTAR-One consultants, AIDSTAR-ONE HTC advisor B) HTC Core Group, HTC laboratory team, AIDSTAR-One consultants

14	July 22	Reviewed the Social and Behavioral Change Communication (SBCC) strategy Revision of the HBHTC participants training manual	AIDSTAR-One consultants
15	July 23	Review of data collection tools Develop the HBHTC training strategy Review implementation strategy	AIDSTAR-One consultants
16	July 24	Working on drafts of deliverables	AIDSTAR-One consultants
17	July 26	A) Revision of HBHTC implementation plan and concept paper B) Review of data collection tools C) Meeting to share lessons on provider-initiated HIV testing and counseling implementation in Uganda	A and B) AIDSTAR-One consultants C) URC HTC technical officer and AIDSTAR-One consultants
18	July 27	A) Sensitization of rural health motivators from Sigangeni and Motshane about their role in the HBHTC pilot implementation B) Facility site operational meetings with clinic staff members from HBHTC pilot sites to mobilize and plan for the HBHTC pilot roll-out	A) HTC Core Group members and AIDSTAR-One consultants B) Clinic staff, expert clients, HTC Core Group members, AIDSTAR-One consultants
19	July 28	A) Refresher orientation of HBHTC counselors prior to launch of HBHTC pilot implementation on tuberculosis screening, universal precautions, post-exposure prophylaxis, and dry blood spot sample collection B) HTC Core Group feedback meeting	A) HBHTC counselors, AIDSTAR-One consultants, HTC Core Group members B) HTC Core Group members, AIDSTAR-One consultants
20	July 29	A) SBCC strategy to discuss and provide recommendations on the SBCC strategy and its operationalization; sharing of Ugandan experiences on the	A) SBCC technical working group members, AIDSTAR-One consultants

		<p>involvement of key target audiences and the applicability to the Swazi setting</p> <p>B) South-to-South TA trip debriefing</p> <p>C) Feedback meeting with PEPFAR Swaziland representative</p> <p>D) Meeting with SWANNEPHA representatives to share experiences on positive prevention and the role people living with HIV groups play in advocating for their rights and responsibilities</p>	<p>B) HTC Core Group members, PEPFAR representative, U.N. representative, MOH Deputy Director for Public Health, Swaziland National Network of People Living with HIV/AIDS (SWANNEPHA) representatives, AIDSTAR-One consultants</p> <p>C) PEPFAR Swaziland and AIDSTAR-One consultants</p> <p>D) SWANNEPHA and AIDSTAR-One Consultants</p>
21	July 30	Departure from and travel to Kampala	N/A

Appendix C: Summary of Meetings

Ministry of Health

A meeting was held with Rejoice Nkambule, Deputy Director of Public Health, Ministry of Health (MOH); Maria Claudia Escobar; Teddy Chimulwa, AIDSTAR-One; and HTC Core Group members Lenhle Dube (MOH), Victoria Masuku (Population Services International [PSI]), and Thembisile Dlamini (Swaziland National AIDS Programme [SNAP]). Key points from the meeting included the following:

- The deputy director emphasized the need for the door-to-door approach because it has not been done before. She cautioned the Core Group to ensure involvement of community leaders at all levels, including the MOH.
- The consultants were asked to compare the different settings for home-based HIV testing and counseling (HBHTC) in Swaziland, both rural and peri-urban.
- The consultants should become familiar with the Humana “People-to-People” Model for HBHTC. Swaziland initially was interested in the Humana model and aims to understand comparisons to that model in terms of cost-effectiveness, applicability, sustainability, replication, and appropriateness.
- The consultants need to have a national outlook on their tasks because all programs are government-led. The documents that will be produced shall be used nationally.
- Regarding provider-initiated testing and counseling (PITC), while progress has been made with acceptance of PITC by providers, further advocacy and capacity building are needed to ensure integration of PITC services into the health facilities. The consultants were asked to share the Ugandan experience of PITC.

Male Circumcision

Maria Claudia Escobar (AIDSTAR-One) visited PSI’s male circumcision (MC) center of excellence to understand the current provision of services and PITC. Key points from the visit include the following:

- PSI services include providing direct clinical MC services, enhancing outreach, and assisting the public sector with MC. PSI has performed approximately 10,000 circumcisions.
- Concerning recruitment of clients, PSI discovered that it was difficult to attract clients to the center. The staff consists of recruiters in the community whose target is to reach 15 clients interested in MC per day; this information is given to the PSI clinic staff members, who then contact the client to book an appointment.
- PSI is currently implementing a campaign targeting male youths, ages 13 and up, during their vacation time from school
- HIV testing information is provided and offered, although not strictly through PITC. Uptake of testing is approximately 80 percent. If a patient refuses to be tested for HIV, the patient is referred to an escalating chain of providers who will discuss testing.
- Less than 5 percent of patients are detected as living with HIV, likely because the

majority of male clients at the clinic are young.

- Concerning minimal adverse events, most complications have been seen with volunteers who have been brought from other countries to perform MC in Swaziland.
- PSI provides a two-day in-service training for volunteers performing MC in Swaziland.
- PSI is exploring implementation of neonatal circumcision.

Provider-Initiated Testing and Counseling

A meeting was held with Lindiwe Mhkatswa, the HIV testing and counseling (HTC) technical officer at University Research Company (URC), to discuss Uganda's experiences with PITC. One of URC's mandates in Swaziland is to support the scale-up of PITC in health facilities across the country. However, challenges were faced, particularly the reluctance by health workers to provide HTC services as part of routine health care. The following is a summary of the highlights of this meeting concerning the Ugandan experience of PITC.

Making PITC Routine

Offering HIV testing routinely cuts across all departments, specialties, and clinics within the facility and ensures the 3Cs of testing (consent, confidentiality, counseling), per WHO guidelines. However, making testing routine is implemented only in tuberculosis (TB) and antenatal care (ANC)/prevention of mother-to-child transmission clinics and is supported by national policy guidelines.

Counseling

- All health workers (e.g., nurses, midwives, clinicians, doctors, laboratory technicians) are trained to offer PITC services as part of the integrated health services. Hence, counseling is done by all at different stages. Group pre-test counseling is done for patients and care givers in the outpatient department, ANC, TB, and in-patient wards, and so forth. Then individual post-test sessions are conducted for individuals and couples by respective cadres.
- Group counseling is conducted from the waiting area while individual counseling is done in consultation rooms. For bedridden patients, counseling may be done at the bedside, with screens around the patient's bed, which may compromise confidentiality. However, health workers are always encouraged to innovate and to ensure confidentiality. Some health units have renovated the clinics to include counseling rooms.
- All medical records are confidential and remain the property of the government, irrespective of the HIV status of the patient. However, each unit maintains records of those tested by using a national register. Unit records are then aggregated at the end of the month by the monitoring and evaluation department through the national health management information system (HMIS).
- Tools used include the national HTC card (filled in for each client counseled and tested), which is used for all models of HTC. Data collected using this tool is then entered into the HMIS. To triangulate the data for PITC, a national HTC register is maintained manually at each service site. No specific counseling data are maintained, because there are no routine counseling services in the public health facilities. Patients that test positive for HIV may be referred to specialized counseling centers

available and within reach of the patient for further psychological support.

HIV Testing

- Testing is conducted by the nurse, doctor, or laboratory technician, depending on who initiates the test to the patient. Testing is recommended to be done at the point of care or ward. Specific health units are engaged to evaluate the feasibility of conducting the test at all points of care. What has worked is the phased approach to introducing testing at the points of care. The laboratory retains the supervision and quality assurance role throughout the facility.
- As to the choice of sample, the finger prick is used for rapid HIV testing at the points of care.
- For identification of the patient, names of the patients are recorded at the registration desk and are assigned unique identifier numbers in the register. All samples and results shall bear the identifier numbers.
- Laboratory supplies and logistics procurement is done centrally by MOH through the National Medical Stores (NMS) following the public procurement and disposal guidelines. Health facilities order from NMS according to need, NMS deliver to health facilities, and laboratory technologists order from the facility stores and replenish the points of care.

Clinical Care

- The nurses refer patients living with HIV to the clinicians for pre-antiretroviral therapy (ART) care and ART initiation and to expert clients for psychosocial peer support.
- However, support provided by expert clients is not adequate because they are not competently trained to offer psychosocial counseling. Hence, clients are sometimes referred to specialized counseling centers.

In addition, Maria Claudia Escobar discussed the situation of PITC in Swaziland with Jason Reed (Centers for Disease Control and Prevention/Atlanta). Key points from the discussion include the following:

- PITC is being implemented consistently in Swaziland. If a patient refuses to test, the patient must attend a series of meetings with various providers (e.g., counselor, nurse, doctor, and surgeon) who will try to understand the patient's reason for refusal.
- Uptake of testing is high, particularly in areas where people have been educated as to why PITC is a more efficient approach than voluntary counseling and testing.
- Most places offering MC are providing HIV testing at point of care and know that it should be PITC.

Mobile Clinical and HIV Services

Maria Claudia Escobar (AIDSTAR-One) conducted a site visit of the mobile services provided by the Luke Commission (www.lukecommission.org), a Christian medical mission providing services, including HIV testing, to remote areas in Swaziland. Important points include the following:

- Outreach medical services were provided in communities where there are no health services are present; these mobile services provide care to approximately 8,000 patients per year.
- Services provided include cataract screening, provision of eyeglasses, glucose screening, HIV testing for children and adults, and referral for ART, medical, and surgical services.
- Uptake of HIV testing is high. The director attributes this level to the fact that rural residents trust this nongovernmental organization (NGO) because it has been providing services for several years in Swaziland; the NGO also provides eyeglasses at these mobile clinics, which is a highly valued service that makes an easy buy-in to other provided services, including HIV testing.
- The Luke Commission, which is partnering with PSI, collects client information for those interested in MC, and follow-up is then conducted by PSI.

U.S. Agency for International Development

A meeting was held with Jennifer Albertini (U.S. Agency for International Development [USAID] Swaziland). Key points from the discussion include the following:

- Assessments or evaluations of programs (e.g., PITC) are not appropriate at this time, because programs are not at a mature stage.
- People welcomed AIDSTAR-One's assistance with roll-out and scale-up of HBHTC.
- People suggested that they should approach the MOH to determine the technical assistance (TA) needs that AIDSTAR-One could address.

Technical Assistance Needs

The meetings and discussions with Victoria Masuku (PSI) and Promise Dlamini (SNAP, acting coordinator) revealed the following TA needs:

- HBHTC training of trainers (TOT)
- Couples testing and counseling (CTC), TOT, and adaptation of CTC in a polygamous context and integration into HBHTC
- Interest in using expertise of Project San Francisco (Rwanda/Zambia)
- Integration of various HTC strategies into one HTC national training curriculum
- Decentralization of Wellness Center Services or care and support of health care workers
- PITC implementation assistance

Technical Assistance Exit Reporting

Before the departure of the AIDSTAR-One consultants, Rejoice Nkambule, the Deputy Director of Public Health, convened a meeting to enable AIDSTAR-One consultants to provide feedback about the TA process and outputs. The meeting was attended by representatives from U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the United Nations, HTC stakeholders, HTC Core Group members, and people living with HIV. A presentation was made

describing the AIDSTAR-One consultants' scope of work, the TA process, the outputs as of July 29, 2010, and the issues that still required attention and overall strategic recommendations for the HBHTC program in Swaziland. Important points included:

- PEPFAR Coordinator Peter Ehrenkranz was impressed with the work that had been done thus far in preparing for HBHTC program implementation and pledged continued support.
- As Deputy Director for Public Health, Ms. Rejoice Nkambule expressed satisfaction with AIDSTAR-One consultants' work and thanked both USAID and AIDSTAR-One for facilitating the process.
- Recommendations included the following:
 - HTC Core Group needs to develop a clear document indicating next steps that will be based on the TA and inputs from the consultants.
 - Trained HBHTC counselors need to be certified by the National Reference Laboratory (NRL) to conduct rapid tests to preserve high-quality services.
 - Partners need to adequately prepare health units in pilot sites and to plan for specific reporting per clinic.
 - People need to arrange for transportation of samples from the field by the NRL.
 - People should consider costing issues implicated in the HBHTC pilot.

Appendix D: Attendance Lists

Attendance List: HIV Testing and Counseling Core Group Meeting and AIDSTAR-One July 9, 2010 Mbabane

	Name	Organization	email
1	Bethany Haberer	U.S. Agency for International Development (USAID), Washington	bhaberer@usaid.gov
2	Victoria Masaku	Population Services International (PSI)	victoria@psi.sz
3	Annie Mpiima	The AIDS Support Organisation (TASO)/AIDSTAR-One	ampiima@yahoo.co.uk mpiimaa@tasouganda.org
4	Kenneth Mugisha	TASO/AIDSTAR-One	mugishak@tasouganda.org kengmug@yahoo.com
5	Teddy Chimulwa	TASO/AIDSTAR-One	chimulwat@tasouganda.org chinted@yahoo.com
6	Mukhosazana Dlamini	PSI	khosi@psi.sz
7	Lindiwe Mkhathshwa	University Research Company (URC)	lindiwem@urc-sa.com
8	Lenhle Nsibandze	Swaziland National AIDS Programme (SNAP)	lenhle@yahoo.com
9	Sifundo Mkandhla	URC	sifundomkandhla@yahoo.com sifundom@urc-sa.com
10	Landiwe Hlople	PSI	Landiwe@psi.sz
11	Scelile Zwane	National Emergency Response Council for HIV and AIDS (NERCHA)	Scelilez@nercha.org.sz
12	C. Kirk Lazell	USAID	klazel@usaid.gov

**Attendance List: Laboratory Quality Assurance Meeting
July 13, 2010
Bethel Courts, Ezulweni**

	Name	Organization
1	Dumile Sibanze	National Reference Laboratory HIV Testing and Counseling focal person
2	Scelile Zwane	NERCHA
3	Sifundo Mkandhla	URC
4	Lenhle Dube	SNAP, Ministry of Health (MOH)
5	Maria Claudia Escobar	AIDSTAR-One
6	Thembisile Dlamini	SNAP Quality Assurance Coordinator
7	Dr. Kenneth Mugisha	AIDSTAR-One consultant
8	Khosi Dlamini	PSI
9	Simangaliso Chitunhu	URC

**Attendance List: Home-based HIV Testing and Counseling
Debriefing Meeting
July 21, 2010
Elizabeth Glaser Pediatric AIDS Foundation Offices, Mbabane**

	Name	Organization
1	Promise Dlamini	SNAP, MOH
2	Victoria Masuku	PSI
3	Dr. Joris	International Center for AIDS Care and Treatment Programs
4	Lindiwe Dlamini	URC
5	Sifundo Mkandhla	URC
6	Lenhle Dube	SNAP, MOH
7	Zandile Lenhle	Elizabeth Glaser Pediatric AIDS Foundation
8	Sipho Dlamini	Swaziland National Network of People Living with HIV/AIDS (SWANNEPHA)
9	Regional Psychologist	SNAP, MOH
10	Maria Claudia Escobar	AIDSTAR-One
11	Teddy Chimulwa	AIDSTAR-One consultant
12	Dr. Kenneth Mugisha	AIDSTAR-One consultant
13	Annie Mpiima	AIDSTAR-One consultant
14	Landiwe Hlophe	PSI
15	Tengetile K	PSI
16	Fexon Ncub	Médecins Sans Frontières

Attendance List: Home-based HIV Testing and Counseling Quality Assurance Meeting
July 21, 2010
University Research Company Offices, Mbabane

	Name	Organization
1	Promise Dlamini	SNAP, MOH
2	Lindiwe Dlamini	URC
3	Sifundo Mkandhla	URC
4	Lenhle Dube	SNAP, MOH
5	Dr. Samson Haumba	URC
6	Teddy Chimulwa	AIDSTAR-One consultant
7	Dr. Kenneth Mugisha	AIDSTAR-One consultant
8	Annie Mpiima	AIDSTAR-One consultant
9	Landiwe Hlophe	PSI
10	Tengetile K	PSI
11	Simangaliso Chitunhu	URC

**Attendance List: TA Exit Debriefing
July 29, 2010
University Research Company Offices, Mbabane**

	Name	Organization
1	Phumzile Mndzebele	SNAP, MOH
2	Lindiwe Mthatshwe	URC
3	Sifundo Mkandhla	URC
4	Lenhle Dube	SNAP, MOH
5	Dr. Samson Haumba	URC
6	Teddy Chimulwa	AIDSTAR-One consultant
7	Dr. Kenneth Mugisha	AIDSTAR-One consultant
8	Annie Mpiima	AIDSTAR-One consultant
9	Victoria Masuku	PSI
10	Scelile Zwane	NERCHA
11	Peter Ehrenkranz	U.S. President's Emergency Plan for AIDS Relief (PEPFAR)
12	Andrew Auld	Centers for Disease Control and Prevention/PEPFAR
13	Sipho Dlamini	SWANNEPHA
14	Philile Thwala	SWANNEPHA
15	Rejoice Nkambule	MOH—Headquarters
16	Thembisile Dlamini	UNAIDS
17	Thembi Dlamini	NERCHA
18	Thembe Dlamini	SNAP
19	Teni Litty	Baylor College of Medicine

SUMMARY EVALUATION OF SWAZILAND HBHTC TRAINING

Summary Evaluation of Swaziland HBHTC Training



*Swaziland HBHTC trainees and HTC Core and AIDSTAR-One teams
Photo courtesy of Teddy Chimulwa*

Introduction

On July 12–19, 2010, AIDSTAR-One consultants conducted training on home-based HIV testing and counseling (HBHTC) at the request of the Swaziland HIV Testing and Counseling (HTC) Core Group, in preparation for the HBHTC pilot project. The training was conducted in Ezulweni, Swaziland, and consisted of five days of classroom training and two days of practicum in the field. This document summarizes the results from the pre- and post-tests and the evaluation completed by participants. The following information may be found in the attached annexes:

- Annex 1. List of HBHTC Training Participants
- Annex 2. HBHTC Training Agenda
- Annex 3. HBHTC Pre- and Post-Test and Evaluation
- Annex 4. HBHTC Trainee Pre- and Post-Test Scores

Trainees

A total of 34 trainees (3 males and 31 females) participated in the training. This number included 14 nurse counselors who work in health units where the HBHTC pilot project will take place and 20 counselors who are to take part in the HBHTC pilot project. Although all of the trainees

participated in the classroom portion, only the 20 pilot project counselors participated in the practicum and completed the pre- and post-tests and the final evaluation.

In the final course evaluation, participants identified their level of experience. Of the 20 pilot project trainees, 85 percent stated they did not have experience in HBHTC, although they did have voluntary counseling and training (VCT) experience. Of the remainder, 5 percent were experienced at providing HBHTC, 5 percent had limited HBHTC experience, and 5 percent did not have experience in VCT or HBHTC.

Evaluation Methodology

Before commencement of the training, a pre-test was administered to the trainees to assess their level of knowledge about key content areas for HBHTC. The tool contained questions on the following: (a) general HIV epidemiology basic facts and (b) transmission, diagnosis, prevention, care and treatment, and HBHTC methodologies. At the end of the training, the same tool was administered as a post-test to gauge the level of knowledge acquisition.

Daily evaluations were carried out to evaluate participants' comprehension and appreciation of topics covered. The few challenges that trainees expressed were handled when participants reviewed the material they had learned on the previous day. An end-of-course evaluation tool was administered that required participants to respond to questions that referred to their skills, knowledge, and competencies before and after the training. The results are summarized as follows:

Pre-and Post-Test Results

On average, more than 65 percent of the participants showed a clear improvement in performance, with a variance of 20 percent and above, between the pre-test and the post-test results. The lowest mark on the pre-test was 37 percent, while the highest was 66 percent; the lowest mark on the post-test results was 59 percent, while the highest was 91 percent. Participants performed best on the post-test in topics covering discordant couple counseling, community mobilization, postexposure prophylaxis (PEP), and the HIV Testing Algorithm. Knowledge gaps were identified in various topical areas in the pre-test, including the following:

- Basic knowledge of HIV/AIDS immunology
- Window period
- Modes of transmission
- Universal precautions
- PEP
- Prevention of Mother-to-Child Transmission (PMTCT)
- Benefits of HBHTC for individual and couples
- HIV testing algorithm
- Child and adolescent counseling and testing.

Evaluation Results

Participants were asked to assess their ability to conduct HBHTC activities. Among the trainees, 61 percent felt capable of providing HBHTC activities before training; this number grew to 99 percent of participants who felt capable after training. Regarding rapid HIV testing, only 28 percent of the trainees stated they were skilled in conducting rapid HIV testing. After training, 95 percent agreed that they could conduct rapid testing in HBHTC.

Regarding the training methodologies used, 99 percent of participants agreed that the teaching methods were effective in enhancing skills and knowledge acquisition of HBHTC. Participants overwhelmingly agreed that the course content was well-organized and relevant to participants' needs and that the facilitators were well-prepared and receptive during the training course.



*HBHTC trainees practicing rapid testing.
Photo courtesy of Maria Claudia Escobar*

Facilitators' Recommendations

Although a comprehensive set of recommendations can be found in *Strategic Recommendations for HBHTC in Swaziland*, the following recommendations stem from the HBHTC training experience:

- *Addressing HIV Knowledge Gaps:* If one is to address the significant gaps in basic HIV/AIDS knowledge that were identified during the training course, a refresher course should be conducted for the HBHTC counselors in these key areas:
 - Basic knowledge of HIV/AIDS
 - Counseling for antiretroviral therapy (ART)
 - PMTCT
 - Nutrition for people living with HIV
 - Family planning.

- *Providing Additional Counseling Skills:* HBHTC counselors will require further training on counseling children and adolescents for HIV testing because those populations constitute a large percentage of household members, and childcounseling is a new area for most counselors.

- *Developing a HBHTC Trainer’s Manual for Swaziland:* Once the HBHTC participant manual has been revised, the HBHTC trainer’s manual must be developed and include training tools and teaching aids.

- *Conducting HBHTC Training of Master Trainers:* If the HBHTC pilot project is successful, and HBHTC is deemed an appropriate strategy for scale-up in Swaziland, a “Training of Master Trainers on HBHTC” will need to be conducted. A full discussion of this approach can be found in *Swaziland HBHTC Training Strategy*.

Annex 1: List of HBHTC Training Participants

	Name	Sex	Organization/Health Unit
1.	Gudu Nxumalo	F	PSI
2.	Muntuza Chamkile Mavimbela	F	PSI
3.	Dumisile Dube	F	PSI
4.	Bonsile Nsibandze	F	PSI
5.	Nkosing'phile Tsabedze	F	PSI
6.	Dlamini Khetsiwe	F	PSI
7.	Ntombifuthi R. Nhlengetfwa	F	PSI
8.	Jabu Maseko	F	PSI
9.	Ignecia Dlamini	F	PSI
10.	S'phesihle Zwane	M	PSI
11.	Sithembile Ngwenya	F	PSI
12.	Hlonphile Ngomane	F	PSI
13.	Francis Fruhwirth	F	PSI
14.	Lilly Masuku	F	PSI
15.	Fisiwe Portia Sukati	F	PSI
16.	Xolile Dlamini	F	PSI
17.	Lindelwa Maphanga	F	PSI
18.	Thabiso Colani Fakudze	M	PSI
19.	Nelsiwe Maigirl Dlamini	F	PSI
20.	Ncamsile Skhanyiso Dlamini	F	PSI
21.	Prudence Zanele Mklabela	F	Sigombeni Red Cross Clinic
22.	Thandwa Dlamini	F	TB Centre
23.	Zandile Vilakati	F	Mahwalala Red Cross Clinic
24.	Sibongukusa Shava	F	Salvation Army

25.	Siqondile Khanye	F	Motshane Clinic
26.	Martha Motsa	F	Salvation Army
27.	Deborah Maphosa	F	Good Shepherd Hospital
28.	Sindie Gamedze	M	TB Clinic
29.	Gugu P. Dlamini	F	Municipal council of Mbabane
30.	Sibongile Simelane	F	SD Hospice @ Home
31.	Samukelisiwe Dlamini	F	Sigangeni Clinic
32.	Mduduzi Ngwenya	F	Red Cross
33.	Busie Kgaledi	F	TB Centre
34.	Dumsile Sihlongonyame	F	NATICC

Annex 2: HBHTC Training Agenda

July 11–19, 2010

Time	Activity
<i>Day 1: Sunday</i>	
4:00–5:30 p.m.	Welcome remarks Workshop logistics
<i>Day 2: Monday</i>	
8:00–9:30 a.m.	Introductory session
9:30–10:15 a.m.	Pre-course assessment
10:15–10:30 a.m.	Introduction to HBHTC: <i>Concepts and Rationale</i>
10:30–11:00 a.m.	TEA BREAK
11:00–12:00 p.m.	Introduction to HBHTC: <i>Approaches and Benefits</i>
12:00–1:00 p.m.	Community mobilization and education: <i>Targeted and General Population</i>
1:00–2:00 p.m.	LUNCH BREAK
2:00–3:30 p.m.	Community entry principles
3:30–4:45 p.m.	Challenges of community mobilization: <i>Barriers to HBHTC in Swaziland</i>
4:45–5:00 p.m.	Day's evaluation
<i>Day 3: Tuesday</i>	
8:00–8:30 a.m.	Recap of day 2 and prayer

8:30–10:30 a.m.	Addressing the Challenges: <i>Supporting Client’s Disclosure of HIV Status</i>
10:30–11:00 a.m.	TEA BREAK
11:00–1:00 p.m.	Addressing the Challenges: <i>HIV Discordance</i>
1:00–2:00 p.m.	LUNCH BREAK
2:00–3:30 p.m.	Addressing the Challenges: <i>Violence Screening and Counseling</i>
3:30–4:45 p.m.	Addressing the Challenges: <i>Suicide Screening and Counseling</i>
4:45–5:00 p.m.	Day’s evaluation
<i>Day 4: Wednesday</i>	
8:00–8.30 a.m.	Recap of day 3 and prayer
8:30–9:30 a.m.	The HBHTC Protocol: Adapting Uganda’s experience to Swaziland
9:30–10:30 a.m.	Household education sessions: <i>Group education</i>
10:30–11:00 a.m.	TEA BREAK
11:00–12:00 p.m.	Household education sessions: <i>Role-Plays</i>
12:00–1:00 p.m.	Test decision counseling and risk assessment: <i>Adult Individuals</i>
1:00–2:00 p.m.	LUNCH BREAK
2:00–3 –30 p.m.	Test decision counseling and risk assessment: <i>Couples</i>
3:30–4:45 p.m.	Test decision counseling and risk assessment: <i>Children and Adolescents</i>
4:45–5:00 p.m.	Day’s evaluation

<i>Day 5: Thursday</i>	
8:00–8:30 a.m.	Recap of day 4 and prayer
8:30–10:30 a.m.	<i>Results Counseling: HIV-Negative Results for Individual Adults, Children and Adolescents, and Couples</i>
10:30–11:00 a.m.	TEA BREAK
11:00–1:00 p.m.	<i>Results Counseling: HIV-Positive Results for Individual Adults, Children and Adolescents, and Couples</i>
1:00–2:00 p.m.	LUNCH BREAK
2:00–3:30 p.m.	<i>Results Counseling: HIV-Discordant Results for Couples</i>
3:30–4:45 p.m.	Role-Plays
4:45–5:00 p.m.	Day's evaluation
<i>Day 6: Friday</i>	
8:00–8:30 a.m.	Recap of day 5 and prayer
8:30–9:30 a.m.	Referral for prevention: PMTCT, FP MMC
9:30–10:30 a.m.	Referral for care and treatment: ART, TB
10:30–11:00 a.m.	TEA BREAK
11:00–12:00 p.m.	Introduction to rapid HIV testing
12:00–1:00 p.m.	Practical sessions on conducting rapid HIV testing using stored blood samples
1:00–2:00 p.m.	LUNCH BREAK
2:00–3:30 p.m.	Drawing blood using the finger stick method
3:30–4:45 p.m.	Preparing a dry blood spot
4:45–5:00 p.m.	Day's evaluation

<i>Day 7: Saturday</i>	
8:00–8:30 a.m.	Recap of day 3 and prayer
8:30–1030 a.m.	QA, HMIS, M&E, GIS training
10:30–11:00 a.m.	TEA BREAK
11:00–1:00 p.m.	Preparation for field practicum
1:00–2:00 p.m.	LUNCH BREAK
2:00–3:30 p.m.	Supervised field practicum
3:30–4:30 p.m.	Supervised field practicum
4:30–5:00 p.m.	Group field reports compilation
<i>Day 8: Monday</i>	
8:00–8:30 a.m.	Recap of day 3 and prayer
8:30–10:30 a.m.	Field practicum
10:30–11:00 a.m.	TEA BREAK
11:00–1:00 p.m.	Field practicum
1:00–2 :00 p.m.	LUNCH BREAK
2:00–3:30 p.m.	De-briefing: Group field reports
3:30–4:15 p.m.	Post-course evaluation
4:15–5:00 p.m.	End of course evaluation and closing ceremony

Annex 3: HBHTC Pre- and Post-Test and Evaluation



Swaziland National HIV/AIDS Program

**Home-Based HIV Counselling & Testing Course
Pre- and Post-Course Assessment**

Instructions:

- 1. This pre-course assessment is composed of two (2) sections.*
- 2. You are required to attempt all the questions.*
- 3. The time allowed for this assessment is 60 minutes.*

Participant's Names:

Designation/Job Title:

Institution/ Workplace:

SECTION A:

1. The Human Immunodeficiency Virus is

- A. A lipid-enveloped virus with a cone-shaped nuclear core that harbours a circular viral DNA genome.
- B. A non-enveloped virus with a round shaped nuclear core that harbours two genomic DNA strands.
- C. A lipid- enveloped virus with a cone shaped nuclear core that consists of viral encoded capsule proteins and harbors two single stranded genomic RNA molecules.
- D. None of the above.

2. The most common route of HIV transmission in Africa is

- A. Breast feeding.
- B. Heterosexual contact.
- C. Homosexual contact.
- D. Infected needles, blood and blood products.

3. Factors that facilitate the transmission of HIV include the following; EXCEPT...

- A. Having multiple sex partners.
- B. Poverty.
- C. Lack of religious commitment.
- D. Sharing of contaminated injection needles.

4. Which of the following is NOT a provider's responsibility in good counselling?

- A. Providing accurate information.
- B. Listening to the client.
- C. Encouraging the client to speak.
- D. Challenging client's decisions.

5. The sensitivity of an HIV test indicates ...

- A. The probability that a test will be negative when infection is present.
- B. The probability that a test will be positive when infection is present.
- C. Both of the above.
- D. None of the above.

- 6. The key element to good and effective pre-test counselling is the ability to**
- A. Establish a dialogue with the client.
 - B. Deliver to the client all available information on HIV and HIV testing.
 - C. Effectively urge every client to test for HIV.
 - D. Persuade each client to sign a consent form.
- 7. What is the strongest predictor of Mother-to-child transmission of HIV?**
- A. Maternal viral load.
 - B. Maternal CD4+ count.
 - C. Maternal age.
 - D. General maternal health.
- 8. Which statement about Post Exposure Prophylaxis [PEP] is true?**
- A. PEP needs to be started within one week of exposure.
 - B. PEP drugs consists of antiretrovirals.
 - C. Health care workers do not need to know the protocols for PEP.
 - D. The same regimen is used for PEP for all types of exposure to HIV.
- 9. One of the following is not an important attribute of the HIV virus?**
- A. High mutation rate.
 - B. Residing in dormancy in the cell.
 - C. Ability to live outside the cell.
 - D. High turnover rate.
- 10. The risk of transmission of HIV to health care workers can be reduced by all of the following except**
- A. Wearing personal protective equipment.
 - B. Wearing protective shoe covers whenever in the delivery room.
 - C. Post-Exposure Prophylaxis.
 - D. Handling and disposing of the placenta and other infectious wastes carefully.
- 11. The World Health Organization [WHO] recommends Polymerase Chain Reaction [PCR] testing of infants' blood:**
- A. At any time after six weeks of age if not breastfeeding.
 - B. If breastfeeding, following breastfeeding.
 - C. If presenting to the health service with signs and symptoms of HIV infection.
 - D. All the above.

12. Home-based HIV counselling and testing should be

- A. Offered only to those people who are at risk of getting HIV.
- B. Requested by the client rather than offered by the provider.
- C. Offered to a client on a subsequent visit if they did not choose it at the first visit.
- D. Carried out on clients as long as you have a chance to talk to them.

13. Components of post-test counselling for a woman who is NOT infected with HIV includes

- A. Discussing the result with the client.
- B. Providing information on preventing future infection.
- C. Inform her about the high risk of transmitting HIV to her infant if she is newly infected during pregnancy or breastfeeding.
- D. None of the above.

14. The risk of transmission of HIV from person to person

- A. Is more likely when either sexual partner has a sexually transmitted infection.
- B. Is not affected by the level of viremia of the source patient.
- C. Occurs after about 1% of needle stick injuries.
- D. In an infant born to an HIV positive mother is more likely to happen during breast feeding than at birth.

15. What is the final HIV status given the following test results using a serial testing algorithm?

- **Test 1: Reactive**
 - **Test 2: Non-reactive**
 - **Test 3: Reactive**
- A. Positive
 - B. Negative
 - C. Reactive
 - D. Can't determine

16. The ABC of prevention of HIV includes all of the following EXCEPT

- A. Abstinence from sex until marriage.
- B. Always being careful to avoid contact with persons living with AIDS.
- C. Being faithful in marriage and monogamous relationships.
- D. Correct and consistent condom use.

17. Choose the MOST APPROPRIATE response to the question below.

When a client's HIV antibody test is non-reactive, what does it mean?

- A. This person is infected.
- B. This person is not infected.
- C. This person is immune to HIV.
- D. Antibodies against HIV were not detected in this person's body at the time of the test.

18. Which of the responses to the question below is NOT CORRECT?

When a client's HIV antibody test is reactive, what does it mean?

- A. This person is infected.
- B. Sero-conversion has occurred.
- C. This person is immune to HIV.
- D. This person has antibodies against HIV.

19. The Kingdom of Swaziland follows a serial testing algorithm. A tester performs 3 tests and the following test results are obtained:

- **Test 1: Reactive**
- **Test 2: Non-Reactive**
- **Test 3: Invalid**

Which statement(s) best describe(s) your next steps in reporting the results?

- A. HIV status should be reported as positive.
- B. Tester should repeat Test 3, and report client as negative if Test 3 is non-reactive.
- C. Tester should review standard operating procedures.
- D. B & C.
- E. Unable to determine.

20. Which of the following statements is an example of *Quality Assurance*?

- A. Checking the expiration date of a test kit.
- B. Testing a new shipment of test kits using known positive and negative specimens.
- C. Participating in an external quality assessment (EQA) program, if you are not too busy.
- D. Reporting accidental sharps injuries only to your co-workers.
- E. A & B.

21. What does this sign mean?



- A. Poisons.
- B. Bio-hazard.
- C. Recycling.
- D. Electrical shock possible.

22. Which factor(s) may compromise the quality of HIV rapid testing?

- A. Recording a reactive result that is visible after 5 minutes, although the manufacturer requires the test to be read between 10-20 minutes.
- B. Checking the expiration date of the test kit prior to use.
- C. Discarding a lancet found on the floor in the waste container designated for “sharps”.
- D. Testing quality control samples once per week.

23. Choose the CORRECT answer.

When performing finger prick to collect blood for HIV testing...

- A. When cleaning the finger with alcohol, start in the center and work outward to prevent contamination.
- B. After pricking the finger, you should **not** collect the 1st drop of blood.
- C. After puncturing the finger, you should collect the first drop of blood to be sure you have enough blood for testing.
- D. You should have the client stand to help facilitate blood flow after puncturing.
- E. A & B.

24. Which of the following statement(s) is CORRECT?

Before performing a rapid test, you must examine the test kit to make sure that...

- A. The test device has not been previously opened or damaged.
- B. The test kit has not expired.
- C. You have adequate supplies and reagents before beginning testing.
- D. The test kit has been stored appropriately according to manufacturer specifications.
- E. All of the above.

25. Choose the CORRECT answer.

When preparing your client for rapid test, you should:

- A. Keep the clients standing during finger prick to ensure the blood does not clot.
- B. Put your client at ease by describing what happens during the rapid HIV test.
- C. Inform the client that the results will be sent to his/her family at no extra charge.
- D. None of the above is correct.

SECTION B:

1. List the three modes of HIV transmission.

.....
.....
.....
.....
.....
.....

2. What does “window period” mean?

.....
.....
.....
.....
.....
.....

3. List 3 benefits of Home-based HIV Counseling & testing to:

a) An individual:

.....
.....
.....
.....
.....
.....

b) A couple:

.....
.....
.....
.....

.....
.....

4. What is a discordant couple?

.....
.....
.....
.....
.....

5. What are the 3 main approaches to HCT?

.....
.....
.....
.....
.....
.....
.....

6. Explain the Kingdom of Swaziland's HIV antibody testing algorithm.

.....
.....
.....
.....
.....

7. List 5 key barriers to home-based HIV counseling and testing in your community.

.....
.....
.....
.....
.....
.....

8. List four points that should be covered in a pre-test counselling session:

.....
.....
.....
.....
.....
.....

9. Imagine in the course of your work you get a needle stick injury in Shiselweni community during HBHCT. List the steps you would take to prevent HIV infection.

.....
.....
.....
.....
.....
.....

**GOOD LUCK
END**

Please assess your skills in the following areas before and after the training. Circle the number (1-4) that best represents your HBHCT skills before and after the training.

	Before the training, I could....				After the training, I can...			
	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
3. Identify the benefits of providing HBHCT to families of HIV+ clients to others.	1	2	3	4	1	2	3	4
4. Educate household members about HBHCT and complete the HH registration form.	1	2	3	4	1	2	3	4
5. Assess an individual household member's risk of HIV infection.	1	2	3	4	1	2	3	4
6. Provide HIV test results to an individual household member.	1	2	3	4	1	2	3	4
7. Assist an individual household member to develop a risk reduction plan and identify safer goal behaviors.	1	2	3	4	1	2	3	4
8. Support a client to disclose to his/her household member(s).	1	2	3	4	1	2	3	4
9. Explain HIV discordance to others.	1	2	3	4	1	2	3	4
10. Provide HIV test results to a couple.	1	2	3	4	1	2	3	4
11. Assist a couple to develop a risk reduction plan and identify safer goal behaviors.	1	2	3	4	1	2	3	4
12. Explain HIV discordance to discordant couples.	1	2	3	4	1	2	3	4
13. Provide counseling to HIV discordant couples.	1	2	3	4	1	2	3	4
14. Explain the guidelines for providing VCT to children to others.	1	2	3	4	1	2	3	4
15. Review the consent procedures for children with a parent/guardian in the home.	1	2	3	4	1	2	3	4

	Before the training, I could....				After the training, I can...			
	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
16. Conduct a child counseling session with the parent/guardian present.	1	2	3	4	1	2	3	4
17. Conduct a child counseling session when parent/guardian is not present.	1	2	3	4	1	2	3	4
18. Explain the safety precautions for conducting HIV rapid testing in the home to others.	1	2	3	4	1	2	3	4
19. Collect blood with a capillary tube using the finger stick method.	1	2	3	4	1	2	3	4
20. Perform sequential HIV rapid testing.	1	2	3	4	1	2	3	4
21. Interpret and report test results.	1	2	3	4	1	2	3	4
22. Prepare a dried blood spot..	1	2	3	4	1	2	3	4
23. Explain quality assurance measures for HIV counseling to others.	1	2	3	4	1	2	3	4
24. Explain quality assurance measures for HIV testing to others.	1	2	3	4	1	2	3	4
25. Conduct an efficient HBHCT visit.	1	2	3	4	1	2	3	4

Please indicate the extent to which you agree or disagree with the following statements. Circle the number (1-4) that best represents your views of the training.

	Strongly Disagree	Disagree	Agree	Strongly Agree
26. The training was well organized.	1	2	3	4
27. The training topics were relevant to my needs.	1	2	3	4
28. The instructors were well prepared.	1	2	3	4
29. The instructors were receptive to participant comments and questions.	1	2	3	4
30. The role-plays and demonstrations helped improve my skills in conducting HBHCT.	1	2	3	4
31. The training enhanced my skills to conduct home-based HCT.	1	2	3	4
32. I now feel confident that I can conduct a HBHCT visit.	1	2	3	4
33. I expect to use the skills I have gained from this training.	1	2	3	4
34. I would recommend this training course to a colleague.	1	2	3	4
35. The Venue was suitable for learning purposes.	1	2	3	4

Finally, please respond to the following items:

36. The most useful part of the training was:
37. Something I would change to make the training better would be:
38. I would like to see future HBHCT training sessions address:

Annex 4: HBHTC Trainee Pre- and Post-Test Scores

	Name	Pre-test Score (%)	Post-test Score (%)	Difference
1.	Gudu Nxumalo	37	78	41
2.	Muntuza Chamkile Mavimbela	48	62	14
3.	Dumisile Dube	50	78	28
4.	Bonsile Nsibandze	52	69	17
5.	Nkosing'phile Tsabedze	56	67	11
6.	Dlamini Khetsiwe	66	79	13
7.	Ntombifuthi R. Nhlengetfwa	50	82	32
8.	Jabu Maseko	50	59	9
9.	Ignecia Dlamini	62	84	22
10.	S'phesihle Zwane	54	74	20
11.	Sithembile Ngwenya	50	83	33
12.	Hlonphile Ngomane	47	78	31
13.	Francis Fruhwirth	61	80	19
14.	Lilly Masuku	53	76	23
15.	Fisiwe Portia Sukati	61	81	20
16.	Xolile Dlamini	45	78	33
17.	Lindelwa Maphanga	62	87	25
18.	Thabiso Colani Fakudze	41	71	30
19.	Nelsiwe Maigirl Dlamini	59	91	32
20.	Ncamsile Skhanyiso Dlamini	44	71	24

SWAZILAND HBHTC TRAINING STRATEGY

Swaziland HBHTC Training Strategy

Background

With 26 percent of its adult population being HIV positive, Swaziland faces the highest HIV prevalence in the world. The country's average life expectancy is projected to decline from 59.7 years in 2001 to 38.3 years in 2015. HIV testing and counseling (HTC) is the entry point to prevention, treatment, care, and support. Knowledge of their HIV status can enable HIV-negative people to remain HIV-negative, while people living with HIV (PLWH) can receive support to adopt positive prevention strategies such as behavior change, adoption of early antiretroviral (ARV) drug treatment, management of opportunistic infections (OIs), and adherence to recommended antiretroviral therapy (ART) regimens. HTC scale-up is also advocated as a way to normalize and destigmatize HIV, thereby increasing the number of people willing and seeking to know their HIV status.

In Swaziland, the HTC models used to enable people to know their HIV status have included the client-initiated approach, which is composed of Voluntary Counseling and Testing (VCT), and, to a lesser extent, Provider-Initiated Testing and Counseling (PITC). HIV testing uptake in Swaziland remains low. According to the most recent Social and Demographic Health Survey (SDHS 2007), only 27 percent of the population had ever taken an HIV test and received the results.

Home-Based HIV Testing and Counseling

Swaziland is working toward improving its low rates of HIV testing. According to the National Strategic Framework 2009, Swaziland's target is to increase the proportion of people knowing their HIV status from 22 percent to 50 percent for women and from 9 percent to 40 percent for men by 2014.

To test the acceptability and feasibility of home-based HIV testing and counseling (HBHTC), the interagency Swaziland HIV Counseling and Testing Core Group (HTC Core Group)—a collaborative team composed of the Swaziland National AIDS Programme, the World Health Organization (WHO) / the Joint United Nations Programme on HIV/AIDS (UNAIDS), the President's Emergency Plan For AIDS Relief (PEPFAR) / the Centers for Disease Control and Prevention (CDC), Population Services International (PSI), Médecins Sans Frontières (MSF), Baylor Medical College and University Research Company (URC)—is conducting a six-month pilot project of door-to-door HIV testing in Swaziland. Following evaluation of the pilot, the HTC Core Group will consider a national, scaled-up HBHTC plan if the strategy is deemed effective and appropriate.

HBHTC Capacity

Presently, human resources for HTC services in the country are not adequate to meet the current need for HTC. As Swaziland attempts to achieve universal access to HTC, more human

resources will need to be trained to provide the necessary services through the various HTC approaches. Developing a HBHTC training strategy will enhance the successful transfer of knowledge and skills for implementation of HBHTC nationally, following the results of the pilot project.

HBHTC Training Strategy

A. Objectives

Overarching Objective: To guide the development of a critical mass of HBHTC professional implementers that will support the scale-up of HBHTC services to increase uptake of HTC services in Swaziland.

- Through training with HBHTC skills and knowledge, the HBHTC professional implementers will be equipped and certified as service providers for the Swazi National HBHTC Program.

Specific Objectives:

- To assess the HIV-related skills and knowledge gaps of the target group (trainees)
- To develop training resources, programs, and curricula for HBHTC training
- To establish a cascade approach that provides knowledge transfer from one level to another
- To provide a framework for delivering standardized, comprehensive, and curriculum-based training for HBHTC service providers.

B. Implementation Strategy

The HBHTC Training Strategy will be implemented using a five-phased approach that is coordinated through SNAP, the HTC Core Group, and other relevant partners and leaders. The geographical roll-out of the training strategy and subsequent deployment of trainers should be developed carefully while considering the availability of human resources and health services in the area, particularly treatment and support services. The activities for each phase of the training strategy are as follows:

Phase 1: Rapid Assessments

Tasks in this phase will include the following:

- Review data on national human resource capacity on HTC and HBHTC service delivery.
- Identify potential trainees for “Training of HBHTC Master Trainers.”
- Conduct training needs assessment to identify the trainees’ technical gaps.

Phase 2: Training Resources Development

Tasks in this phase will include the following:

- Review existing training resources.
- Adapt and develop a HBHTC training curriculum with attention to integration of adult learning techniques, Swazi cultural context, and past HBHTC experiences.
- Develop a master trainers HBHTC training manual with teaching aids and trainer’s tools.
- Develop an HBHTC mobilization strategy.

- Obtain MOH approval and certification of training materials.
- Determine and establish a process of certification for HBHTC trainees.

Phase 3: Cascade Training Approach

Tasks in this phase will include the following:

- Conduct a master trainers' course for HBHTC (training of trainers). Proposed cascade training model:
 1. Master training course will involve 20–25 participants for 2-week duration.
 2. Master trainers who graduate from the master training course will train, in pairs, approximately 20–25 trainers for 2-week duration.
 3. Trainers (participants from step #2) will train counselors in HBHTC, approximately 20–30 trainees for 5–7 day duration.
 4. Trainers who conduct the master training course should assist and supervise pairs who will train HBHTC trainers to ensure quality and to help with troubleshooting.

Phase 4: Refresher Courses

Tasks in this phase will include the following:

- Conduct refresher training for existing HTC and HBHTC counselors and nurses for 3–5 day duration (depending on needs).

Phase 5: Monitoring and Evaluation Training Programs

Tasks in this phase will include the following:

- Develop monitoring and evaluation (M&E) tools for HBHTC training programs.
- Develop M&E for HBHTC.

C. Factors for Success

The following elements will contribute to the success of implementing the HBHTC training strategy:

- Adopt and implement an HBHTC approach using the Swaziland HTC guidelines that recommend development of a skilled HTC cadre.
- Obtain a commitment from identified stakeholders to provide financial, logistical, and technical requirements for implementing the training strategy.
- Select an existing cluster of skilled HTC cadre within Swaziland for further training in HBHTC.
- Provide Swaziland MOH certification for HBHTC service providers.

D. Quality Assurance for HBHTC Training Strategy

Several elements will need to be in place to provide quality assurance for the training strategy, including the following:

- Standardized tools for rapid assessments
- Standardized HBHTC training resources
- Standardized selection criteria of trainees

- Standardized methodologies of delivery of training
- Checklist and criteria for support and supervision of various HBHTC trainees
- Clear definition of roles and responsibilities of stakeholders in implementing the HBHTC Training Strategy
- Certification and registration of trained HBHTC Service Providers.

E. Monitoring and Evaluation of the HBHTC Training Strategy

Monitoring and evaluation of the strategy will contribute to effectiveness and quality. Activities may include the following:

- Develop end-of-course evaluation tools designed to assess the effect of the cascade training approach.
- Establish HBHTC M&E tools in coordination with the national M&E program.
- Develop HBHTC health management information systems (HMIS) tools designed to evaluate the training strategy.
- Ensure a centralized reporting system for HBHTC training partners.
- Identify lessons learned and review approaches to challenges met.
- Produce and share a report on the HBHTC training strategy with Government of Swaziland officials and partners.

Conclusion

The proposed HBHTC training strategy is one approach to help increase the reach and uptake of HTC services in Swaziland by using the HBHTC model. The strategy is designed to increase HBHTC human resource capacity, as well as to produce technical tools if HBHTC is deemed an appropriate intervention for national scale-up.

References

The following references that were used for this report are internal Swaziland documents.

Swaziland National Strategic Framework for HIV and AIDS. 2009–2014.
 Swaziland Concept Note: Home-Based HTC Pilot Implementation. May 2010.
 Swaziland National HTC SBCC Strategy. May 2010.

SUMMARY COMMENTS ON HBHTC FIELD PRACTICUM AND TRIAL RUN

Summary Comments on HBHTC Field Practicum and Trial Run

To assist the Swaziland HTC Core Group in preparing for HBHTC pilot project implementation, AIDSTAR-One conducted several activities that included a) HBHTC classroom training, b) HBHTC training field practicum, and c) HBHTC trial run. Drawing on the experiences of the HBHTC field trials, the AIDSTAR-One team proposes the following recommendations to ensure effective HBHTC implementation. A detailed explanation of each of the activities and highlights from the trials can be found herein. A complete list of strategic recommendations for HBHTC can be found in the document titled *Trip Report and HBHTC Strategic Recommendations*.

HBHTC Pilot Training

From July 12 to 19, 2010, AIDSTAR-One consultants conducted training on home-based HIV testing and counseling (HBHTC) at the request of the Swaziland HTC Core Group in preparation for the HBHTC pilot project. The training was conducted in Ezulweni, Swaziland, and consisted of five days of classroom training and two days of practicum in the field.

A total of 34 trainees (3 males and 31 females) participated in the training. The trainees included 14 nurse counselors who work in health units where the HBHTC pilot project will take place and 20 counselors who will be part of the HBHTC pilot project. Although all of the trainees participated in the classroom portion, only the 20 pilot project counselors were involved in the practicum and subsequent HBHTC trial run.

HBHTC Field Practicum

Field practicum on HBHTC was conducted at two different sites: Mahwalala in Mbabane East Inkundhla (peri-urban community) and Sigangeni in Motshane Inkundhla (rural community). Those two communities will participate in the HBHTC pilot project.

The field practicum teams included Swaziland HTC Core Group members, AIDSTAR-One consultants, the AIDSTAR-One HTC advisor, HBHTC trainees, clinic nurses, and rural health motivators (RHMs). The RHMs, who are resident community volunteers selected by the community members, work as resource persons for health-related issues within their communities. Both the clinic nurses and RHMs helped serve as gatekeepers, thereby facilitating access to households. Each field team consisted of five HBHTC trainees, two supervisors (one AIDSTAR-One consultant and one HTC Core Group member), and one RHM. Each team visited one home at a time, with RHMs providing the introduction to each household.

Each team visited an average of six homes, although not all household members that had been educated on HIV were tested. A total of 10 people were tested at Mahwalala, all of whom were HIV-negative. In Sigangeni, 19 people were tested, with 2 testing HIV-positive.

At the end of each practicum day, the AIDSTAR team conducted a debriefing session with counselors to share experiences, challenges, and lessons learned to plan for subsequent field days.

HBHTC Trial Run

A one-day trial run of actual HBHTC implementation of the pilot project was conducted on July 20, 2010, at Sigangeni. On the basis of these experiences of the HBHTC practicum, the methodology was subsequently revised.

HBHTC counselors were paired up, assigned to specific target areas, and dispatched from a central place within the community. According to the feedback from households in the field practicum, RHMs did not accompany the counselors. The supervisors followed up with the counselors after household visits to observe progress and provide any support that was required.

During the trial run, a total of 42 people were tested, with 8 people testing HIV-positive. Among those who tested HIV-positive, one was bedridden.

Experiences from the Field Trials

- Characteristics of the communities visited:

Mahwalala Community	Sigangeni Community
Peri-urban	Rural
Households are close to each other.	Households are far apart.
Residents were reluctant to agree to testing, though willing to get information about HIV.	Residents were more likely to request testing.
Household members were less likely to be found at home.	Household members—particularly females—were more likely to be found at home.
In both communities, whenever the household head (man) was not found at home, the woman more easily consented to HBHTC services.	

- Counselors had many positive experiences, reporting that they:
 - Appreciated the feasibility of the HBHTC approach, which boosted their confidence.
 - Demonstrated competence in providing HBHTC services.
 - Were motivated by the community’s positive reception.
 - Gained exposure to various counseling situations, including counseling for couples, discordant couples, children, and people with disabilities (PWD), as well as clients experiencing gender-based violence.
- Counselors reported experiencing challenges, including the following:
 - Too many data collection tools.
 - Security concerns, such as requests for testing to be conducted in bedrooms, and counseling by single female counselors of male clients alone indoors.
 - Potential stigma created because RHMs chose the homes to be tested.
 - Distrust of RHMs expressed by households because of fears that they would not respect confidentiality; clients who preferred that only counselors visit.
 - Three cases where caregivers refused to give consent for PWD to be tested.

- Long distances between households, especially in rural areas; the walk is exhausting for counselors.



Households in rural areas are spread out requiring counselors to walk long distances in difficult terrain. (Photo courtesy of Maria Claudia Escobar)

- From some households, requests for proof that the HBHTC counselor is from the Ministry of Health.
 - The poverty of some households that cannot afford health services, which makes referrals unrealistic.
 - The perception of some that support services are weak or lacking, as expressed by one household member: “Why test us and leave us here without any support?”
 - Lack of lunches for counselors working the entire day in the field.
- Important lessons were learned and emerged from the field trials:
 - HBHTC services appear to be highly acceptable, especially in the rural communities.
 - With good supervision and support, counselors are able to competently roll out the HBHTC pilot and to produce high-quality results.
 - People living with HIV (PLWH) should be involved in planning, implementing, and monitoring HBHTC pilot activities.
 - Mapping of service points and networking for effective referrals are critical.
 - Innovative approaches are needed to capture the men and to handle the complexities of disclosure among multiple concurrent partnerships, which are common.

Follow-up Actions Following Field Trials

AIDSTAR-One consultants held a meeting with the HTC Core Group to discuss the results of the field trials and to identify follow-up actions. The following issues were resolved:

- The HTC Core Group, to whom AIDSTAR-One consultants provided feedback, will revise and consolidate data collection tools to reduce the paperwork that counselors must use while in households.
- Sensitization about the HBHTC pilot program and expected roles of RHMs was conducted with RHMs, clinic staff members, and expert clients at the Sigangeni and Motshane clinics.
- AIDSTAR-One consultants conducted a re-orientation for the HBHTC pilot project counselors on dried blood spot (DBS) sample collection, post-exposure prophylaxis, tuberculosis (TB), infection control, and care for the caregivers (health workers).
- Counseling cue cards will be laminated and fastened together to make them easier to use.
- The list of requirements for each HBHTC field visit will be attached to the cue cards to help remind counselors.
- The HBHTC implementation concept paper was revised to resolve issues highlighted by the field trials.

Outstanding Issues Observed from the Field Trials

The field practicum and trial run highlighted additional issues that remain outstanding, as follows:

Referral and linkages:

- The distance to health facilities is long for most households, especially in the rural areas, which presents an even greater obstacle for bedridden clients.
- The clinics within the pilot sites are not currently initiating patients on antiretroviral therapy (ART). Clients who need ART must be referred to the Mbabane government hospital, which further complicates the linkage to care and treatment.

Logistics: Transport of counselors to and within the communities is difficult, given the long distances between the homes, particularly in rural settings.

Reporting: How should data flow from the field to the national level? Apparently, it was not clear how data collection, storage, entry, retrieval, and reporting should be done to facilitate reporting.

Quality assurance: Supportive supervision and performance monitoring are not clearly planned for both counseling *and* rapid testing.

Programming: How should a counselor's performance be measured per day? Is it the number of households visited, or the number of people educated about HIV, or the number counseled and tested? The field trials showed that several households received education on HIV but refused testing.

Protocol: How should missed opportunities be addressed? One example would be when a 22-year-old female or male is found at home and is willing to test but cannot because the head of household is away.

Recommendations for HBHTC Pilot Project Implementation

1. *Multipronged mobilization strategy:* There is a need to ensure sensitization of all leaders down to the household level. Specifically, political, cultural, and religious leaders and royal leaders should be engaged to get their buy-in and authorization to mobilize community members. The RHMs are well placed to mobilize and sensitize households.
2. *Mapping strategy:* An accurate mapping strategy would help avoid repeat visits to households. A zoning strategy that allocates specific geographic areas to counselors to ensure that all households are covered may be worth considering.
3. *Alternative transport:* Given the long distances between households, a cost-effective and sustainable mode of transport should be identified and evaluated before adoption. Options include motorbikes or taking a group of counselors in one vehicle and dropping them at one central place for a specific mapped area from where they will visit the households.
4. *Clear reporting strategy:* A clearly defined reporting strategy needs to be developed to ensure completeness of records, adequate storage of data, retrieval, and timely reporting of HBHTC data. An HBHTC focal person who is based at the clinic in the pilot sites can be responsible for ensuring completeness of data tools from the field, and data entry should be performed at the clinic within the pilot sites.
5. *Supportive supervision:* To ensure high-quality service delivery in the homes, supportive supervision is necessary. Options include a counseling and laboratory supervisor (technically competent) for each pilot HBHTC site and a telephone hotline that counselors in the field can call for assistance.
6. *Ensuring security:* To minimize risks, especially to female counselors, HBHTC counselors should work in pairs. This pairing would also help counselors complement each other's skills and knowledge, especially when faced with challenging situations.
7. *Preventing counselor burnout:* Given the prevalence of HIV in Swaziland, HBHTC providers will undoubtedly experience stress and burnout. The Swaziland National Aids Program (SNAP) may consider actively engaging the Swazi Wellness Unit to provide a "care for the carer" package to prevent counselor burnout. Daily debriefs using standardized criteria and twice-monthly group therapy led by a counseling psychologist are also recommended. In addition, setting realistic daily HBHTC targets for the counselors goes a long way toward preventing burnout.
8. *Strengthening referral system:* It is necessary to strengthen referrals to ensure that clients diagnosed at home receive appropriate care and treatment, as well as referrals to important services such as PMTCT and male circumcision, which are currently being scaled up in

Swaziland. Strategies include a) decentralizing HIV care, particularly ART initiation; b) distributing information flyers about where to go for care; c) forming PLWH support groups; and d) having PLWH and expert clients create follow-up systems.

SUMMARY OF RECOMMENDATIONS FOR HBHTC DATA COLLECTION TOOLS

Summary of Recommendations for HBHTC Data Collection Tools

Summary

As a part of the South-to-South Technical Assistance (S2STA) in home-based HIV testing and counseling (HBHTC) provided by AIDSTAR-One, the HBHTC data collection tools were reviewed. Swaziland has decided that it will incorporate HBHTC into the national HIV testing and counseling (HTC) data tools, instead of creating new HBHTC forms. The tools reviewed included the following:

1. Swaziland HTC Client Intake Form
2. HBHTC Reporting Form
3. Referral Form
4. TB Screening Form
5. Household Profile for HBHTC
6. Swaziland HBHTC Session Quality Assurance Guide for Supervisors
7. Assessment of HBHTC Quality of Services

The following recommendations are provided in accordance with the tool reviewed.

Swaziland HTC Client Intake Form

1. On the form, the site code should include HOME as another venue for HTC.
2. In Question 7 to accommodate HBHTC, replace “center” with “service” in “How did you learn of this center?”
3. In Question 21, replace the word “presistant” with “persistent”
4. So you can reduce on the number of data collection forms, we suggest that the tuberculosis (TB) screening information should be incorporated onto the Client HTC Intake form. Thus, the TB Screening Form can be eliminated.

HBHTC Reporting Form

1. Suggested title for the form is “HBHTC Monthly Reporting Form”
2. After “Month Reporting For,” include the “YEAR”
3. Below the “YEAR,” indicate the name of the counselor’s health facility.
4. Items 5–9 should read “total number of...”
5. Item 13 should be deleted because it is repeated under section on referrals (item 2).

6. Under the section on “Referrals,” change items 3–10 to read “Total number”
7. Align this form with the referral form so that data are properly captured for referral to specified services.
8. Under Comments, include guidance for the counselor such as (“Mention any emerging issues and challenges faced”).
9. Insert page numbers.
10. The rest of the HBHTC reporting tool is consistent with the programmatic needs.

Referral Form

1. This form should remain independent.
2. The services referred to “care and treatment services” are not specific. Yet, the monthly reporting tool disaggregates pre-antiretroviral therapy (ART) and ART services. There is a need to align this data so as to obtain clear information easily.
3. Among the reasons for referral, include DNA, polymerase chain reaction (PCR), Prevention of Mother-to-Child Transmission (PMTCT), and male circumcision (MC).

TB Screening Form

1. We propose that this form is included on the Client HTC Intake form to reduce the number of forms a counselor should complete.
2. The section on patient information should be deleted because this information is already collected on the Client Intake Form.
3. We propose that item 6 on the TB screening form be deleted.
4. We propose that item 8 on the TB screening form be deleted.
5. For item 9, clarify the following: which cases of TB retreatment need to take treatment for over 6 months?
6. We suggest that item 11 should read “Have you been in contact with a person with a long standing cough in the past 3–6 months?”
7. Instead of using the word “Instructions,” we propose that it be replaced with “Counselor’s Note” to make the tool more “user-friendly”

Household Profile for HBHTC

1. This form should remain separate.
2. The HIV test results column should read, “HIV test results today.”
3. The Referral column should read, “Referral for (indicate service).”
4. The column, “If Pos, check HIV care card,” we suggest you clarify what the counselor should do in this column after checking the client’s care card.
5. In the column titled “Comment on consenting and declining services,” we suggest you clarify what the counselor should do.

Swaziland HBHTC Session Quality Assurance Guide for Supervisors

1. Indicate in brackets below the title: (For use during support supervision of individual HBHTC counselors). This information could be in italics. The start time should be indicated here instead of at the end of the tool.
2. Under “Group pre-test:”

Describe conditions for receiving HIV and testing
Provide information on HIV and clarify myths

These two items are not specific. Conditions for receiving an HIV test are covered under eligibility. We recommend deleting or clarifying what information you are seeking.

3. We suggest introducing a section titled “Eligibility criteria for consenting and testing.”
4. Consider changing the cell to “Identify couples, individuals, and children.”
5. Under “Test decision,” we suggest the following order: “Assured confidentiality”; “Reviewed test process”; “Risk assessment conducted”; “Addressed client concerns”; “Explained possible test results and implications”; “Explained the test processes”; and “Discussed roles and responsibilities of the couple if couples session.”
6. Under “HIV rapid testing: a) appropriate safety observe” we propose the following order: gloving, appropriate labeling, appropriate disposal of nonsharps, and appropriate disposal of sharps.
7. Under “screening test-serial” rearrange the statements as follows: “Conducting the test”; “Timing of the testing procedure”; “Interpretation of results”; and “Recording of test results”

8. Under “Post-test counseling” we propose the following order and revisions: “Provide and explain results clearly and simply”; “Explore client’s understanding/reactions to results”; “Provide support, address emotions”; and “Discuss positive living strategies if results are positive.”
9. We propose changing “Overall skills” to “General counseling skills.”
10. We suggest using “session” before start and stop time.

Assessment of HBHTC Quality of Services

Overall, the form is lengthy, which requires a significant amount of time from the person conducting the survey and the household member willing to participate. Also, surveys often ask questions that may be interesting information to know, but ultimately, may change nothing about the service or its quality. To significantly reduce the number of questions included, consider asking and answering the following questions for each question in the survey:

- How will the answer to this survey question affect the quality of HBHTC services?
- By asking this survey question, will it help us to change or improve the program? The service provided by a counselor?
- What will we do with the answer to this question? Is it necessary?

1. We suggest including COMMUNITY as a heading for questions 104–108.
2. We suggest including HOUSEHOLD as a heading for questions 109–112.
3. Various questions in the form must be formatted so that a YES / NO response can be circled on the form. See questions 200, 332, 334 in Section 6.
4. For question 205, we suggest adding as an answer option: “Only female counselors at the household.”
5. Consider deleting questions 301–304 because they appear repetitious from previous questions in the survey.
6. Question 312 seems vague; we are unclear what information is trying to be captured. Consider consolidating it with question 309.
7. For question 314, consider changing answer options to “very well, well, poorly, very poorly.”
8. For question 316, consider revising the answer option to “Have one faithful sexual partner.”
9. Question 317 might fit better in the counseling section.
10. Consider adding a question about waste left in the client’s home or homestead.
11. Question 607 could be deleted.

SUMMARY COMMENTS ON HBHTC TRAINING PARTICIPANTS' MANUAL

Summary Comments on HBHTC Training Participants' Manual

Summary

As a part of AIDSTAR-One's South-to-South Technical Assistance (S2STA) in home-based HIV testing and counseling (HBHTC), AIDSTAR-One consultants reviewed and revised the *HBHTC Training Participant's Manual*. AIDSTAR-One consultants discussed and reviewed the manual's content with the HTC Core Group and proposed revisions. Next is a summary of the key areas for revision. In addition, the revisions can be found within the *Revised HBHTC Training Participant's Manual With Tracked Changes*.

Key Revisions

1. Alterations were made to the contributors and acknowledgements sections to accurately reflect the various actors involved in this publication.
2. Notes for the trainees have been added under the following content areas: "Disclosure," "Gender-Based Violence (GBV)," "Suicide Screening," and "Medical Male Circumcision." Notes on GBV were revised, edited, and enriched for completeness. The section on suicide screening was expanded, because this was a specialized area requiring more clarity.
3. Flow charts were inserted for the chapter titled "Referrals and Linkages," which covered the following areas: antiretroviral therapy (ART), Prevention of Mother-to-Child Transmission (PMTCT), tuberculosis (TB), MMC, and postexposure prophylaxis (PEP).
4. The chapter titled "QA for Counseling" was revised, and a PEP flow chart was added.
5. In the chapter titled "Conducting a Rapid HIV Test," the figure showing possible HIV test outcomes using the serial algorithm was deleted because it was confusing to the trainees.
6. The section titled "HIV-Positive results giving" was rearranged to enhance the logical flow of the narrative.
7. Appendix 5 has been deleted because it contained information that is wholly covered in other chapters.
8. The data collection tools have been deleted from the appendices because they are being consolidated and revised. Once the final tools have been approved, they should be reinserted into the appendices.

Next Steps

1. Data collection tools will be revised after a review of AIDSTAR-One's recommendations and agreement by the HTC Core Group; and will then be inserted into appendices.

2. After all changes are made and approved, the HTC Core Group will format the document and revise the table of contents.
3. Printing the manual double-sided will help reduce “bulkiness” and will save paper.

MENTORING PLAN AND FOLLOW-UP ACTIVITIES

Mentoring Plan and Follow-up Activities

Objective

To develop a process of providing ongoing technical support and mentoring to the Swaziland HTC Core Group to ensure effective implementation of the HBHTC pilot project.

Methods and Approaches

Technical support and mentoring will be provided through email messages, phone calls, and scheduled teleconferences between the AIDSTAR-One consultants, the AIDS Support Organization (TASO in Uganda), and the HIV Testing and Counseling (HTC) Core Group in Swaziland. AIDSTAR-One will participate and assist with coordination as needed.

Key Mentorship Activities

Mentoring activities may include the following:

- Discuss progress of addressing issues raised in the HBHTC trial run.
- Identify challenges encountered and provide solutions, alternative strategies, or both.
- Share best practices.
- Identify key tasks and planning needed.
- Discuss monitoring and evaluation of the HBHTC pilot project.
- Encourage documentation of key lessons learned.

Expected Outcomes

The HTC Core Group will be able to effectively implement the HBHTC pilot project and to document key lessons learned at the conclusion of the project.

Proposed Timeline

	Activity	Timeline	Person Responsible	Method/ Approach
1	Discuss experiences 3–4 weeks after launch or implementation of pilot HBHTC.	Third week of September 2010	HTC Core Group will identify date. Teddy Chimulwa will coordinate call once date is specified with Maria Claudia Escobar, AIDSTAR-One.	email + Teleconference

2	Conduct monthly follow-up calls to track progress and to address challenges and issues encountered in HBHTC implementation.	Once per month: September, October, November 2010	HTC Core Group will identify feasible monthly dates from September to November. Annie Mpiima, AIDSTAR-One consultant, will coordinate once dates are specified with the HTC Core Group and Maria Claudia Escobar, AIDSTAR-One.	email + Teleconference
3	Share key lessons learned from the pilot project.	End of February 2011	HTC Core Group will provide date. Kenneth Mugisha, AIDSTAR-One consultant, will coordinate with Maria Claudia Escobar, AIDSTAR-One.	email + Teleconference
4	Communicate through email and phone calls to address specific requests from HTC Core Group as needed.	September 2010– February 2011	HTC Core Group will initiate communication.	email + Teleconference

**CHECKLIST FOR MINIMUM
PACKAGE OF HBHTC
SERVICES—CUE CARD**

Checklist for Minimum Package of HBHTC Services—Cue Card

Overview

A package for HIV testing and counseling (HTC) service provision to meet the national minimum standards will include the following:

- Pre-test counseling materials
- Onsite rapid HIV testing
- Post-test counseling materials
- Ongoing and disclosure counseling forms
- Nutritional counseling materials
- Tuberculosis (TB) screening forms
- Sexually transmitted infection (STI) screening forms
- Family planning (FP) counseling materials
- HTC information, education, and communication (IEC) materials
- Multiple and concurrent partners (MCP) messages
- Gender-based violence messages
- Condom demonstration and distribution
- Male circumcision (MC) counseling and referrals
- HTC partner referral forms
- Referral forms for pre-antiretroviral therapy (ART) and ART

Checklist for Minimum Requirements for HBHTC Implementation—Cue Card

Before a counselor goes into the community, the counselor should have the following supplies for HBHTC implementation:

1. HBHTC protocols
2. TB screening form
3. HIV testing algorithms
4. HBHTC job aids and cue cards
5. Lancets (spring-loaded)
6. Alcohol pads or spirit
7. 10% hypochlorite solution (jik)
8. HIV test kits

9. Cotton wool
10. Gloves
11. Disposable or biodegradable lab coats
12. Sharps container
13. Biohazard bags
14. Masking tape
15. Counselor's uniform
16. Name tags
17. Small cooler boxes
18. Soap or hand sanitizer and paper towels
19. Timer or watch
20. HBHTC kit (bag pack, portable table, and utilities)
21. Umbrella
22. Rain coats
23. HBHTC cap or hat
24. Files
25. HBHTC tools (i.e., intake forms, referral forms, TB screening forms) ¹

¹ The HTC Core team should provide a detailed list here of all the tools once approved so the counsellor can be sure to have all the necessary tools/forms.

For more information, please visit aidstar-one.com.

AIDSTAR-One

John Snow, Inc.

1616 Fort Myer Drive, 11th Floor

Arlington, VA 22209 USA

Phone: 703-528-7474

Fax: 703-528-7480

Email: info@aidstar-one.com

Internet: aidstar-one.com