Targeting High-Risk Groups through Mobile HIV Counseling and Testing and Referral Services

BACKGROUND

HIV/AIDS presents serious demographic, social, economic, and developmental challenges in Ethiopia. The HIV prevalence among adults age 15-49 is estimated to be 2.1% (*Single Point HIV Prevalence Estimate*, Federal HIV/AIDS Prevention and Control Office [HAPCO], June 2007). Knowledge of HIV status is relatively low, with an average of 3.8% of adult women and 4.9% of adult men ever having received an HIV test result (Ethiopia Demographic and Health Survey 2005).

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

Data from rapid HIV counseling and testing (HCT) assessments conducted by the Private Sector Program-Ethiopia (PSP-E) indicate that at-risk populations may not be utilizing HCT in facility sites due to facilities' hours of operation, distance, long waits, reagent shortages, and perceived lack of confidentiality. To increase the accessibility of HCT services for key populations and people living areas along the major transport corridors, PSP-E began conducting mobile HCT services in Oromia region in July 2007. Since then PSP-E has implemented mobile HCT services in 40 towns in Oromia, Amhara, and Afar regions, reaching a total of 69,144 clients.

Mobile services are set up in convenient locations to faciliate access to high-risk groups

This publication was produced for review by the United States Agency for International Development (USAID). It was prepared by the Private Sector Program-Ethiopia (PSP-E) program.
The PSP-Ethiopia is a five-year task order (September 2004 to September 2009) funded by the United States Agency for International Development (USAID) through the President's Emergency Plan for AIDS Relief (PEPFAR). PSP-Ethiopia works to increase access to high-quality TB and HIV services and prevention programs by building sustainable partnerships between the public and the private sector. Abt Associates leads a team of international partners that includes IntraHealth International (IHI), Population Services International (PSI) and Banyan Global in implementing PSP-E. Abt Associates also works closely with many Ethiopian partner organizations to implement PSP-E program activities. For more information on PSP-E: http://psp-one.com/section/taskorders/psp_ethiopia

Program Summary

TECHNICAL STRATEGY

PSP-E's strategic approach for mobile HCT is to provide key populations with confidential, high-quality counseling and testing services that are connected with HIV and AIDS treatment, care, and support services through referral linkages. PSP-E has implemented several strategies to deliver quality mobile HCT service to key populations.

- **Partnership with local stakeholders:** PSP-E collaborates closely with the respective Regional Health Bureau (RHB), local health officials, and community stakeholders to design, plan, and implement mobile HCT services in each region. The RHB and Regional Reference Laboratories participate in all steps of implementation including leading the consensus-building and review meetings with stakeholders, rapid assessment of towns, site selection, logistics, social mobilization, supportive supervision, and quality assurance.
- **Targeted intervention to reach at-risk populations:** To reach key populations, mobile HCT activities are implemented in urban and peri-urban areas along the four major transportation corridors that link Ethiopia to Kenya, Djibouti, and Sudan. Towns and HCT sites within towns are selected to facilitate access to key populations, including commercial sex workers, petty traders, truck drivers, migrant workers, clients of sex workers, separated/divorced individuals, and pregnant women. Hours of operation are adapted for each town to facilitate maximum uptake of services by key populations. The mobile HCT services are offered for five continuous days (Wednesday to Sunday, using weekend and luchtime services as an opportunity to reach workers) and are repeated for multiple weeks depending on the anticipated demanded. In some towns, there are women-only days, and "moonlight" services are provided during evening hours to increase uptake among clients who prefer the evening hours and/or to avoid the very high daytime temperatures found in some sites. In addition, PSP-E conducts at least two rounds of service in each town.
- **Service delivery by qualified health providers:** PSP-E subcontracts out the HCT services to experienced local health service providers under subcontracts with Abt Associates. The subcontracted organizations are responsible for conducting HIV counseling and rapid testing in full compliance with national guidelines and standards and providing condom demonstrations and appropriate client referrals. Subcontractors are selected based on their personnel, prior experience with HCT, references, business credentials, license to provide HCT, and reasonableness of the cost.
- **Community mobilization:** Intensive community mobilization is used as a strategy to ensure uptake of the mobile HCT services, particularly by key populations. PSP-E implements a variety of community mobilization strategies to create demand for and increase uptake of both mobile and static HCT services in collaboration with key stakeholders, including town health offices, women's associations, and anti-HIV/AIDS clubs.
- **Referrals linkages:** PSP-E provides referrals to HIV-positive clients (identified through the mobile HCT services) to private and public institutions for follow-on care and support services or for further diagnosis and treatment.

KEY ACTIVITIES

- **Rapid assessment of towns:** PSP-E conducts a rapid assessment in selected towns to collect data that are used to design effective mobile HCT services that target key populations in each town. A principal investigator and data collectors conduct key informant interviews with representatives from the RHB, HAPCO, local organizations providing HIV/AIDS services, people living with HIV and AIDS and support groups, *idirs*, and local government officials. The team conducts in-depth interviews with commercial sex workers and focus group discussions with community members such as in- and out-of-school youth and daily laborers. The rapid assessment also solicits information on HCT utilization, behavior of key populations, and willingness to use mobile HCT services. The information collected from the assessment is distilled into a report on the region assessed, with details on each target town.

  Interviewers also collect information to complete a referral directory by interviewing key service providers identified by the town health offices. The information on the services provided by each organization, working hours, and contact details is compiled into a referral directory.
- **Consensus-building meeting with stakeholders:** PSP-E and the RHB convene a meeting with key stakeholders to explain the mobile HCT approach, targets, and timeline for implementation services and to identify roles and responsibilities for each community-level organization that will assist with coordination and implementation of services.
- **Site selection:** A site selection committee is established in each town to select appropriate sites for implementation of mobile HCT. The site selection committee chaired by the local health offices includes representatives from the mobile HCT subcontractor, PSP-E, HAPCO, town police force, local government, women's associations, and providers.

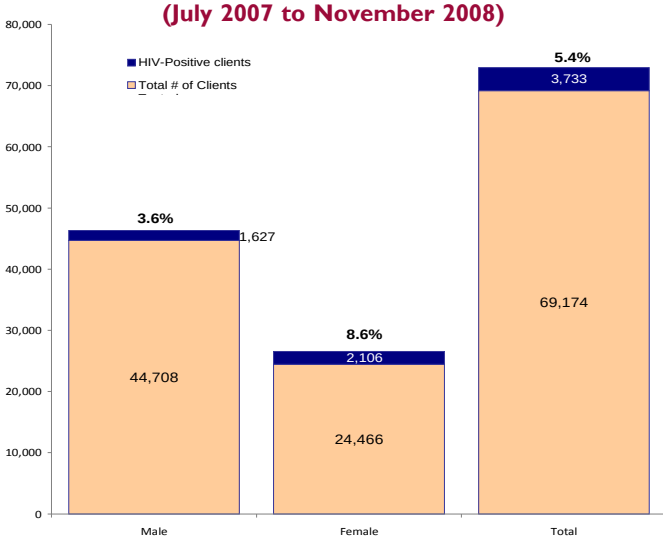
- **Community mobilization activities:** To publicize the mobile HCT services and create demand, PSP-E actively promotes mobile HCT services in the community between one day and one week before the service is provided. Community mobilization continues during the implementation of services. Community mobilization strategies used to reach key populations include car announcements in targeted areas, evening video shows, and workplace promotion, as well as door-to-door mobilization by women promoters who distribute coupons that enable women to be served first at the mobile HCT site, and coffee ceremonies with sex workers. Leaflets, posters, banners, and brochures are also used to promote the services (complete with the dates, times, and locations) and provide information on the importance of HCT.
- **Mobile HCT service implementation:** A local service provider is subcontracted by PSP-E to implement mobile HCT services in targeted towns. The service provider forms a mobile HCT team composed of 5-6 counselors, a site coordinator, health educator, laboratory technician, receptionist and cleaner, and three security guards. At each selected site, a reception tent, group education tent, and 5-6 small tents for individual counseling and testing are set up. The local service provider coordinates the supply of all consumables for service provision and PSP-E provides HIV test kits. The mobile HCT team provides services from Wednesday to Sunday in each town for eight hours a day. Each counselor aims to counsel and test 15 clients per day of service provision. Clients identified as HIV positive, with their consent, are referred to other care and support services or for further diagnosis and treatment.
- **Monitoring and evaluation:** PSP-E has developed recording and reporting formats based on forms included in the national HCT guidelines to collect and record data on HCT service delivery. All members of the mobile HCT team are oriented on accurate completion of the forms. The data collected from the monitoring and evaluation system are routinely analyzed to improve program implementation. In addition, PSP-E routinely sends standard HCT reports to local health offices within 15 days of completing a mobile HCT visit.
- **Quality assurance:** PSP-E and the RHBs implement a number of quality assurance activities, including daily debrief sessions with counselors, review of counselor self-reflection forms, direct observation of the HCT session with clients, and client exit interviews, to ensure that HCT services are being implemented according to national guidelines. The system is also used to provide feedback and support to counselors with the goal of enhancing each counselor's skills in delivering service. In addition, the Regional Reference Laboratory conducts external quality control (EQC) activities (blind rechecking of results and proficiency testing of counselors performing HIV tests).

ACHIEVEMENTS AS OF DECEMBER 2008

Some of the major achievements in the specified period of time are:

- **Rapid assessments:** PSP-E conducted baseline site assessments in 59 towns of Oromiya; Amhara; Afar; Southern Nations, Nationalities, and People's Republic; and Dire Dawa to inform the design of mobile HCT services.
- **Logistics:** PSP-E has purchased the tents and furniture required to implement the services and produced and distributed standardized monitoring, recording, and reporting tools/formats and guidelines/procedures with prior in-depth training of the counselors and mobile HCT supervisors. PSP-E has also drafted an operational manual to guide partners in how to implement mobile HCT in Ethiopia.
- **Building local capacity:** To date, PSP-E has engaged and built the capacity of four local service providers in implementation of mobile HCT services.
- **Service delivery:** Since the initiation of mobile HCT services in July 2007, PSP-E provided the service to a total of 69,144 clients (24,337, or 35.2%, were female) in 40 towns. A total of 3,707 clients (5.4%) were found to be HIV positive (3.7% of males and 8.5% of females tested). 55.8% of all HIV-positive clients were female. Among HIV-

Percentage HIV-positive in Total Tested by Gender Mobile HCT in Amhara, Oromiya and Afar (July 2007 to November 2008)



positive individuals, 3,255 accepted (87.8% acceptance rate) referrals for treatment, care, and support services.

- **Laboratory quality:** The Regional Reference Laboratory conducts laboratory quality assurance activities routinely, either through blind rechecking of results or proficiency testing for counselors conducting HIV tests. EQC data from Rounds 1 and 2 indicate a high level of testing quality, with discordant results occurring in less than 0.2% of tests conducted.

Region	# of samples collected for EQA	EQA Results	
		Concordant	Discordant
Amhara East	1,443	1,443	0
Amhara West	1,006	1,000	6
Oromia South	677	677	0
Total	3,126	3,120	6
	Percentage	99.8%	0.2%

Note: EQA-external quality assurance

- **Monitoring and evaluation:** After each round of mobile HCT, PSP-E organized review meetings to evaluate the program performance and draw lessons for the next phases of the MCT. In addition, mobile HCT data (from client intake forms) are routinely analyzed to improve service delivery and revisit community mobilization approaches.

LESSONS LEARNED

- **Strong partnership with stakeholders to allow for effective resource mobilization and networking to support service delivery:** PSP-E partnered with health facilities to use existing infrastructure to support cold chain and waste disposal, the regional laboratory to support EQA, obtained safety boxes from the USAID-funded Making Medical Injections Safer project and engaged local volunteers from women's associations and anti-AIDS clubs for community mobilization.
- **Building capacity locally to deliver mobile HCT services:** By outsourcing service delivery to local service providers, PSP-E has strengthened the skills of these service providers to provide quality mobile HCT services.
- **Using data and evidence from rapid HCT assessments to design services targeting key populations:** PSP-E utilized the findings and recommendations from stakeholders and key populations to provide confidential, accessible, and acceptable mobile HCT services. For example, key informants recommended using counselors who did not reside in mobile HCT towns to ensure confidentiality and privacy of clients. Female-only HCT days and moonlight services were provided at the suggestion of female sex workers interviewed during the rapid assessments.
- **Using flexible and innovative approaches to address barriers that limit uptake of services:** As PSP-E implemented mobile HCT services, service delivery was tailored to address challenges and issues that came up and to meet the needs of each local area. For example, due to the low attendance of women at mobile HCT sites during initial rounds, PSP-E engaged women promoters and introduced coupons for women referred by the promoters to be prioritized at the mobile HCT. PSP-E also shifted the timing of mobile HCT from Tuesday-Saturday to Wednesday-Sunday to increase access for daily laborers, other workers, and in-school youth. Service hours are also flexible depending on the situation and needs of each town. In some areas, services were offered during early morning and early evening hours to accommodate the schedules of agricultural workers. In other areas, services were offered in the evenings, to avoid extreme mid-day heat or to increase uptake by clients who are unable to attend services during the day (including weekends). Moonlight services increased participation of women clients – reasons they cited include being busy with household activities during the day and more privacy at night.
- **Referral and follow-up of HIV-positive clients:** As part of the mobile HCT services, PSP-E established and/or strengthened the referral system to provide follow-up care and treatment services for all HIV-positive clients. Initial data collected from referral slips indicate that 520 or 26% of the 1,956 clients referred between March and August of 2008 had reached the referral facility within approximately two months.