FEASIBILITY STUDY OF THE MOBILE VAN FOR VOLUNTARY COUNSELLING AND TESTING (VCT) FOR HIV/AIDS

FINAL REPORT

SUBMITTED TO

The Uganda Program for Human and Holistic Development (UPHOLD)
P. O. Box
Kampala
Uganda

By

Asingwire Narathius
Dept. of Social Work & Social Admn.
Makerere University
P. O. Box 7062
Kampala-Uganda

E-mail: nasingwire@ss.mak.ac.ug
Tel:075-790594/041-53411

July 2004

Acronyms

AIC:	AIDS Information Centre
ARVs:	Antiretroviral drugs
CBOs:	Community Based Organizations
CDC:	Center for Disease Control
FGDs:	Focus Group Discussions
HBC:	Home Based Care
HSD:	Health Sub-District
IEC:	Information Communication, Education
KMs:	Kilometres
LC:	Local Council
MoH:	Ministry of Health
MVS:	Mobile Van System
NGO:	Non-Governmental Organizations
OIs:	Opportunistic Infections
PMTCT:	Prevention of Mother-to-Child Transmission of HIV
SOW:	Scope of work
STDs:	Sexually Transmitted Diseases
STI:	Sexually Transmitted Infections
TB:	Tuberculosis
ToR:	Terms of Reference
Ug.Shs:	Uganda Shillings
UPHOLD:	Uganda Program for Human and Holistic Development
USAID:	United States Agency for International Development
VCT:	Voluntary Counselling and Testing

Table of Contents

List of Tables and Figures

EXECUTIVE SUMMARY

Background and Methodology

This report contains the findings of "The Feasibility Study on the Mobile Van for Voluntary Counselling and Testing (VCT) for HIV/AIDS in Uganda", which was commissioned by The Uganda Program for Human and Holistic Development (UPHOLD). The study aimed at documenting the viability of this option in delivering VCT services especially to "hard to reach" groups and make recommendations for an effective mobile van service package and ideas for scale up. Using an exploratory design, a multifaceted rapid assessment approach was adopted to generate descriptive and analytical information, both qualitative and quantitative.

Findings and Analysis

Accessibility to VCT Using Mobile Van Service

Study findings show that the majority of potential clients of VCT services, who are otherwise constrained due to costs of transport, and of service, consider the van as a great opportunity. Many people are aware of the existence of VCT services and would like to take a test for HIV. The mobile van brings VCT services closer to the people, and hence ensures equitable access to VCT service. Different socio-economic and demographic groups are provided the opportunity for service. It is thus appropriate to equip mobile vans to move to where people live and work, including schools and recreation centers.

Gender Considerations

A quick count at any point in time, while the AIC Mobile Van VCT service period lasted at a particular site, would reveal more women than men in the queue. The young men, mainly of adolescent and late 20s or early 30s did not feature prominently in the queues, although the few who made it to the end were ready to be interviewed. Partly because the services at AIC Mobile Van VCT are free of charge, all community people, including women, some of whom would otherwise be denied service for lack of control of financial resources, find it easy to obtain service. The nature of the service thus caters partly for gender and other socio-economic considerations, which commonly constrain accessibility of services to which fees are attached. Assessment of service received also shows no peculiar gender related challenges.

Comparative Cost of Providing Mobile Van VCT

There is marked reduction in comparative cost of establishing and sustaining Mobile Van VCT systems in vast communities as compared to establishing more indirect sites at health units composed of few regular staff providing services on a regular basis. One indirect site in a district or geo-political area can suffice if boosted by regular mobile services from the regional AIC office. Care should, however, be taken to ensure the team is well equipped and motivated to ply the communities and provide quality services to the communities.

Response of Clients to Mobile Van VCT

The Mobile Van attracts more clients to VCT compared to static VCT services. Given that, in many situations, VCT has been associated with behavior change irrespective of the results of the test, more people turning up to test implies more likelihood of improvement in the country's response. Potential clients of VCT services who would otherwise be constrained to seek service due to fear of anonymity and confidentiality are catered for.

Quality of Service at Mobile Van VCT Site

With appropriate support for staff and adequate equipment, quality of service can be guaranteed with the Mobile Van VCT system, for instance in terms of length of counseling sessions, quality time provided to clients, safety of equipment used, hygiene and meeting other health concerns of those suffering from AIDS related complications. The AIC Van can draw lessons from Kitovu Mobile on the kind of essential services that community people seek from HIV/AIDS service agencies. While not all services can be provided, a few essential support kits are necessary.

Organizational Issues to Consider

Other issues that are important in developing a sustainable highly attractive Mobile Van VCT system that meets the demand for VCT within and across communities include: developing partnerships with support agencies for continued care and support for PLHAs, community mobilization and sensitization prior to the visit by the Mobile Van Team, allowances for community/district based support teams, notification of local leadership and ensuring that the Mobile Van enters early into the community to be served before people disperse to engage in other everyday activities.

Challenges of Mobile Van VCT

The major challenges of the Mobile Van, which should be addressed, include the need to articulate measures for continuity, especially taking care of those who test positive, information about treatment, referral systems for psychosocial, economic and legal support, and adequacy of community education and sensitization about the service. There are issues of stigma to be addressed especially considering that the testing and counseling are conducted in open air or full view of community others. Education and sensitization of communities before and during service delivery at Mobile Van VCT sites should address the reluctance of some people to take advantage of a service brought nearest to them.

Overall Assessment of Mobile Van VCT

Overall, the Mobile Van arrangement for VCT is a viable endeavor. It is possible to maintain quality services by moving AIC qualified staff and equipment from one place to another within their regional areas of coverage. The van can effectively target a category of population who would otherwise be inconvenienced and inaccessible if they were to rely on fixed facilities. More important, continuity of care for the clients can be guaranteed if deliberate partnership systems are developed with other agencies and support groups nearest to clients.

Main Recommendation

Drawing from the study, it is recommended that UPHOLD, CDC, and USAID support the AIC Mobile Van VCT service, taking into account the adjustments highlighted in this report. In partnership, UPHOLD, CDC, and USAID should identify among the support requirements for an effective mobile van those areas that each agency can address. The major requirements include the following:

1. Vehicles equipped to suite Mobile VCT services, both laboratory and personnel. The vehicle should conveniently be able to move such items as washbasins, towels, and medical consumables such as gloves, needles, syringes, lancets, swabs, spirit, sharps disposal and standard waste disposals. Since these items have to be transported, the vans should be equipped with cooler boxes and relevant samples kept refrigerated.

2. Allowances for AIC staff and support staff at district AIC indirect sites such as counsellors whose active participation fills the necessary gaps articulated in this report.

3. Capacity building of relevant units of AIC (management, counselling, technical) required to run Mobile Van VCT through training and logistical support to AIC to expand and improve service availability to wider sections of hard-to-reach groups.

4. Support to partnership building initiatives by AIC to link with other agencies in order to make available services for post test care and support, treatment, and impact mitigation to clients in need. This is necessary to make VCT more relevant and attractive to majority of reluctant members of the community

SECTION ONE: BACKGROUND AND METHODOLOGY

1.0 Introduction

This report contains the findings of "The Feasibility Study on the Mobile Van for Voluntary Counselling and Testing (VCT) for HIV/AIDS in Uganda", which was commissioned by The Uganda Program for Human and Holistic Development (UPHOLD). The report provides a detailed background and objectives of the study, methodology used, findings and conclusions.

1.1 Background

UPHOLD is a five-year program funded by the United States Agency for International Development (USAID) whose overall goal is to improve the quality, utilisation and sustainability for the delivery of services provided in health, education and HIV/AIDS prevention, care and support.

One of UPHOLD's priorities in HIV/AIDS prevention, care and support is to increase the availability, access and utilization of VCT services. For this reason, UPHOLD is supporting AIDS Information Centre (AIC) in the delivery of VCT services. AIC proposed a Mobile Van System (MVS) as one way to improve the delivery of VCT services. The assumptions were that:

1. It would be possible to maintain quality services by moving qualified staff and equipment from one place to another;

2. The mobile van would target a category of population who would otherwise be inconvenienced and inaccessible if they were to rely on fixed facilities. According to this perspective, it is more prudent to equip mobile vans to move to where people live and work, schools and recreation centers; and

3. Continuity of care for the clients would be guaranteed.

Currently, AIC operates five main branches (referred to as direct[1] sites) in Kampala, Jinja, Mbarara, Mbale and Arua. It has 55 indirect[2] testing sites in 24 districts that provide VCT services. By the end of September 2002, AIC had served over 700,000 since it began its operations (1990) both at the main branches and the district sites. Since the VCT sites have been overwhelmed by excessive demand, AIC is trying other options of dealing with this problem including creation of more indirect sites[3]in which case some health units (both government and NGO) are being considered as delivery points of VCT services. The other option is that of the mobile van for VCT, which attempts to address the above problems, for it is hoped that this would guarantee quality of service and confidentiality. It is in this respect that with support from USAID, AIC secured a

[1] At the direct sites integrated VCT services including family planning treatment of STDs and other opportunistic infections, screening & treating TB, support counseling through post test clubs. These centers are fully owned and operated by AIC.

[2] At indirect sites, there are VCT services provided through the existing facilities of government, NGO and private sector). Here, AIC enters into an agreement with the agencies to provide services through their facilities.

Mercedes Benz van that became operational with effect from July 2003 to provide VCT services. In order to scale up the mobile van system, UPHOLD commissioned this study to document the viability of this option in delivering VCT services especially to "hard to reach" groups.

1.2 Assumptions Underlying the Feasibility Study

1. The majority of potential clients of VCT services are aware of the existence of services. They know what is involved in VCT having been sensitized about the service through various IEC approaches by public and civil society agencies.

2. Most people recognize the relevance of VCT in influencing behavioral decisions to prevent the spread of HIV/AIDS. The service marks a turning point in the lives of those who test irrespective of the results of the test.

3. Some potential clients of VCT services are constrained in seeking service due to their fear of losing anonymity and confidentiality. The permanent location of VCT services at conventional health units of Government and civil society agencies discourages these potential clients, as they perceive there likelihood of disclosure of their HIV status to wider community members. Some clients are hard to reach due to their mobility and distance from the direct services.

4. Potential clients of VCT are kept away from seeking service at established direct and indirect sites of VCT because they know and interact with service providers they are socially acquainted with, or may clearly not trust them with sensitive and personal experiences such as one's HIV status. Many would be more comfortable with Mobile Van VCT managed by providers least known to clients. Providers that are not known to communities tend to be trusted and, therefore, attract more clientele.

5. People who have used VCT services at established Health Units report various experiences at points of service and socio-psychological consequences, many of them negative. The extent and depth of pre and post test counselling at the established VCT centres is glaringly inadequate to allay all the emotional and social consequences.

6. Community members are discouraged to seek VCT services due to facility related factors (including fear of losing anonymity and attendant stigma and discrimination) more than their own contextual, socio-behavioral challenges (such as perception of risk of infection, and assumed HIV status)

7. Quality of service at established direct and indirect VCT facilities is largely considered insufficient as to motivate potential clients to seek VCT services.

8. Gender and other socio-economic considerations have a strong influence on:
   - Accessibility to service at established VCT centres
   - Compliance with the requirements of counselling that clients have received
   - Positive and negative consequences that emerge following service at the centre

9. The Mobile Van arrangement enhances the possibility of continuity of care on the part of the clients, especially if the service can be sustained by the provider to the convenience of the clients.

10. A simple Cost Benefit Analysis will reveal how the Mobile Van system significantly reduces the fixed cost of service provision at static/permanent sites while enhancing the likelihood of reaching wider populations that would otherwise be constrained by structural, access related factors.

1.3 Guiding Research Questions for the Feasibility Study

1. Does a Mobile Van VCT service provide opportunities for equitable distribution of service across socio-economic and demographic population groups? What are the issues that still have to be addressed in a Mobile Van VCT system to realize its comparative contribution in meeting demand for VCT?

2. What mechanisms are required to ensure continuity of care in a Mobile Van VCT system? To what extent, if at all, would a Mobile Van VCT system compromise continuity of care even when sufficient attention is placed on ensuring that the Van is regularly available?

3. Given the mobile nature of the Mobile Van VCT arrangement, does it provide quality services, in line with the protocol developed by MOH for VCT services? For instance, is quality guaranteed in terms of length of counselling sessions, quality time provided to clients, safety of equipment used, hygiene and meeting other health concerns of those suffering from AIDS related complications, etc?

4. What is the comparative (personnel and other variable) cost of establishing and sustaining Mobile Van VCT systems in vast communities as compared to establishing indirect sites at health units composed of few regular staff providing services on a regular basis

5. A Mobile Van inadvertently attracts attention of all categories of community members, others simply interested in who takes the service and what the outcome of the HIV test is. Onlookers will attempt to guess the reasons for seeking the test. How would the service providers address the challenges of likely stigma based on suspicions against those who accept to be served?

6. What other issues (organizational and /or community based) are important in developing a sustainable highly attractive Mobile Van VCT system that meets the demand for VCT within and across communities?

1.4 Justification of the Feasibility Study

The Mobile Van System (MVS) is meant for 'hard to reach' groups. So far, one mobile van has been purchased for the Kampala branch and was found to be inappropriate for mobile services. As a result, the van had to be modified. In addition, three more vans are to be purchased for mobile activities in Mbarara, Jinja and Mbale branches. The experience so far with the current van is that there is high demand for VCT services in the areas visited, although there was a problem of staff being overwhelmed by the numbers that in a way might affect the quality of services. It was also

observed that clients who showed up in most cases were mainly middle-aged women, and a few men and youths.

UPHOLD agreed to fund the modifications of the current van as well as the activities associated with it. Center for Disease Control (CDC) will fund purchase of three more mobile vans and the implementation of the related activities. In order to scale up the mobile van activities, a need arose to carry out a feasibility study that would address the following critical issues:

1. Adequacy of preparations to package the van to suit the different contexts where this service is to be delivered.

2. Input from the consumers in this option of VCT service delivery.

3. Measures for continuity especially for taking care of those who test positive. The current AIC plan does not articulate measures to be put in place to deal with this problem.

4. Evidence that groups the van is meant to serve such as students, market vendors, fishmongers and commercial sex workers is what they need.

5. How to address issues of stigma especially considering that the testing and counseling are conducted in open air.

6. Feelings of the people in the beneficiary communities about the mobile van VCT service.

It is from such background that a feasibility study was proposed to pave way to consolidate the mobile van services.

1.5 Objectives of the study

1.5.1 General

To study the feasibility of the mobile van service and make recommendations for, an effective mobile van service package, including ideas for scale up.

1.5.2 Specific objectives

1. Review the current AIC mobile van activities in terms of quality, equity, cost effectiveness and sustainability of services;

2. Explore the consumers' perspective about obtaining services from the mobile van;

3. Establish the areas where the mobile van has a comparative advantage over other options in VCT service delivery;

4. Explore mechanisms through continuity of care of those who test positive can be established at the community level;

5. Make recommendations to AIC, UPHOLD, CDC and USAID for improving the current AIC mobile van VCT services;

6. Examine the extent to which other services such as family planning, STI management and TB are integrated into the mobile VCT service delivery;

7. Generate the ideas for monitoring and evaluating mobile van VCT services;

8. Identify potential areas for establishing post-test clubs and how they can be linked to continuous medical and support programs; and

9. Identify barriers that may inhibit demand for VCT services and suggest strategies to overcome such barriers.

1.6 Methodology

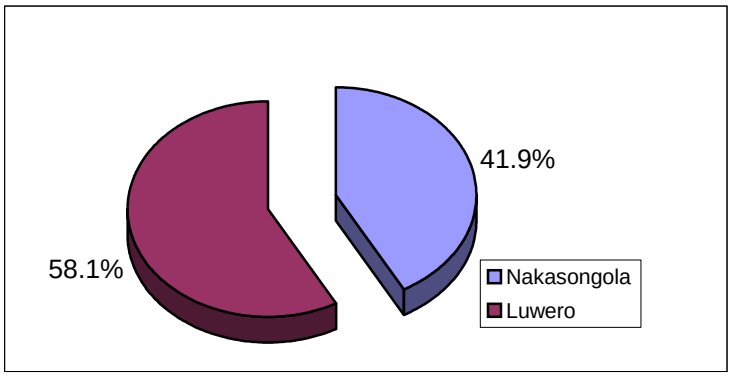
1.6.1 Overall research design

The study was exploratory, adopting a multifaceted rapid assessment approach. A range of qualitative data collection techniques was applied in this study. The data were triangulated to address the critical questions and issues of the study.

1.6.2 Study areas and respondents

The study was conducted in three districts, two where the mobile van services have been provided and another where the services have not been provided by AIC, but an almost similar mobile approach has been used to provide care to people living with HIV/AIDS and persons seeking to know their status. After consultation with AIC, Nakasongola and Luwero districts were considered ideal districts where the mobile van services have been delivered by AIC and Masaka as a control district. The later was included particularly to capture the experiences of Kitovu Mobile Program, an agency providing comprehensive mobile home care for people suffering from AIDS related complications, and affected families through HBC and community outreach. The selection of the two categories of districts was meant to provide a comparative analysis of where only VCT service is delivered (for the case of Nakansongola and Luwero) and where VCT service is a component of home-based care.

Figure 1: Sample of Exiting Clients by District of Study



In the districts where service has been provided, Nakasongola and Luwero, data were collected from community members who had been exposed to the service. These were further divided into those who had used the service (36 for Luweero and 26 for Nakasongola) and those who were exposed to the service but did not use it (the rest of the people in the communities visited with Mobile Van). Only nine exiting clients were recruited from Masaka after the Research Team followed Kitovu Mobile HBC community outreach program van. Many of the clients the agency staff served at various outreach sites were old clients seeking treatment for OIs and other material supplies the staff van distributed. The Research Team moved with Kitovu Mobile HBC

Team to a total of six sites in Kyazanga, Kyetume, Mbirizi, Kinoni and Lukaya but was only able to find few new clients seeking VCT.

1.6.3 Assumptions underlying the selection of the study participants

1. Some people were or have been exposed to the mobile van VCT service, and therefore, there are compelling reasons for using the service

2. Among the people who have used the service, there are those who experience negative effects as well as those who experience positive effects

3. People who do not use the service and yet they are aware of the service, there are inherent factors in the service delivery that they do not like

4. Gender and other socio-economic circumstance will have an influence on:
   - Whether the people use the service
   - Comply with the requirements of the counseling they receive
   - Problems that emerge
   - Benefits that accrue

1.6.4 Data collection techniques

Data were collected using participatory qualitative methods; focus group discussions, key informant interviews, in-depth interviews, observation and exit interviews.

Focus Group Discussions: - Focus group discussions were organized to study the attitudes and perceptions of the community members. Two FGDs were conducted, one with community people in Nakasongola district, male adults, who had been exposed, but never used, the mobile van VCT. The second FGD was with female exiting clients of Kitovu Mobile, Masaka District, who had been reported to seek VCT service. For both cases, this was their first contact with VCT service providers.

In-depth Interviews: - These were held with staff of AIC and staff of health centers/agencies involved in the delivery of VCT services. Among them were the VCT supervisor, Nakasongola, and two community-based workers under Kitovu mobile, Masaka.

Key Informants Interviews: - These were conducted with selected officials in District Directorate of Health Services and community leaders for Nakasongola District, CBOs in the area of study working in the related fields (Kitovu Mobile for Masaka District). A total of 9 participants, among them the Advocacy Officer AIC, Lab Technician AIC, Senior Counselor AIC, and two Staff of Kitovu Mobile were informally interviewed and their work in the communities visited was observed.

Observation: - Observation of VCT service delivery was crucial to generate data on client behaviors, and the range and quality of service. Hence, there was need to work hand in hand with AIC to arrange mobile service visits so that part of data collection would include observation.

Exit Interviews: - During the service delivery, it was possible to conduct exit poll interviews with some of the clients. A total of 62 exit interviews were conducted for users of AIC mobile van VCT in Nakasongola and Luwero Districts and nine interviews for the control, Masaka. All exiting study participants had been exposed to the Mobile Van VCT service and had been served accordingly. All of them had gone through the entire VCT process, including receipt of test results. About twice this number had been exposed, and had utilized the Mobile Van service but were unavailable for interview mainly due to time constraints and other personal reasons.

Informal, spontaneous individual and community discussions: - Although not initially planned as part of the data collection process, the Research Team held impromptu discussions with individuals and small groups in and around the sites for Mobile Van VCT, asking them to comment on VCT, and on the mobile van service in particular, mainly as the Research Team waited for clients to exit. This was done informally, without interrupting whatever chore an individual or group were doing. Other community people would also walk to members of the Research Team, taking them to be part of the Mobile Van Team. Through this natural process, the Team clearly noted that the proportion of community people who offered to receive VCT service were only a small section of the community. The majorities were exposed, never opted for service, and had never taken VCT. Among community members exposed but who did not use the service, a few had tested elsewhere.

1.6.5 Data management

Qualitative data were manually analyzed using content and thematic approaches. The thematic areas for analysis included, but not limited to; perceived cost effectiveness, how user- friendly, confidentiality and immediate support systems for the clients who test positive. Other analytical considerations addressed included stigma, attitudes and perceptions of clients, quality of services in the communities and access in respect of gender and the implication this have on couple relationships.

Research Assistants and a Supervisor verified, edited and coded all the quantitative data. All coded exit questionnaires were entered into computer using an EP-INFO program, and converted into SPSS to analyze possible relationships between and among various variables.

1.7 Organization of the report

The report is structured into Five Sections along the objectives of the study; Section 1.0 is Introduction and Methodology highlighting the background, assumptions underlying the feasibility study, the guiding research questions, study objectives, and the approaches and methodology used throughout the study.

Section 2.0 reviews the current AIC mobile van activities focusing on description of the site, methodology used to mobilize clients, adherence to the VCT protocol and satisfaction with the service. The section also looks in detail at the issue of equity, cost effectiveness and sustainability of the mobile van VCT service. The sections that follow (3.0 and 4.0) present consumers' perspectives about obtaining services from the Mobile Van, and the comparative advantage of Mobile Van VCT over the static VCT centres as well as the mechanisms for continuity of care particularly focusing on resources such as personnel, financial, community perception and issues of stigma and discrimination. The last section (5.0) of the report presents the conclusions and recommendations arising from the feasibility study findings.

SECTION TWO: REVIEW OF CURRENT AIC MOBILE VAN ACTIVITIES

2.1 Description of Service and Quality Assessment

One of the key issues for analysis in this study was to gather and analyze data for assessing the quality of service provided by the mobile van. The question was whether or not the Mobile Van VCT arrangement does provide quality services, for instance, in terms of length of counselling sessions, quality time provided to clients, meeting other health concerns of those suffering from AIDS related complications, etc? Similarly, while providing VCT, attention has to be put on the nature of the site, for instance, crowded, open ground, private place, protection from rain and sun etc). More important, mobile or static, VCT must adhere to protocol (privacy and confidentiality, satisfaction with the service etc).

The national policy implementation guidelines for VCT services recognize three categories of VCT facilities namely, freestanding sites, health unit-based sites, and outreach sites. Under the outreach sites, the policy recognizes that mobile vans, while helpful in mobilization and staff transportation, should not be used for actual VCT service delivery because follow-up and support are difficult. However, geographical inaccessibility of services in parts of the country, compelled AIC to devise options of reaching more people by use of mobile vans; to deliver VCT services in addition to the direct and indirect sites. Some of the observations by the Research Team and experiences of the clients seeking mobile van for VCT service as well as those exposed to the van that remained reluctant to be served are presented in the succeeding sub-sections.

2.1.1 Site Description

In the districts of Nakasongola and Luwero where service of the mobile van for VCT has been provided, the sites of Tumba and Nakaseke were visited.

Visit to Tumba landing site*: *A case of hard-to reach community

Tumba landing site is the typical hard to reach community in terms of essential services. Located about 20 Kms from the district headquarters of Nakasongola, the landing site is a remote area with no essential services such as health centre, clean water, schools, and electricity. The houses are crammed together most of which are of the mud and wattle. Through observation it was realized that matters of hygiene regarding human waste are in a remorseful state; toilets are scarce. At the time of visit, the road to the site was in good shape, though it was indicated that during the rainy season it becomes impassable.

Communities served by the Mobile Van at the time of study, particularly Tumba landing site, can undoubtedly be described as hard to reach localities. These are clearly isolated in terms of distance and basic social services in and around the sites visited. One can summarize them as poor, vulnerable, powerless communities, lacking key social infrastructure and opportunities for social and economic transformation. The Mobile Van was obviously a rare opportunity for the communities to be provided a service within the proximity of their homesteads.

According to the national policy implementation guidelines for VCT, with regard to outdoor counselling, the client and counselor should be well isolated from others at the centre and seated under a shed. However, in the case of Tumba landing site, it was not easy to find a suitable

place for the counselling and testing exercise. For instance, registration of clients took place under a tree. Again, because the houses were crammed together, it was not possible for counselors to sit at a distance away from within hearing reach of other people at the site, therefore, the Mobile van Team decided to hire 4 rooms to serve as laboratory and counseling rooms respectively. However, none of the rooms hired could offer sufficient privacy; the walls were not sound proof, one standing outside could follow with ease the discussion between the client and service providers inside. Secondly, since the tiny rooms had no windows, doors had to be left open. Again because the Team had tentatively hired the rooms, access of other tenants sharing the hut/block to their rooms could not be easily denied. Only one of the counselling rooms was an independent unit, the other 2 were on blocks being shared by other tenants. For instance, the block that had the laboratory and one of the counselling rooms also had a room occupied by a community member selling fish. She continued to transact her business despite the counseling being conducted next door.

Visit to Nakaseke Hospital: A case of an established VCT outreach site

Nakaseke Hospital in Luwero district, the site for the second visit with the mobile van, was a case of an established outreach site for VCT as part of the district program. The mobile van for VCT only added to the technical and human resources used. According to the AIC Team, the site was being prepared to become a fully-fledged static site offering VCT services. Therefore, the purpose of the visit was to offer support and to orient the trained counselors at the site. The site is a well-established facility protected from both rain and sun. It is not in a crowded place. It would not pass as a hard-to-reach community.

At the time of visit, the hospital authorities designated one of the patients' waiting arenas for registration and waiting for test results, three rooms positioned at the end of a corridor, were set aside for counselling and testing of blood samples (to serve as the laboratory) respectively. Although the rooms were not sound proof and had very wide windows, there was some level of privacy. At the time of post-test counseling, the counselor would admit one client at a time. For one of the rooms, the door was closed while for the other the curtain improvised by the hospital was used. Counselors spoke in low tone to ensure that no third party listened to the discussion. For the case of Tumba landing site, speaking in low or high tone could never make a difference given the close proximity of the seemingly inquisitive community people to the points of service.

Visit to Kitovu Mobile Sites in Masaka

The six sites visited for the days the Research Team moved with the Home Based Care Team of Kitovu Mobile were long designated for service by the agency. The time for the Team to be at a particular site in known, and largely adhered to. Most of the sites are at or near a church of the Roman Catholic denomination, or at premises of a devout member. Needless to mention, service would only start after a prayer had been said, led by one of the Team members, or a member of the laity at the site. Among the clients, one also notices signs of faith-related convictions, verbal and non-verbal. However, the service is open to all people in the community. The staff knows majority of clients seeking treatment and material items brought by the visiting Team, having served some of them for quite long. The clients also know some of the service providers by name, except new clients seeking VCT or other service from the mobile team for the first time.

2.1.2 Mobilization for Mobile Van VCT Services

Prior contact with communities in which a mobile van will be used emerges as one critical issue for consideration in provision of mobile VCT services. It would have been assumed that

communities can be reached at short notice or even no notice and be served effectively. Drawing from the observations the Research Team made, this may pose some challenge. Consumption of VCT services, unlike other socially marketable services is compounded with clear education and sensitization about the realities of taking an HIV test on the part of the potential client, and, perhaps on how this may affect the family and significant others. Community people have many fears and misconceptions that have to be rested before responding to VCT. This calls for the need to mobilize and educate communities prior to the mobile VCT visit.

At all the mobile VCT sites visited, a cloud of doubt engulfed many community people. Some (at Nakaseke Hospital) indicated that if the van had gone to operate within their community without the participation of somebody from the district known to them, they would not seek for the service because it would be difficult to trust total strangers:

These are people I have never seen, I do not know them, they are strangers; how can I trust them. It is difficult. I cannot trust them (Client, Mobile Van VCT, AIC Site).

An assumption had been made that potential clients of VCT avoid seeking services at established direct and indirect sites of VCT because they know and interact with service providers they are socially acquainted with, or because they clearly not trust the service providers with sensitive and personal experiences such as one's HIV status. Many would be more comfortable with Mobile Van VCT services managed by providers not known to clients, the assumption continued. Providers that are not known to communities tend to be trusted and, therefore, attract more clientele, the assumption concluded. This is not universally the case.

In light of the above, in Nakasongola, mobilization of clients for the mobile van VCT services had been done by the District VCT Team one week prior to the scheduled date for providing the service. Initial contact with communities with the aid of the area local leaders was done to sensitize and motivate potential clients to respond to the mobile service. The cost of this initial exercise has to be calculated into an effective program for mobile van VCT. According to the District VCT Supervisor, and the Research Team concurs, it is important to take communities through the process and relevance of the exercise, addressing potential clients' fears and misconceptions before, to enable them gain the motivation to seek the service after clearly understanding the benefits of VCT.

In the case of Nakasongola, the advance Team used loudspeakers to communicate to people about the impending activity, when the service would be due, where it was to take place and who was to brace it. The HIV education and benefits of VCT were explained at the planned venue for the mobile van VCT service. This was corroborated by information from community members when asked how they got to know of the service:

We heard about the mobile van VCT over a week ago, health workers saying they would be coming here on 11th June 2004…(FGD participant, exposed non-users, AIC Site).

The community people interacted with during the visit further revealed that during the mobilization exercise, the team of health workers from the district informed them that those screened and found to be HIV positive would be given medicine and material support, although the latter would be extended to mainly those families that would be found vulnerable. Support would take the form of food items such as beans, maize flour, and others items like blankets.

Cross-examination with the VCT Team that did the mobilization helped clarify the source of the material support as World Vision not the mobile van team. The advance team revealed all the above to allay community concerns as to what happens to persons found infected, save for proclamation of their sero-status.

Although the Tumba community had been mobilized days to the visit by the Mobile Van team from Kampala, it was still necessary for the district VCT team to drive ahead of the Kampala teams (AIC Mobile Van and Makerere University researchers). The District VCT Coordinator later explained to the research team that communities have to be served last minute reminders to put some time aside for the exercise. For Tumba in particular, these are largely transient populations, many getting in and out of the lake; others run petty trading activities; others do all kinds of casual, odd jobs at the landing site; while others begin taking alcohol quite early in the day. Clearly, such a population had to be reached with a reminder early in the morning on the day of the Mobile Van service.

In Nakaseke, however, there was no prior mobilization for the mobile van VCT. This was attributed to lack of effective communication from the AIC Team to the team at Nakaseke Hospital. Information had been channeled through the District VCT Supervisor who had not passed it on to the hospital authorities. Consequently, the hospital staff was not prepared to receive the AIC Team. As one of the impromptu measures, messages were drafted for the neighbouring communities and read out using a loudspeaker system. The AIC vehicle moved about 7miles into the communities, informing them of the mobile van VCT services to be offered at the hospital by a Team from AIC Kampala.

It remains inconclusive whether or not short notice mobilization of clients for VCT impacted negatively on turn-up of clients. Discussions with service providers revealed that even in communities where prior mobilization is done, on the scheduled day for the Mobile van VCT service, reminders have to be sent out to the communities again using the loudspeaker system. The important point is to provide convincing sensitization to communities and answer their numerous concerns prior to the test. For the case of Nakaseke, community people turned up anyway and many registered as potential clients for Mobile Van VCT. Some were simply not served because they had turned up late (in the afternoon), yet the AIC Team had to be done by about 2.00pm for clients starting the VCT process.

In the case of Kitovu Mobile, community workers too try to encourage people to seek HIV testing. Having been served through outreach for many years, people know about the service. Many have been alerted and encouraged by those the agency has served in the past. It is now largely a case of an informal grapevine:

*For me to learn about this service, I have my husband who first came here to test. He later revealed to me that he is sick (*suffering from HIV/AIDS*). I also decided to come for the same test to confirm whether I am alive or dead* (FGD participant, exposed users, Kitovu Mobile Site).

For me to learn about this service and get motivated to come, it was my husband and his younger wife who tested first. They kept it secret, and avoided me. He later told me he had feared to reveal it to me…….so I decided to come for this service (FGD participant, exposed users, Kitovu Mobile Site).

Kitovu Mobile attracted few people seeking VCT in the areas the Research Team visited with the Mobile HBC Team of the agency. It was explained that these were communities the agency had served for long, some over five years. Each site is visited twice a month. The visits are regular. Thus, many community people had been served in the past; some knew they could be served any time during the succeeding visits; while others were exposed non-users. The research Team also learnt that communities have generally associated Kitovu Mobile mainly with care of infected persons and their families. This was possibly the reason why almost all new clients seeking VCT with Kitovu revealed they wanted to confirm their HIV status having been suspicious for long; some having nursed their partners suffering from AIDS related complications. They looked forward to the care and support services provided by the agency.

2.1.3 Adherence to the Protocol for VCT

Regarding adherence to the protocol for providing VCT services, the mobile van VCT Team tries within the context of communities visited to observe the protocol as provided for in the policy implementation guidelines for VCT. However, given the nature and demands of an outreach service, the procedure for conducting VCT services is sometimes not adequately and precisely followed. Given that the Team from AIC (Kampala in this case) has a time constraint/factor in mind, the temptation is to handle some of the key stages hurriedly. The epitome of the omission is to clearly disregard the VCT protocol. For instance, at both mobile van VCT sites visited i.e. Tumba Landing site and Nakaseke Hospital, no time was devoted to HIV education and addressing of potential clients' fears and misconceptions prior to registration and preparation for the pre-test counseling session. It was perhaps assumed that the relevant district and local authorities had handled that part sufficiently. This was not the case. The observed scenario inevitably contravenes the concept of VCT for HIV.

The national policy implementation guidelines for VCT state that communities should be given mass education, while explaining the meaning of HIV positive and HIV negative results and the procedures at the VCT centre so as to encourage the public to take advantage of VCT services voluntarily. Clearly, a rapid assessment of community knowledge and awareness of the VCT process revealed glaring gaps. Many did not know the different stages they were supposed to be taken through and/or the minimum requirements for a counseling session to commence.

2.1.4 Expectations at Mobile Van VCT Site

With the exception of Nakaseke, where some of the clients that turned up for VCT had come to care for their sick at the hospital, the majority of people that turned up at both mobile van sites had come purposely for the mobile van HIV testing. All clients who were registered received HIV testing and their test results. As shown in Table 1, the clients have understood the message that they should take a blood test. They are not aware of the post-test service, except one client.

Table 1: Type of Service sought vis-à-vis Service received at AIC Mobile Van VCT

Aspect of measurement	Frequency	
	n	%
Services Clients came to seek at Mobile Van* (N=62)		
Pre-test counseling	30	48.4
HIV Testing	58	93.5
Post-test counseling	1	1.6
Information	4	6.5
Referral	2	3.2

Treatment/drugs	11	17.7
Others	1	1.6
Services Clients Received at Mobile Van* (N=62)		
Pre-test counseling	50	80.6
Post-test counseling	48	77.4
Information	13	21.0
Referral	5	8.1
Post-test Club services	2	3.2

*****Multiple responses were allowed

As clients exited, most had received pre-test and post-test counseling, but about 1/5 (21%) had received other VCT related information. It is recommended that for VCT services, in case of high turn-up of clients at an outreach site, group counselling should be offered but giving time for a brief moment with each client individually to take a decision on whether to test for HIV or not and therefore sign or thumbprint the consent form. From observation by the Research Team, this procedure is not followed. The common practice is to offer group counselling and consent is seemingly assumed.

According to one of the service providers accompanying the mobile van from the district, by the time a client turns up for the mobile van VCT service, he/she is ready to go through all the stages of VCT. This is simply a blanket assumption. The norm should be that, regardless of the reasons for VCT, client consent should be sought and should be documented by the VCT client signing or thumbprint on consent form when ready for HIV testing.

2.1.5 Satisfaction with the service

A major element in assessing service provision is the level of client satisfaction with the service. This is perhaps more accurately measured at exit. In the case of the mobile van VCT service, majority (90.3%) did not find anything in particular they did not like about the counseling services that had just been offered to them. What is evidently of utmost importance in scaling up mobile VCT services is that despite the observed gaps by the study team, the consumers perceive the quality of the service to be high. About 2/3 (65.6%) of the clients when asked to assess sufficiency of information given to them by the personnel/counselors on the mobile van, they assessed it as very sufficient. Only 3.3% said the service had been insufficient. Details are summarized in Table 2.

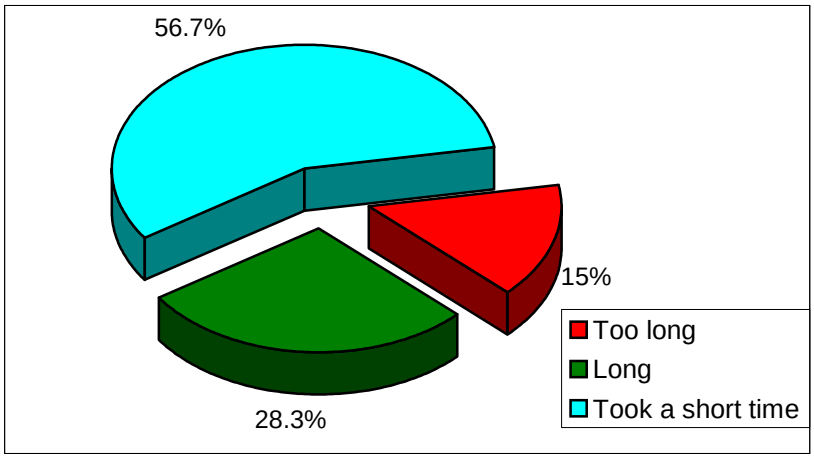
Table 2: User Assessment of service provided at AIC Mobile Van VCT

	Frequency	
Aspect of assessment	**n**	**%**
Time taken by Clients to be attended to (N=61)		
Less than 30 minutes	18	29.5
30 minutes to 1 hour	31	50.8
Over 1 hour	12	19.6
Assessment of time spent to be served (N=59)		
Too long	12	20.3
Long	13	22.0
Just enough	32	54.2
Short	2	3.4
Client satisfaction with test results (N=62)		
Yes, I am satisfied	58	93.5
Not satisfied	4	6.5
Client satisfaction with entire Service Provided (N=62)		

Very satisfied	30	48.4
Satisfied	28	45.2
A little satisfied	4	6.5

Two measures of time spent can be distinguished; first, time taken before one is served/attended to, and, second, total time spent at point(s) of service. In case of the former, half of clients had taken 30 minutes to one hour to be attended to. More that ¼ had taken much less time to be served. Given the process of setting up points of service (for counselling and laboratory), and the number of clients seeking service, time taken before people are served seemed too long or simply long for a recognizable proportion. However, for the entire process, the total time put together seemed short for most clients (see Figure 2).

Figure 2: Client Assessment of time taken during entire VCT process



Furthermore, almost all (93.5%) were satisfied with the outcome of the test results. The study team was not able to interview some of the exiting clients. Some were clearly in a hurry to attend to other demands of socio-economic value while others seemingly sneaked away unnoticed. Some were definitely the disappointed lot, unhappy either with the outcome of the test or tired of the process itself. It should be clarified that the assessment of service was therefore done with exiting clients who accepted to be interviewed.

There are other gaps in the delivery of mobile van VCT that the study was able to reveal. For instance, a section of clients thought that the amount of information that was shared at point of service was not sufficient to enable one to cope and live positively. Table 3 shows that some of the clients (about 1/3) had wanted particular services that were not offered by the mobile van VCT team. While a few needed drugs and material support items, others needed more information and education, for instance on PMTCT, ARVs, discordant cases, etc.

Table 3: Gaps in Service Delivery and Future Prospects among AIC Clients

Aspect of Measurement	Frequency	
	n	%
Education and Counseling for +ve Living (N=61)		
Yes, it was sufficient to enable +ve living	47	77.0
No, it was no enough	14	23.0
Particular services Client required but not offered (N=60)		
Yes	18	30.0
No	42	70.0
Future utilization for Mobile VCT services (60)		
Yes, intend to come back	54	90.0
No, will not ask to be served gain	6	10.0
Would advise relative or friend to Mobile service (50)		
Yes	50	100.0

Overall, majority of clients showed readiness to utilize services offered by the Mobile Van team and expressed willingness to advise other people in the community, relatives and friends to seek the service as well, thus underlining their interest in the mobile service. As already shown, these were the category of exiting clients consenting to be interviewed. This is not to imply that those not interviewed at the end would have significantly varied impression; some, having stayed at point of service for three hours were keen to embark on their daily chores immediately they got their test results.

Generally, the need to provide more HIV education on benefits of VCT is particularly important. It is assumed that most people recognize the relevance of VCT in influencing behavioral decisions especially with regard to prevention of further spread of HIV/AIDS. It is also assumed that the service marks a turning point in the lives of those who test irrespective of the results of the test, however, it is not binding for all clients. Interaction with exposed non-users of the service revealed that some sections of community saw no advantage in VCT:

> *There is a brother of mine who was tested for HIV one time; thereafter he decided to squander all he had acquired saying,* "let me eat and die" *and yet before testing for HIV, he used to ask for support to be taken to hospital for treatment. After knowing that he was HIV positive, he resolved to die since he had died anyway …* (FGD participant, exposed non-users, AIC Site).

Throughout the discussions with exposed, non-users of VCT, one got a sense of a reluctant, less informed community with little appreciation of VCT services in general. They had many misconceptions and negative experiences they had heard or learned about testing for HIV from other people they observed or interacted with. They also had many questions for which they needed answers before accepting to test. For instance, during the FGD in Tumba landing site, participants were keen to answer questions from the researchers but also requested to have their concerns addressed as well. After the mutual discussion, some of them opted to be served by the Mobile Van VCT Team who unfortunately had closed service to new clients due to time constraints.

2.2 Equity

Some of the ways issues of equity can be analyzed is to consider the main consumers of a service, for instance in terms of their dominant socio-demographic characteristics. The other way is to examine the criteria for eligibility for the service, in this case, the mobile van VCT service, whether it is universal or selective etc. These and other issues are studied and findings presented in the succeeding sub-sections of this report.

2.2.1 Main Consumers of the Service

Mobile van VCT services are open to all adults of sound mind in the communities visited. This is not to deny the factors that tend to deny eligible categories within society the benefits (and risks) of common services in everyday life. In the case of mobile van VCT, analysis of the categories of exiting clients shows almost equal proportions of male and female community members who benefit from the free service. See Table 4.

Table 4: Socio-demographic Characteristics of Exiting Clients at AIC Mobile Van VCT

Characteristic	Frequency	
	n	%
Sex of Clients (N=62)		
Male	30	48.4
Female	32	51.6
Age of clients *(N=62)*		
15-24 years	18	29.0
25-39 years	26	41.9
40 years and above	18	29.0
Marital Status *(N=62)*		
Never Married	13	21.0
Currently married	31	50.0
Cohabiting	4	6.5
Widowed	1	1.6
Separated/Divorced	13	21.0
Locality of Usual Residence *(N=62)*		
Village	34	54.8
Trading Center	26	41.9
Town	2	3.2

Analyzed according to age groups, majority are middle aged (25-39 year olds) naturally going through the etiquette of marriage and remarriage, separation and divorce. They are more sexually active, and, perhaps concerned with the pressures of positive living. Many have lost their sexual partners, or are concerned about the health status of their current or former partners. Others are themselves feeling unwell. Persons currently married are concerned about the fidelity of their partners. This is common with women.

According to some of the people in the communities visited, the main consumers of the mobile van VCT service are young women faced with marital challenges such as cheating or polygamous husbands. Others include widows and men who have recently lost their partners. In the case of Kitovu mobile in Masaka, the sickly are the main consumers:

……It is mainly those who consider themselves to be sickly and, likely to be infected with HIV/AIDS in need of care and support (Community Health Worker, Kitovu Mobile).

The main thing for almost all of us (referring to FGD members) *is to confirm whether we are infected or not. You get motivated when you feel your body is unwell* (FGD participant, exposed users, Kitovu Mobile Site).

With regard to level of education, people with primary schooling as the highest level constituted majority of exiting clients.

Table 5: Occupation and Level of Education of Exiting Clients at AIC Mobile Van VCT

Characteristic	Frequency	
	n	%
Occupation of Clients *(N=62)*		
Peasant Farmer	25	40.3
Salaried Worker	2	3.2
Student	3	4.8
Commercial/business	18	29.0
Fishing	7	11.3
Driving/cycling	1	1.6
Other	6	9.7
Level of Education of clients *(N=62)*		
No Education	3	4.8
Primary	41	66.1
Secondary	15	24.2
Post secondary	3	4.8

One would be cautious in drawing inference from this data. It is possible that those with higher level of education were much fewer among the hard to reach communities visited with the mobile van at the time (such as Tumba fishing Village). The latter also occupy the higher echelons of society able to obtain anonymous VCT away from their immediate community. On the other hand community members with no education have possibly not yet internalized the relevance of taking VCT, especially given the scanty, hurried community education and sensitization about the service prior to the arrival of the mobile van. Even among the educated people who are aware of the benefits, motivation is still low. Motivation is beyond the level of education.

However, through observation, the mobile van VCT service attracts clients with diverse backgrounds and of various socio-demographic characteristics. For instance, at Tumba landing site, the clients that turned up for the mobile van HIV testing and counseling were a mixture of ethnic groups speaking different dialects. Majority were Luo speakers mostly Langi and Acholi. Other main groups included Baluri, Banyoro, Baganda, and a few Basoga and Bakiga.

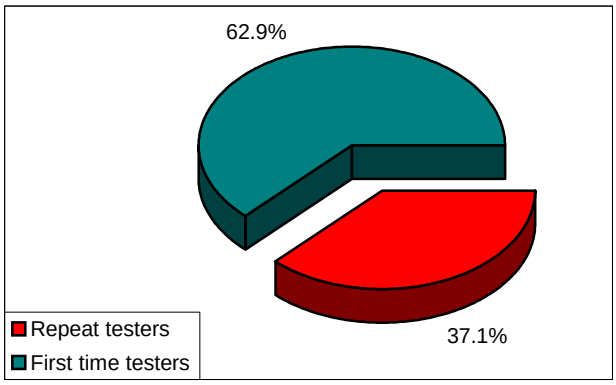
The experience with mobile van VCT services was, however, not the same at all mobile van VCT sites. In Nakaseke, almost all clients that turned-up could understand Luganda easily and speak fluently though not all were necessarily Baganda. This meant that no counselor

was either rendered redundant or overwhelmed with clients. Cases of asking clients to wait for quorum in order to attend a pre-test counseling session were non-existent.

At all the mobile van VCT sites visited, over half (51.6%) of the clients who turned up were women either currently married or once married but separated. Over ¾ of the clients were family people or at least had children of their own. Peasant farming followed by commercial/business job specification characterized the main occupation of most of the clients that turned up for the mobile van VCT services that is 40.3% and 29% for peasant farming and business respectively.

Interaction with clients who turned-up for VCT services revealed that only 9.5% of the clients had accessed services of a mobile van VCT. A bigger proportion had ever taken an HIV test at some of the indirect sites of AIC (see Figure 3). A few had tested from the main AIC branches in the country. Almost 2/3 constituted first time testers.

Figure 3: Client Experience with VCT Services



The data presented in the table below also shows that health workers had reached many mobile van clients with information during the pre-visits. A significant population knew through their peers and friends, or through local community leaders such as Local Council officials

Table 6: Knowledge and Experience with Mobile Van VCT Service among Users

Aspect of Measurement	Frequency	
	n	%
Place/site of previous VCT Service (N=21)		
Hospital	8	38.1
Health Unit/facility	8	38.1
AIC	2	9.5
Mobile van	2	9.5
Other	1	4.8
Prior knowledge of Mobile Van VCT Service (N=61)		
Yes, knew before	24	38.7
Never known of mobile service	37	59.7
Source of information about Mobile Van VCT* (N=58)		
Through friends	11	31.4
Health workers	26	41.9
Local officials	17	27.4
Others (local poster, grapevine)	22	31.9

*****Multiple responses were allowed

2.2.2 Criteria for eligibility for mobile van VCT service

At registration, every client that turns up in time is eligible for the mobile van VCT service provided he/she is sober. With the exception of potential clients who were turned away because of time, the rest were attended to. Cases of client turn away were evident at both sites visited. For instance, at Tumba landing site as a result of closing registration at 2:00pm, a number of potential clients were turned away including the area LC1 Chairman who was busy mobilizing people to turn up for the service. People came at intervals and sometimes one by one. The initial batch of clients constituted mainly elderly men, although the younger generation of mainly mothers joined later. The case was almost the same at Nakaseke; registration closed at about the same time. The first client exited at 1:30pm. Many potential clients were left unattended to.

2.2.3 Selected gender aspects

Access to Mobile Van VCT Service

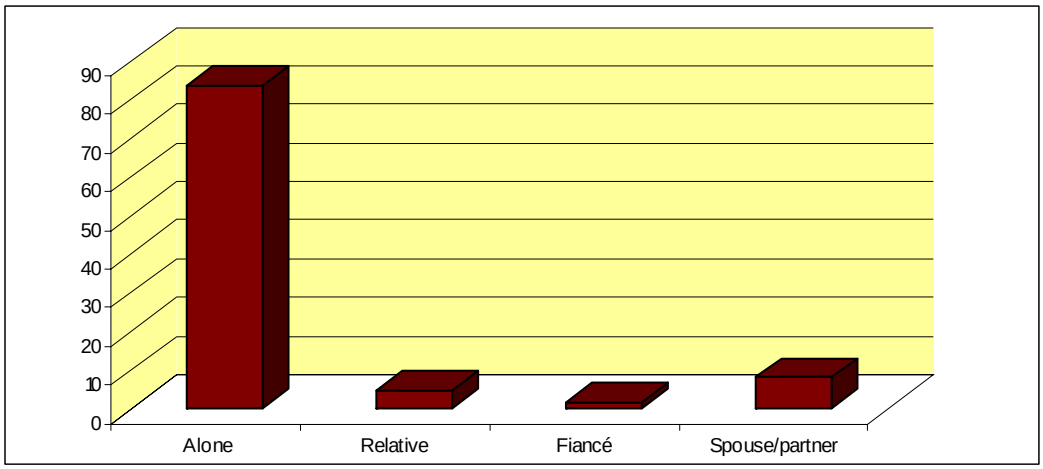
Through observation by the Study Team, the mobile van attracts both men and women in the community. Rather than feel constrained as earlier hypothesized at the onset of this study, scores of women, young and mature, lined up for VCT at each mobile van site. A quick count at any point in time, while the service period lasted, would reveal more women than men in the queue. The young men, mainly of adolescent and late 20s or early 30s did not feature prominently in the queues although the few who made it to the end were ready to be interviewed.

Partly because the services at AIC Mobile Van VCT are free of charge, all community people, including women, some of whom would otherwise be denied service for lack of control of financial resources, find it easy to obtain service. The nature of the service thus caters partly for gender and other socio-economic considerations, which commonly constrain accessibility of services to which fees are attached.

Couple testing, notification, and sharing

A significant proportion of exiting clients (85.2%) did not go for HIV testing in the company of their partners/spouses nor later on discuss with them about undertaking an HIV test.

Figure 4: Person with whom Client came for Mobile VCT Services



Slightly less than half (44.9%) indicated that they would share the results with their spouses/partners and over 1/3 (37.7%) mentioned they would share the results of the test with relatives. Apparently the proportion of clients willing to share results with significant others such as partners and relatives was higher than the proportion willing to seek the service in the company of anybody.

Table 7: Couple Testing, Partner Notification and Sharing among AIC Mobile Van Clients

Aspect of Measurement	Frequency	
	n	%
Discussed with your partner/Spouse before coming for the HIV test? (N=60)		
Yes	12	24.0
No	38	76.0
With whom are you going to share your result? * (N=62)		
Nobody	6	9.7
Relative	26	41.9
Girl/Boy friend	6	9.7
Spouse/partner	31	50.0

*Multiple responses were allowed

Both through observation and frequency statistics generated at the AIC and Kitovu Mobile sites there was apparent reluctance for people to test as partners. Many people in the communities visited associate couple testing with persons intending to get married and consider this the major reason for young people to use VCT. However, there was no evidence of young couples intending to marry coming to the VCT sites for service together. Those who revealed sharing boy/girl friend relationships, like majority of their married counterparts, came alone.

The idea of men and women in relationships, including marriage, taking VCT is well appreciated. People know that if they have gone together as husband and wife for the test and find out that they are negative, the quality of their partner relations will improve. The male partner (usually considered more prone to casual or cohabiting tendencies with other sexual partners) will most likely endeavour to live a more faithful relationship with the spouse with whom they took the test. A few respondents expressed knowledge of

existence of the practice in the communities. They revealed that they have cases of couples that have gone for testing together.

Reasons why they did not test with partners/spouse include, fear of partner violence, fear of partner becoming suspicious of your fidelity while some partners were opposed to testing, some respondents alleged.

Others, mainly women, have some reservations about the practice of couple testing. There are still challenges, respondents argue, for married because, though it would be better for them to go as a couple, in most cases the man refuses. Yet in the absence of both partners going to test together, it is hard to trust the man when he brings home results of his status. He might lie to you and say that everything is okay, female study participants allege.

It seemed as though the level of satisfaction from the post-test counselling sessions or with the test results themselves is a motivating factor for disclosure. One of the objectives, and ultimately the expected outcome of effective post-test counseling is to prepare clients to share their HIV test results with significant others. The practice of concealment and non-sharing of HIV test results mostly is common among boy/girl friend relationships.

2.3 Cost effectiveness

Cost effectiveness of a service is an important denominator that helps motivate actors to provide particular services. In the case of a mobile van for VCT, analysts would be interested in convenience of the van in transporting the equipment and staff at the same time and the suitability of the van vis-à-vis rough roads. Other issues to consider include reliability of the van, resource requirements for providing VCT service to a client as compared to other options, costs for providing VCT services by the mobile van, and other requirements to run a mobile van for VCT services. Some of these critical issues may not be sufficiently examined since, at the time of the study, the actual van meant and designed as 'The Mobile Van' for VCT was not available as it was being modified. Instead, observations were made following mobile outreach services conducted by AIC using the usual transport vehicles for staff and equipment.

2.3.1 Convenience in transporting the equipment and staff at the same time

The model of mobile van that was purchased for the Kampala branch was considered inappropriate for mobile services, and was therefore undergoing modification at the time of the study. Consequently, the Team traveled for mobile visits using a Double Cabin pick-up truck. On both visits, the Team constituted of two counselors not necessarily the same for every visit, one Laboratory technician, the VCT advocacy officer and a driver making a total of five people. For a Double Cabin pick-up truck that is not air-conditioned but moving long distances of more than 200kms to and from a site, the amount of inconvenience was obvious. Perhaps the utmost number to travel using the van could be four persons.

The testing kit included Capillus, Sero-cards for confirmatory tests and Multispot as tiebreakers as well as syringes and specimen containers all packed in boxes and transported at the back of the pick-up vehicle. The boxes used were the everyday cardboard boxes with no special modification resilient enough in the event of shocks due to

bumpy roads. Doubtless, given the way the kit was packaged vis-à-vis the nature of the roads, murram and potholed, the vehicle that was used to transport both equipment and staff was not suitable for the assignment.

2.3.2 Reliability of the van

Again, given the nature of the roads in the country and the vast area of operation for each AIC branch, it goes without saying that the van is faced with frequent mechanical breakdowns. A mobile van serving rural communities as far as 200kms to sites for VCT services on a routine basis will definitely break down. It requires brand new model vans with ground clearance and four-wheel systems. The van would need to be regularly serviced, repaired, and/or replaced. The mobile van service is particularly meant for hard-to-reach, underserved communities such as the case of Tumba Landing Site visited during the study. The terrain will definitely require a sound van (or vans should one break down) for the service to be reliable.

2.3.3 Resource requirements for providing Mobile van VCT service

Regarding the resource requirements for providing mobile van VCT services to a client, unlike services at the static sites, mobile van VCT services require having sufficient funds to motivate counselors, adequate numbers of well trained staff to allow for counselors to rest in turns and overcome fatigue. To take care of the time factor, the mobile van team should have community workers to help in mobilization and provision of mass HIV education to address potential clients' fears and misconceptions consequently preparing them for VCT after clearly understanding the benefits of VCT. This aspect is well integrated into the Kitovu mobile service:

> *It is we community health workers who give counselling particularly to first time testers/clients so that the visiting Team concentrates on drawing blood for testing* (Community Health Worker, Kitovu Mobile Site).

More still, the team should devote more time to Post-test counselling. This is a very important element in VCT for HIV/AIDS. It must entail an elaborate discussion that consists of giving the test results clearly, without ambiguity, assessing the client's emotional and mental understanding of the test results, addressing any immediate emotional reactions, making plans for involving significant others, making on-going plans for care and risk reduction, and making arrangements for follow-up support. This is only possible with well-motivated staff. The case with both the AIC Mobile Van Team and the Kitovu Mobile HBC Team one would easily pick a sense of workers that may need to be more motivated to undertake these critical roles with selfless dedication and enthusiasm. Both material and non-material rewards serve as important entry points for enhancing morale of staff working under the circumstances that a Mobile Van service places upon them. Indeed, there were members of staff among the teams who showed exceptional humility, understanding, enthusiasm and tirelessness while serving their clients.

Furthermore, to reduce cases of turning away potential clients, provisions could be made for the Team to stay within the community for a while where such demand arises. Therefore each region should have one or more vans to ensure that the set calendar is adhered to.

Drawing from the schedules drawn for VCT outreach activities by the District VCT coordinators, most of the hard to reach communities targeted for mobile VCT are deficient in basic facilities for service in terms of infrastructure. To avoid working in contravention of the policy implementation guidelines for VCT, the Mobile Van VCT Team should be equipped with portable tents and chairs where deemed necessary. For the case of Tumba, for instance, the advance team from Nakasongola carried along plastic chairs and improvised wooden benches to use by clients at several service points. Being an open site, exposed to sunshine and/or rain, the need for tents cannot be overemphasized.

Consideration for the mobile van VCT Team from AIC working hand-in-hand with a VCT Team in the district of visit should be explored and institutionalized to reduce on the load per counselor and also address issues of language barrier. Attention should also be placed on general concerns and questions community people want addressed not only on VCT, but also on other issues on health and HIV/AIDS.

2.3.4 Type of costs for providing VCT services by the mobile van

Although, fuel expenses cannot be underestimated, the major costs for providing VCT services using a mobile van lie in the fact that it contravenes the set guidelines. As already mentioned, mobile vans, while helpful in mobilization and staff transportation, should not be used for actual VCT service delivery because follow-up and support are difficult. VCT services that are not physically located in an existing health facility should have a strong referral system with other services, and efforts should be made to offer other related services such as AIDS care and support, family planning and STD care in an integral manner. It should have an easy link with post-test services to facilitate ongoing counselling and guidance. However, through observation and interaction with exiting clients, one picked the impression that this linkage is not sufficiently developed. Through discussions with the District VCT Coordinators for instance in Nakasongola, revealed that no services were specifically set aside to address the peculiar health problems of AIDS patients in the district. Such services as palliative care, Home based care, ART, Nutritional support, and Home visiting for psychosocial support were yet to be institutionalized in the District Health and Community services departments. In providing Mobile VCT, it is important that the teams have in mind the kind of support services existing in the community and can easily make referrals.

Other costs are in terms of counselors, due to fatigue, compromising on quality and working in disregard of the minimum ethical requirements and expectations of a trained counselor. As was observed with Kitovu Mobile, over time counselors develop a lot of fatigue to a point of sometimes handling clients in a manner, which would be termed unpleasant and unexpected of a trained counselor. Inadvertently, though not a common practice, counselors lose patience with some clients. Given the amount of work involved in providing mobile services, for instance the strain on counselors handling many clients in a day, staff on the mobile van may themselves require counseling and support from peers and significant others.

As required, according to the policy implementation guidelines for VCT, that every laboratory for HIV testing should be linked to a higher level laboratory for quality assurance, the mobile van VCT facility should be equipped with a refrigeration system and cooler boxes for transporting specimens.

2.3.5 Per-capita costs for providing VCT services by mobile van

Unlike Nakaseke where clients come from as far as 7 miles, at Tumba landing site the majority of the clients were from within the environs of the chosen testing site. Consequently, the most used mode of transport was walking (62.9%). Even those that moved a significant distance to get to the testing site in most cases paid no transport fares because they used their own bicycles. Only 8.1% and 6.5% used Taxis and Motorcycles respectively to reach the venue for the mobile van VCT testing site and consequently only 15% of the clients paid some money in form of transport.

However, in-depth scrutiny revealed that those who paid money had not come particularly for VCT services, like in the case of Nakaseke they had come to care for their patients who had been referred to the hospital. The Nakaseke clients appeared for VCT because the health workers attending to their patients asked them to use the opportunity and get to know their HIV status at no cost. Likewise at Tumba landing site, it being a commercial place, some of the clients that turned up for testing were business people who by coincidence were found in the community and did not want to miss the opportunity of knowing their sero-status. For successful mobile VCT service, the cost of community mobilization will have to be included in the calculation.

Again because the majority of the clients served on both occasions of the visit by the mobile van VCT were coming from within the environs of the chosen testing sites, over half (57.4%) considered the time it took them to move from their homes to the testing sites just enough; only 6.6% mentioned that it was too long. The shortest time cited was less than one minute while the highest was four hours.

Unlike Kitovu Mobile where there is cost sharing, the service of the mobile van for VCT from AIC is free of charge. In the case of Kitovu mobile every new client is required to pay Ug.Shs1,000/= for his/her blood to be drawn for HIV testing. This is irrespective of age and gender. Although this may be a token figure, cumulatively the contribution enhances ownership, and meets part of the cost of travel for the mobile van. For clients who cannot afford the user fee, Kitovu Mobile staff has the prerogative to exempt them. This was for instance applied in one case in Kyazanga Masaka with an old client seeking treatment for an ailing 8-year-old grandson. For others who seemingly were not in dire need for care, staff would insist they pay at least a proportion of the user fee. In the case of a user fee therefore, modalities need to be put in place to safeguard equity in access through clear criteria for exemption.

2.4 Sustainability of services

2.4.1 Calendar for service provision

Regarding adherence to the calendar for service provision, the VCT outreach Team in Nakasongola had and followed a calendar unlike the mobile van VCT Team from AIC. According to the Advocacy Officer AIC mobile van VCT Team, lack of resources was the main constraint hindering the team from having and following a clear program of service provision. He pointed out that allowances for field activities of counselors on the mobile van VCT Team were calculated in terms of kilometers moved away from the station. Therefore limited resources hindered the Team from making frequent visits and even

follow-up visits. The issue of remuneration was also raised by the District VCT supervisor, Nakasongola saying that because they offer only Ug.Shs 3,000/=, counselors prefer staying at the station than go out for outreach visits.

During the visit to Tumba landing site, the Research Team got interested in the case of one counselor, the only Luo speaker among the team from the district who looked overworked. He was the only one available to interact with the majority of clients who could neither speak English nor Luganda. The Research Team learnt that other trained counselors at the district who double as medical staff at Nakasongola were reluctant to join the Mobile Van team due to low remuneration. Allowances for counselors providing VCT are a responsibility of AIC.

On the other hand, Kitovu mobile followed a definite schedule. Each centre was visited fortnightly. On any given day, the Team had a list of centres to visit before the day ends. For instance, the first day the Research Team moved with the van, it visited five centres namely, Kabalungi in Kyazanga, Katogo, Kyetume, Mbirizi and Bugonzi towards Lukaya. Consequently, each centre had a fixed time although delays were common:

> *Yes, the time we* (community and community workers) *expect the mobile service to reach here is known, between mid-day and 1:00pm. We understand when there are delays. ……. When they reach the centre, they spend about two hours. They can never leave a centre when there are still clients to be served* (Community Health Worker, Kitovu Mobile Site).

> *More important, is the schedule of VCT here…everybody knows when the mobile people come here…every 2nd Tuesday of the month* (FGD participant, exposed users, Kitovu Mobile Site).

The importance of a regular schedule for service provision in communities is to alert potential clients well in time to set aside their other chores of the scheduled day and prepare themselves emotionally as well. During the visit to Nakasongola and Luweero, a number of potential clients had learnt of the service that same day. Hurriedly, some were served but others missed. A woman running a small restaurant kept busy looking for fish on the lakeshores to prepare for the Research and Mobile Van Teams. By the time she was done, service had closed,

2.4.2 Essential equipment/kit required for mobile van for VCT

Outdoor counselling which is the equivalent of the mobile van VCT service requires that the client and counselor should be well isolated from others at the centre and seated under a shed. Basic furniture for VCT customarily is some chairs and a table. In all cases there must be access to laboratory space and equipment for HIV testing. Essential equipment required include wash basin, towels, and medical consumables such as gloves, needles, syringes, lancets, swabs, spirit, sharps disposal and standard waste disposals. Regarding the testing kit, MoH, currently proposes three different types of algorithm series, Determine, Uni-Gold, and Hemastrip as first, second and tie-breaker test respectively or Capillus, Serocard and Multispot or Bionor, Determine and HIV Orgenic. In cases where specimens for HIV testing have to be transported by a car, it should be packed in cooler boxes and samples kept refrigerated in the range of 4oc to 8oc.

However, drawing from experience of the two site visits with the mobile van for VCT currently, Capillus, Sero-card and Multispot constitute the HIV testing kit while medical consumables mainly including gloves, needles, syringes, and spirit constitute the equipment carried by the AIC mobile van VCT Team. The AIC van used at the time of study had no provision for refrigeration facilities and therefore both equipment and specimens were not transported in cooler boxes.

SECTION THREE: CONSUMERS' PERSPECTIVE ABOUT OBTAINING SERVICES FROM THE MOBILE VAN

3.1 Source of interest in seeking VCT provided by the mobile van

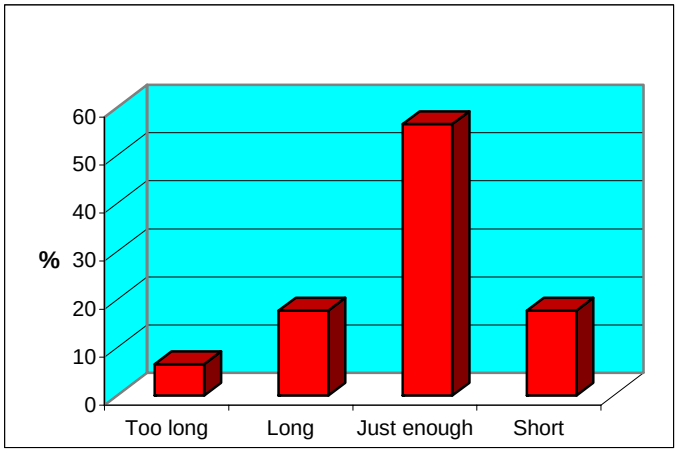
3.1.1 Perceptions and attitudes towards obtaining mobile van VCT services

Whereas the people at Tumba landing site were able to see how a mobile van for VCT operates, in Nakaseke, the community did not get an opportunity to appreciate the whole concept of a mobile van because the service was provided in the hospital premises. They understood it as one of the services offered by the hospital. The Kitovu mobile van service is an old service known to all community people, mainly as a care and support unit for people suffering from AIDS, not for healthy looking persons trying to know their sero-status.

Arrival of a mobile van for VCT in a community attracts a lot of people both young and elderly. In the case of Tumba landing site the arrival of the two vans (from AIC and Nakasongola district) and the announcements on the loud speaker, attracted people. Initially those who turned up at the site stood at a distance away from the point of registration, reluctant to convene at point demarcated for registration but eventually started registering for the service.

Findings revealed that a significant proportion of community people were prompted to use the mobile van VCT services because it brought services to their community thus saving them the cost and time of moving to the static site. See Figure 5.

Figure 5: Time taken to reach Mobile Van VCT site



Thus, the mobile van is considered to be convenient in terms of time; it stays in the community almost the whole day and clients save on time as it allows them to attend to their other responsibilities and duties at the same time:

> *I prefer the mobile van because it helps us not to waste time away from our work, like I was in my shop when the van came, I just went out briefly take a test then I went back latter to receive my results* (Exiting Client, AIC Site).

On my part the mobile van VCT is a good idea because it cuts on the costs of traveling to seek for services. It makes it cheaper and easier to test for HIV (Exiting Client, AIC Site).

Regarding the timing of the mobile van in the community, almost all exiting clients (94.7%) were comfortable with the time it reached and stayed in the community. Again because like in the case of Tumba landing site, they had been informed of the scheduled day for the visit, all found the day convenient to them.

Table 8: Convenience of AIC Mobile Van VCT to Users at service site

Aspect of measurement	Frequency	
	n	%
Day mobile Van service is provided convenient (N=19)		
Yes	18	94.7
No	1	5.3
Time mobile van services are provided convenient (N=19)		
Yes	16	84.2
No	3	15.8
Time taken to reach service site (N=61)		
Too long	4	6.6
Long	11	18.0
Just enough	35	57.4
Short	11	18.0

In the case of Kitovu mobile, although it is not an issue of proximity alone, it also plays a part in influencing the decision to seek services. It was revealed that although other sources for VCT are known, distance to them limits access. The majority of clients for Kitovu mobile travel long distances, between 5 and 10 miles yet the service is not free; there is cost sharing:

Yes we do……in Masaka they screen blood as well, but it is very far from our community. For instance, we have walked on foot to this place; *from Kamuhuga and Makondo about 7-9miles away* (FGD participant, exposed users, Kitovu Mobile Site).

In that case it is the comprehensiveness of the care and support that attracts people:

One goes to other facilities and sees no difference in the health condition, and then he/she is advised that Kitovu Mobile provides better care (Community Health Worker, Kitovu Mobile).

Interaction with exposed non-users at the mobile van site, however, revealed that there were people who held different perceptions regarding the mobile van VCT facility. They indicated that given that a mobile van comes to the community, colleagues and/or girlfriends would see you going for the testing and definitely demand to know the results; even if you decline to reveal your status, they will make their own conclusions:

Like for me, I would find it very difficult to go for an HIV test here because I have been known to have a number of girlfriends so if I was seen lining up, many would be interested in knowing my status. Even if I decline to reveal it, they would draw their own conclusions (FGD participant, exposed non-users, AIC Site).

> *Let the service be brought near, for instance at the sub-county. My wife can sneak on her bicycle and test. I can also do the same. But when the mobile van comes here, everybody sees who has gone for the test* (FGD participant, exposed non-users, AIC Site).

They also pointed out that since the mobile van brings together many community people with easy propinquity at one site, it also creates fears of suspicion regarding one's HIV status:

> *This* (mobile van VCT) *service is generally not a bad one except if you, the service providers, spoil it by revealing people's HIV status. It is important that each client is served in strict confidence. Now look (pointing at one of the make-shift counseling rooms that had been improvised), some people are hanging around; too close; they will hear. They will start moving around the community spreading the story that so and so died long ago* (FGD participant, exposed non-users, AIC Site).

> *Even if we do not hear what the counselor says, we are here observing the expressions of those who are coming out. Some cannot hide their depressed faces…*(FGD participant, exposed non-users, AIC Site).

Furthermore, although knowledge of the benefits of VCT is assumed widespread, there are still cases of misconception. Some proportions of study respondents expressed fear that if seen lining up for the mobile van VCT, the community would conclude that they are infected with HIV the virus that causes AIDS:

> *Mobile van VCT is good but it is not easy here* (in Tumba) *because everybody will see you take an HIV test and wonder whether you do not trust yourself. If I really want to know my status, I would rather get money and move to the static sites miles away like in Nakasongola where my people do not know. This way I will avoid rumormongering in my own community; that I am a moving corpse* (FGD participant, exposed non-users, AIC Site).

> *…Many fear being turned into laughing stock in the community if people learn that they have tested positive…….the fear that people will shun them…*(FGD participant, exposed users, AIC Site).

Others pointed out that knowledge of HIV status (positive sero-status) would get you worried and instantly sick and, according to them, it would be better to live blindly i.e. without knowing your HIV status:

> *If you tested HIV positive, you will begin to worry so much to the point of thinning. You may even get bedridden earlier than would otherwise been the case; yet before testing you were going about your daily business without any worries* (FGD participant, exposed non-users, AIC Site).

> *…It is not easy to offer yourself to test whether infected or not. There is no good in VCT, knowing that I am going to die earlier, where is the benefit? I would rather*

persist (without knowing HIV status) *so that I die once. Why should I torment myself, and die twice*…(FGD participant, exposed non-users, AIC Site).

Indeed let me interject, now look at me, I apparently look healthy. If you tell me (after HIV testing) *that I am sick* (infected)*, I may worry so much and even fail to eat* (FGD participant, exposed non-users, AIC Site)!

For instance, there is one woman they have just tested for HIV, she has not yet picked her results, but she is already complaining of a stomachaches. If she tests positive she will die earlier than should have (FGD participant, exposed non-users, AIC Site).

In all, the general community negative perceptions regarding people who seek VCT services have to be addressed to increase possibility of using the mobile facility.

3.1.2 Reasons for Seeking Mobile van VCT services

Through the poll exit interviews, reasons for seeking for mobile van VCT services were ascertained and a significant proportion of clients indicated that they just wanted to know their HIV status so as to act/behave responsibly either to avoid contracting the virus (if found HIV negative) or plan for the future.

Testing for VCT helps those found to be free from the virus not to roam all over too much and avoid infection… Even those found infected, VCT helps to make them aware; you may not have confirmed your status in the past, but now you confirm which helps you to calm your heart and accept the reality (FGD participant, exposed non-users, AIC Site).

VCT will also enable you continue enjoying your conjugal rights but with a condom so that you do not re-infect yourself (FGD participant, exposed non-users, AIC Site).

You may fear to test for HIV yet you are not infected. It would be better to test, know that you are fine and consequently be more careful (FGD participant, exposed non-users, AIC Site).

Other clients chose to undertake an HIV test, because they had a history of persistent illness. Hearing about the mobile van VCT service prompted them to seek for confirmatory tests and therefore stand a chance of benefiting from treatment:

For me to have decided that I seek for VCT, it all depended on the way I felt about my health. I have for long felt my body wasting away so I decided to come and check …(FGD participant, exposed users, Kitovu mobile Site).

For me I have a disturbing illness…it started as a pimple, itching effect, but it has now expanded, and ultimately, I have general malaise. I then took the decision to test my blood …(FGD participant, exposed users, Kitovu Mobile).

In case of the mobile van VCT, there were high expectations for drugs among the clients. Needless to say, lack of drugs for treatment was cited as the key factor, which could hinder

positive living. A small proportion sought for HIV testing in order to reduce on the load of work i.e. stop doing strenuous work, which could affect and hence weaken their immune system.

3.2 Perceptions and experiences about the quality of service

3.2.1 Assessment of Quality by Research Team Vs Clients

Quality assurance is conventionally understood as the process of ensuring that performance is done according to the set standards. Based on this understanding, the Research Team was keen throughout the visits in communities to observe and assess service. Given the mobile nature of the service, the question was whether it provides quality services, for instance, in terms of length of counselling sessions, quality time provided to clients, meeting other health concerns of those suffering from AIDS related complications. The Research Team has considerable fear about mobile van VCT service compromising the quality of counseling and attention to clients. This was clearly manifested in the hurry with which the process is handled.

From the findings, 62.9% of the clients were first time testers at any VCT site, and 60.7% had never known that VCT services could be accessed from a mobile van. It is therefore difficult to expect them to effectively assess the quality of the service and the sufficiency of the information provided to them by counselors.

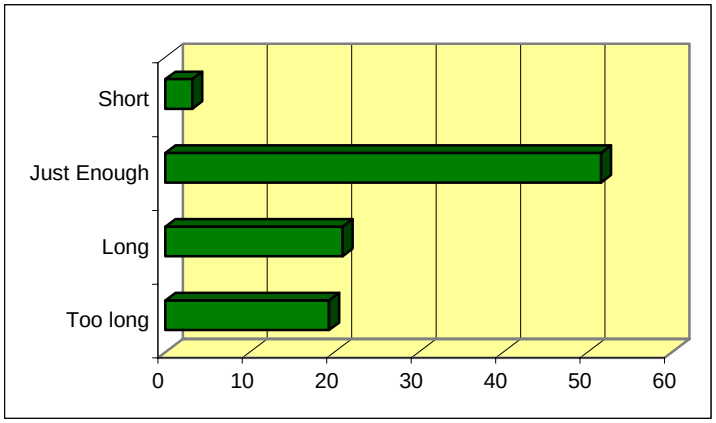
Still at Nakaseke, given that the counselors had to be oriented in preparation for the launching of the site as a fully-fledged static site, they attended sessions on pre-test counseling, prevention and risk assessment but not post-test counseling. However, when they started handling clients, they were in-charge of even post-test counseling. Therefore given that post-test is by far the most crucial component of VCT; this poses questions on the quality of service that was being rendered.

3.2.2 Time taken to serve Clients

Taking a look at the time clients spend with counselors at mobile testing sites, it was observed that clients would spend between 10 and 15 minutes during pre-test counselling session and about 5 minutes for the post testing session in which clients are given their test results. Both at the point of bleeding and receiving test results, clients had to wait a little longer to access service. At Tumba landing site for instance, clients had to line up at the bleeding point as well as to get their test results. Inadvertently, waiting clients could hear the results of the client being attended to. Clients practically crammed the entrance while waiting for their turn to go in for the risk assessment and post-test counseling session.

From the majority clients' perspective, time spent before being served at mobile VCT site was just enough. Only less than a fifth of the clients met in this study thought that time spent was too long. See Figure 6.

Figure 6: Time spent before being served at Mobile Van VCT site



The maximum time, according to the laboratory technician on the AIC Team, for testing and screening thick and reactive blood sample is 20 minutes. For majority (98.4%) of clients, service at the mobile van took a total of one hour from the point of registration to receiving test results. In a few cases, for instance at Nakaseke, clients had to wait longer than would have been the case partly because orientation had to be done for the trained local counselors before they could be given an opportunity to handle clients.

Although the divergence between what people felt about the service and what the Research Team felt is quite high, there is potential for improvement. The communities perhaps understand their contexts quite well and can be content with what is available. For instance, soundproof facilities for counseling may never be available in the short run. As long as care is made to isolate the client from the highly inquisitive community keen to follow the counseling session, service can still be provided effectively. For the people, the service is quite good, thus the potential for success is high. See Table 9. The important thing is to address the issues of quality within the context of communities being served.

Table 9: AIC Mobile Van User Assessment of Client/Provider Interaction during service

Aspect of Assessment	Frequency	
	n	%
On today's visit, were you given any information? (N=58)		
Yes, Counselor provided information	9	15.5
No	49	84.5
Sufficiency of Information Provided (N=61)		
Insufficient	2	3.2
Some what sufficient	19	30.6
Very sufficient	40	64.5
Privacy of Counseling (N=62)		
Yes, adequate privacy was ensured	59	95.2
No	3	4.8
Comfort during Counseling (N=61)		
Yes	60	96.8
No	1	1.6
Time taken to go through entire VCT process (N=60)		
Too long	9	14.5
Long	17	27.4
Took a short time	34	54.8
Clients' Overall Assessment of VCT Process (N=61)		
Liked the entire VCT process	59	96.7
Did not like the process	2	3.3

3.2.3 Language barrier

Given the nature of some of the sites visited mobile van VCT for instance, Tumba Landing site, challenges springing from language barrier particularly for the AIC Team from Kampala, were inevitable. As earlier mentioned, the community at Tumba landing site was a mixture of tribes and therefore different languages. However, since the AIC Team was not working in isolation with the district team, they were able to get a district-based counselor fluent in those two languages to attend to that category of clients. Again this stands to emphasize the need for the mobile van VCT Team to work with local institutions such as the district VCT Team. Counseling is an interaction which requires that both the client and service provider understand each others' verbal and non-verbal cues, sufficiently to enable the client develop satisfying relationships and standards of emotional and psychosocial wellbeing to live in harmony with the rest of the community. Spontaneous feedback to the counselor is required before the session is closed to ensure that the client will cope after the professional relationship is terminated. The importance of language and effective communication (encoding, decoding, and feedback) cannot be overemphasized.

3.2.4 Care and attention by the staff

Regarding care and attention by the staff, it was revealed that 98.4% felt comfortable with the staff that attended to them. This was made possible by the openness demonstrated by the counselors and the way they presented themselves. It was revealed that counsellors were humble and showed interest in the clients although with time the amount of time allotted to a particular client was reduced.

From experience, given that mobile van VCT services are usually offered at no charge to the client, turn-up is often high. This was the case with the two sites visited the AIC Team, for instance, a total of 68 clients at Tumba landing site and 81 clients at Nakaseke Hospital. Although the policy implementation guidelines for VCT services, provide that a counselor should handle not more than 6 clients per day, in this case the above number of clients were successfully taken through all the stages up to receiving test results. This inadvertently affected the quality of counselling because as mentioned client-service provider time for interaction was tremendously reduced. For instance, post-test counseling sessions especially for those who tested HIV negative lasted only about 3 minutes. In the case of Nakaseke, counselors worked till late in the evening (past 6:00pm) to serve all the clients who had registered:

> *The counselor tells you that you are HIV negative; do you wish to undertake another test in future (after 3 months)? … And with that she bids us farewell* (Client, Mobile Van VCT, AIC Site).

According to some clients, the practice at a mobile van VCT facility is to rush through the sessions leaving clients with many unanswered questions.

3.2.5 Quality of Information Shared

The case of a female, middle-aged woman who traveled about 7 miles on foot to seek service at a mobile site in Kyazanga, Masaka under Kitovu Mobile summarizes some of the situations of inadequate response from service providers in contact with inquisitive clients:

Well… we have been taught…but (hesitates) *there are some issues about which we were not sufficiently enlightened… for instance, supposing I have offered to take this test like I have, and my husband refuses to test as well, what shall we do? We cannot use condoms because he will not accept. For him it is confirmed he has HIV/AIDS. If by luck I am found negative, won't he kill me if I refuse to sleep with him? I asked this to the counselor. She only told me that for them* (as counselors)*, they are not allowed to separate married couples…. that perhaps I should go to Kampala and seek guidance from other authorities she did not reveal… the issue remained hanging*

3.2.6 Anonymity and Confidentiality

Anonymity and confidentiality have great influence over demand for VCT services including ongoing counseling and guidance. Potential clients of VCT are kept away from seeking service at established direct and indirect sites of VCT partly because they know and interact with service providers they are socially acquainted with, or may clearly not trust them with sensitive and personal experiences such as one's HIV status. Many would be more comfortable with Mobile Van VCT managed by providers least known to clients.

Findings revealed that providers that are not known to communities tend to be trusted more than those known and, therefore, attract more clientele. For instance, at Nakaseke, a number of clients especially those living in the hospital environs were reluctant to approach the counselors based at the hospital for on-going counseling and guidance. There was a general fear although nobody pointed a finger at anyone, that if the local counselors got to know their test results (HIV positive), other people in the community would definitely know as well. Indeed some revealed to the Research Team that if it had not been the visiting team from AIC, they would not have sought for the service:

> *These counselors have told us that there will be testing for HIV in the near future but they have not told us whether they will be the ones coming back; will they be coming back? Because for me I would not want to be handled by these counselors here; I stay here in the hospital, they know me. If they got to know that I have AIDS, they would spread it* (Client, Mobile Van VCT, AIC Site).

However, mobile van VCT is not synonymous with substandard delivery of service. Depending on the personnel on the team, services can still be good, provided strict observance of the norms of providing VCT is ensured. The team of counselors that visited Nakaseke as part of the AIC Mobile Van service for instance was patient and handled clients with prudence ensuring that all were taken through the different stages of VCT as recommended. A quick discussion with exiting clients would show how they had benefited for all the stages. Clients easily narrated their interaction with staff of the mobile van, from reasons for seeking a test, risk assessment and preventive counselling, bleeding, and finally post-test counseling.

3.3 Other services provided apart from VCT

Although the need for materials on behavior change is not limited to clients visiting the static sites only, the Team from AIC did not carry any packaged information on VCT such as leaflets, brochures, handouts, flyers, posters etc as well as information on STI

management, TB, and treatment of OIs. Given that the mobile van serves the hard to reach communities, distribution of such information would help address stigma and discrimination related perceptions and hence correct negative attitude towards VCT and boost improved care and positive living among HIV positive people.

Furthermore, although distribution of condoms is a good initiative, it is not proper to assume that everyone knows how to use them correctly. Boxes of condoms were given out without any education and demonstration on correct and consistent use as well as disposal.

3.4 Continuation of using the mobile van VCT services

It is possible to track clients who have benefited from the Mobile Van service for purposes of follow up, psychosocial support and treatment (if required). Clients are registered before they are taken in for the pre-test counseling session. The HSD Teams in Nakasongola and Luwero engaged in VCT outreach services, as is the practice in VCT service delivery, maintains a register which has details of the client; name, age, sex, village of origin, parents, and date of visit among others. The Team makes referrals to sources of support and care for clients that express wish for continued support. However, not many opportunities are available to clients seeking further assistance particularly for treatment , care and material support. The practice is to refer them to Kampala for specialized care services such as ART. In Nakasongola, World Vision International provides assistance to needy PHAs registered in the post-test clubs. Categories of clients of VCT who are not willing to come out in the open to declare their status have to contend with no post VCT services, as are those that cannot easily access World Vision due to geographical dispersion. In short, possible referral areas are scanty.

However, there are no follow up services in the communities for most clients who tested positive for HIV in the District of Nakasongola. None of the exiting clients mentioned that they had been advised to join any post-test club. Furthermore, although the frequency of visits to a given outreach site by the district VCT outreach team is 3 months, only new clients and repeat testers are attended to i.e. no time is allotted to those who want on-going counseling, the AIC Team did not show any signs of coming back to Tumba landing site to offer follow-up services namely repeat testing and on-going counselling. However, after testing, HIV positive are advised to go to the HSD at Nakasongola for treatment for any emerging opportunistic infections.

SECTION FOUR: COMPARATIVE ADVANTAGE OF MOBILE VAN VCT AND MECHANISMS FOR CONTINUITY OF CARE

4.1 Merits of using a mobile van for VCT service over Static Centres

4.1.1 Turn-up of Clients

Unlike the static sites where the average turn-up of clients is five per day, turn up for the mobile van VCT services is high. A review of the performance of the Nakasongola HSD outreach VCT services shows that demand for VCT increased four folds with the introduction of outreach programs. This is corroborated by figures obtained during the two mobile van VCT visits. For instance, a total of 68 clients at Tumba landing site and 81 clients at Nakaseke Hospital were successfully taken through all the stages up to receiving test results. There is overwhelming evidence to show that the Mobile Van system increases turn up. The experience narrated by the District VCT Coordinator, Nakasongola district, and available records at his office attest to these facts. For instance, the only VCT site in the area, located at the main district health unit, attracts 5-10 clients a week; a few of them repeat testers. A visit to one mobile site in the communities attracts an average of 30-40 clients, and many others are not served due to time constraints. Subsequent visits (after three months) to the same community sites with a Mobile Van still attract an average of 30 clients, some of them repeat testers.

Table 10: Accessibility to AIC Mobile Van VCT Service

Aspect of Measurement	Frequency	
	n	%
Distance traveled to Mobile Van Service site (N=58)		
Less that 1 KM	28	48.3
1-2 KMs	11	19.0
3 KMs and beyond	19	32.8
Mode of Transport used to Mobile VCT site (N=62)		
Walking	39	62.9
Bicycle	14	22.6
Motor-cycle	4	6.5
Bus/Taxi	5	8.1
Cost of Travel to mobile van VCT site (U.shs) (N=60)		
No Cost	51	85.5
500	4	6.5
1,000 – 10,000	5	8.0
Time taken to reach mobile van VCT site (N=59)		
Less than 30 minutes	40	67.8
30 minutes to 1 hour	10	16.9
Over an hour	9	15.3

However, in the case of KItovu mobile where there is cost sharing, potential clients who do not have the required Ug.Shs1,000/= to undergo an HIV test stay away:

> *For some, it is poverty. There are a few who wanted to come here but lacked money for the test. If you lack this money, definitely you cannot walk only to be denied service*... (FGD Participant, Exposed Users, Kitovu Mobile Site).

4.1.2 Information Dissemination

The mobile van VCT service attracts many people in the community, which provides opportunity for mass HIV education, addressing potential clients' fears and misconception,

sharing the VCT protocol as well as information on referral system. This is not possible with a static centre because in its case only those that want to seek for VCT go there.

However, as earlier mentioned this was not done with the mobile van VCT visits. Consequently, a significant number of residents in the community kept approaching the Research Team seeking information especially regarding the length of time it takes for someone to receive his/her test results. Majority had the impression that it takes some days before test results can be confirmed; they were not sure whether confirmation could be done instantly. On realization that all tested clients would receive their test results, some wished but found it difficult to sneak away from the curious community members with their results.

4.2 Demerits of using a mobile van for VCT service over Static Centres

4.2.1 Time constraint

In the mobile van VCT service, time is always a crucial factor determining quality of service and satisfaction of clients' needs. As earlier highlighted, mobile van VCT service is characterized by turn-away of potential clients. Registration closes as early as 2:00pm therefore any potential client that comes after is advised to try another time in future although even the date is not given.

Although it is understandable that a counselor has got a limit on how many clients he/she can counsel in a day, when sending away potential clients, an effort should be made to at least give them a brief session on basic HIV education for VCT to address their fears and misconceptions about HIV/AIDS, hence preparing them to seek for the service in future. Given that a mobile van VCT facility operates in the hard to reach communities, it goes without saying that the assumption that majority of potential clients of VCT services know what is involved in VCT having been sensitized about the service through various IEC approaches by public and civil society agencies is wrong. The mobile van VCT Team should also communicate to the community about the closure of registration as was done (using loud speakers) while mobilizing them to turn-up for the service.

4.2.2 Cases of Inconvenience to Clients

Particularly in multilingual communities, with a mixture of various ethnic groups such as transient populations, cases of inconvenience are observed. For instance, at Tumba landing site, the Luo speaking categories of clients were at registration, made to wait longer than other clients to raise the required numbers for a pre-test group counselling session. In addition, they had to wait for one particular counselor who could speak their language to receive their test results. Linguistic heterogeneity had earlier been recorded as a challenge in Kiryandongo area, a community of refugees and other displaced persons, AIC sources revealed.

The exposure of VCT service to the entire community inevitably creates some inconvenience to potential clients who would have preferred the service to be close enough but not necessarily exposed as is the case of the Mobile Van. The Van attracts whole communities many of them merely onlookers keen to observe who takes or does not take the service. A few non-users confided in the Research Team that they would rather incur the cost of transport to main AIC centres for confidential VCT than take advantage of the

mobile service at the site. Apart from these few, majority of the community people seemed less bothered by the presence of onlookers. Some were instead encouraged to test for HIV having seen their colleagues test.

4.2.3 Lack of Continuity in service delivery

Findings reveal that when VCT services are provided free of charge and taken nearer to the people in their communities, many are willing to seek the services. However, in the absence of follow-up services (continuity especially for ongoing counseling and guidance), the relevance of testing people for HIV in the hard to reach communities is questionable. Throughout the field visits, the issue of additional support on top of VCT services came out clearly. Some clients pointed out that one of the things that can constrain positive living is absence of drugs for treatment and poverty:

> *We would have appreciated the mobile van VCT since it does not involve costs of travel, but we would be more convinced to seek for the service if they* (mobile van VCT staff) *also carried medicine. We would be very happy if they brought drugs as well* (FGD participant, exposed non-users, AIC Site).
>
> *Yes, it is true; you cannot simply come here, pronounce my HIV status and then drive away* (FGD participant, exposed non-users, AIC Site).

Clients indicated that, although it does not take the worrying away, people need support mainly in form of nutritious foods, blankets etc., it means that the mobile van VCT Team cares and supports clients. It is some kind of consolation, they admitted.

Furthermore, the practice of changing counselors from one team to another frustrates the idea of building a strong counselor-client relationship as is the case with Kitovu mobile. This practice is especially not good in situations where results are not issued to the client immediately. As it was revealed, the Kitovu mobile Team follows a program where each centre is visited fortnightly to treat, issue test results and draw blood for HIV testing where applicable. It was observed that under such a system, it would be important to recap the pre-test counselling session before going the client his/her results but because of time, the practice is to give the client HIV test results and prescribe treatment.

4.3 Analysis of the existing services for care of clients who test positive

Within the AIC arrangement, there is little evidence of integrated service systems to cater for persons found to be infected with the virus that causes AIDS. Referrals can be made to different care and support systems even when a mobile van is used for VCT service but systematic linkages within communities visited during the study period were not immediately apparent. In Nakasongola, for instance, district officials were hopeful that those in need of care and support would benefit from their traditional support systems and from World Vision, the only NGO running a component of post test club in the area. For Nakaseke, attempts are made to handle cases in need of post-test support. Being a hospital, there is opportunity for clients to be cared for and supported.

The critical issue for mobile van VCT therefore is the need to develop clear linkages with support systems, not simply to pronounce the HIV status of community people. In the

absence of such opportunities, it is clearly challenging how the mobile service can be justified. An assumption had been made that the Mobile Van arrangement enhances possibility of continuity of care on the part of the clients, especially if the service can be sustained by the provider to the convenience of the clients. For the AIC mobile van, this assumption could not be approved.

In establishing a mechanism of care, there are issues for consideration as well. The Case of Kitovu Mobile provides important lessons. Firstly, the financial resource base of the agency has to be taken into account as are requirements for personnel, and organizational capacity. Kitovu Mobile runs an integrated community outreach and HBC program. It is a well established agency with medical personnel, social workers, and specialist others to handle issues of physical health, psychosocial challenges and socio-economic needs of clients simultaneously. Short of providing such comprehensive support, the agency running mobile VCT has to develop partnerships through formal understanding with other support groups to which clients can be referred, not simply to assume and hope that the existing agencies in and around the communities visited will care.

SECTION FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

Mobilization for Mobile Van VCT Services

Consumption of VCT services, unlike other socially marketable services is compounded with clear education and sensitization about the realities of taking an HIV test on the part of the potential client, and, perhaps on how this may affect the family and significant others. Community people have many fears and misconceptions that have to be rested before responding to VCT. This calls for the need to mobilize and educate communities prior to the mobile VCT visit.

Adherence to the Protocol for VCT

The Mobile Van VCT Team tries within the context of communities they visit to observe the protocol as provided for in the National Policy Implementation Guidelines for VCT. However, due to lack of appropriate infrastructure in typically poor hard-to-reach communities, the procedure for conducting VCT services is sometimes not adequately and precisely followed. Added to time constraints on the part of the service providers, the temptation is to handle some of the key stages hurriedly. The epitome of the omission is to clearly disregard the VCT protocol.

Satisfaction with the service

The majority of clients have good words for Mobile Van VCT services offered to them. They show readiness to utilize services offered by the Mobile Van team come next time, and express willingness to advise other people in the community, relatives and friends to seek the services as well. They perceive the quality of the service to be high.

Information gaps

A section of clients, however, would have preferred to get more information and guidance to competently cope and live positively. Listening to exposed, non-users of VCT at the mobile sites, one gets a sense of a reluctant, less informed community with little appreciation of VCT services in general. There is need for more education and sensitization specific to VCT.

Equity and Gender issues

Gender and other socio-economic considerations have a weak influence on accessibility to service at VCT centres. There is little evidence of inequity in service accessibility, save for people with low or no education who require concerted sensitization and education about the benefits of VCT to gain motivation. Compliance with the requirements of counselling that clients have received is more to do with the skills and attitudes of counselors than with their bias towards particular population groups. Some gender related problems are eminent when it comes to couples. They are a few who test as couples. Those who test without their spouse's approval tend to be very much worried about the supportive behavior that would be required from their partners.

Cost of service provision

Analysis of data clearly reveals how the Mobile Van system significantly reduces the fixed cost of service provision at static/permanent sites while enhancing likelihood of reaching wider populations that would otherwise be constrained by structural, access related factors.

Convenience of the Mobile Van

Many people recognize the relevance of VCT in influencing behavioral decisions to prevent spread of HIV/AIDS. Motivation for VCT is still largely influenced by an individual fear of likely infection, and VCT is largely taken as a confirmatory test. A significant category is, however, attracted to the mobile van due to the convenience they enjoy compared to the static services miles away from potential users. The mobile van alleviates many of the facility related factors that tend to discourage people from seeking VCT services. The van brings services to the people; what remains is for people to deal with their own contextual, socio-behavioral challenges related to VCT.

Anonymity and confidentiality

Potential clients of VCT services previously constrained to seek service due to fear of losing anonymity and confidentiality are better served from mobile van VCT. Permanent location of VCT services at conventional health units of Government and civil society agencies discourages some clients, as they perceive likelihood of disclosure of HIV status to wider community members. However, a Mobile Van inadvertently attracts attention of communities, and thus there are challenges of likely stigma based on suspicions against accepting to obtain service. This constitutes one of the reasons for non-use of mobile van VCT by some of the community members exposed to the van.

Overall appropriateness

It is clear from the study findings that the Mobile Van for VCT services is an appropriate form of delivering service to the "hard-to-reach" populations. However, the van still requires time and resources for community support. It is not a matter of simply moving with a mobile van to communities unannounced. Potential clients and entire communities need to be supported. Technical and political structures within district and communities are key partners to the success of the Mobile Van system.

Services for care and support of clients

The critical issue for mobile van VCT therefore is the need to develop clear linkages with support systems, not simply to pronounce the HIV status of community people. There is little evidence of integrated service systems, for instance to cater for persons found to be infected. Referrals to different care and support systems are important even when a mobile van is used for VCT service. Systematic linkages need to be developed.

In summary, the major strengths of the Mobile Van VCT include the following:

1. Majority of potential clients of VCT services who are otherwise constrained due to costs of transport, and of service, consider the van as a great opportunity. Many people are aware of the existence of VCT services and would like to take a test for HIV. The van brings service to the people.

2. The Mobile Van brings equitable access to VCT service. Different socio-economic and demographic groups are provided the opportunity for service. Those that would

otherwise be constrained by childcare, gardening, housekeeping and other household based chores, mainly women, are able to be served. The same is the case for the unemployed and the poor. It is thus more prudent to equip mobile vans to move to where people live and work, including schools and recreation centers.

3. The fact that the Mobile Van attracts more clients to VCT is itself a strength. Given that, in many situations, VCT has been associated with behavior change irrespective of the results of the test, more people turning up to test implies more likelihood of improvement in the country's response.

4. There is marked reduction in comparative (personnel and other variable cost) of establishing and sustaining Mobile Van VCT systems in vast communities as compared to establishing more indirect sites at health units composed of few regular staff providing services on a regular basis. One indirect site in a district or geo-political area can suffice if boosted by regular mobile services from the regional AIC office. Care should, however, be taken to ensure the team is well equipped and motivated to ply the communities and provide quality services.

5. Potential clients of VCT services who would otherwise be constrained to seek service due to fear of anonymity and confidentiality are catered for. Some community people perceive likelihood of disclosure of HIV status to wider community members by counselors known to them. This, the Mobile Van VCT system handles.

6. With appropriate support for staff and adequate equipment, quality of service can be guaranteed with Mobile Van VCT system, for instance in terms of length of counseling sessions, quality time provided to clients, safety of equipment used, hygiene and meeting other health concerns of those suffering from AIDS related complications. The AIC Van can draw lessons from Kitovu Mobile on the kind of essential services that community people seek from HIV/AIDS service agencies. While not all services can be provided, a few essential support kits are necessary.

Some of the weaknesses of the Mobile Van, which need to be addressed so as to make the mobile van for VCT more appropriate include:

1. Measures for continuity especially for taking care of those who test positive are not sufficiently developed. The current AIC plan needs to articulate measures to be put in place to deal with this problem.

2. The challenge of HIV/AIDS in communities goes beyond VCT. The Mobile Team needs to be sufficiently equipped with information on common issues of concern regarding HIV/AIDS, including information about treatment, referral systems for psychosocial, economic and legal support.

3. The level of community education prior and during service delivery needs to be scaled up. There are issues of stigma to be addressed especially considering that the testing and counseling are conducted in open air or full view of community others. The inadequacy of this education and sensitization constitutes one of the reasons for reluctance to take advantage of a service brought nearest to people.

4. Other issues that are important in developing a sustainable highly attractive Mobile Van VCT system that meets the demand for VCT within and across communities seem to be weak or are lacking in the current AIC mobile van delivery service. These include: developing partnerships with support agencies for continued care and support for PLHAs, community mobilization and sensitization prior to the visit by the Mobile Van Team, allowances for community/district based support teams, notification of local leadership and ensuring that the mobile van enters early into the community to be served before people disperse to engage in other everyday activities.

5.2 Recommendations

In all, the Mobile Van arrangement for VCT is a viable endeavor, which needs support. It is possible to maintain quality services by moving AIC qualified staff and equipment from one place to another within their regional areas of coverage. The mobile van can effectively target a category of population who would otherwise be inconvenienced and inaccessible if they were to rely on static facilities. More important, continuity of care for the clients can be guaranteed with deliberately developed partnership systems with other agencies and support groups nearest to clients of Mobile Van VCT service. In partnership, UPHOLD, CDC, and USAID should identify among the support requirements for an effective mobile van those areas that each agency can address. The major requirements include the following:

1. Vehicles equipped to suite Mobile VCT services, both laboratory and personnel. The vehicle should conveniently be able to move such items as wash basins, towels, and medical consumables such as gloves, needles, syringes, lancets, swabs, spirit, sharps disposal and standard waste disposals. Since these items have to be transported, the vans should equip with cooler boxes and relevant samples kept refrigerated.
2. Allowances for AIC staff and support staff at district AIC indirect sites such as counsellors whose active participation fills the necessary gaps articulated in this report

3. Capacity building of relevant units of AIC (management, counselling, technical) required to run Mobile Van VCT through training and logistical support to AIC to expand and improve service availability to wider sections of hard-to-reach groups

4. Partnership building initiatives by AIC to link with other agencies in order to make available services for post test care and support, treatment, and impact mitigation to clients in need. This is necessary to make VCT more relevant and attractive to majority of reluctant members of the community

Drawing from the study, it is strongly recommended that UPHOLD should fund the Mobile Van VCT service, taking into account the adjustments highlighted in this concluding section of the report.

Annexes: Data Collection Instruments

The Uganda Program for Human and Holistic Development (UPHOLD)

Feasibility Study of the Mobile Van for Voluntary Counseling and Testing (VCT) for HIV/AIDS

Questionnaire

To be administered to people who have just received Mobile Van VCT services or have been in contact with Mobile Van VCT services

My name is ……..I am working with Makerere University, Department of Social Work and Social Administration as an Interviewer, which is undertaking a study for the Uganda Program for Human and Holistic Development (UPHOLD) on issues of voluntary counseling and testing. As a person who has just received the service, you can help us by answering a few questions. It is hoped that your participation in this study will help the provider of the service to strengthen the delivery of VCT services. Information gathered in this feasibility study will be used to help improve and develop health programs for both men and women in Uganda. Keep in mind that we have not come here to judge you or judge your behavior. We simply want to learn more from you about your concerns, your aspirations and your practices concerning your health. We thank you in advance for your participation in this study, because if every selected person like you participates, our information will be more useful. Your answers will be kept strictly confidential.

IDENTIFIERS

Sub-county……Parish…….Village…….
Name of the Testing centre……
Description of the Location……...

SECTION 1: IDENTIFICATION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS			
No	**Question**	**Answer Codes**	**Skip**
100	District	Masaka……. 1 Nakasongola…… .2	
101	Sex of Respondent	Male……. ..1 Female…… …2	

SECTION 1: IDENTIFICATION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS			
No	**Question**	**Answer Codes**	**Skip**
102	How old are you now (in complete years)?	_____Years Do not Know……99	
103	In which month and year were you born?	Month_____Year_____	
104	What is your marital status?	Never married…….1 Currently Married……...2 Cohabiting……...3 Widowed…….4 Separated/divorced……..5	
105	Do you have any children of your own?	Yes……..1 No……2	***to Qn 107***
106	How many children do you have?	Number of Boys_____ Number of Girls_____ Number of children [__|__]	
107	Currently, what is your main occupation?	Peasant farmer…….1 Salaried worker……...2 Student…….3 Commercial/Business……..4 Fishing…….5 Driving/Cycling……..6 Others (Specify)……	
108	Have you ever attended school?	Yes……..1 No……2	***to Qn 110***
109	What is the highest level of education you have attained?	Primary……1 Secondary……2 Post secondary…….3	
11	What is the place of your usual residence?	Village……	

SECTION 1: IDENTIFICATION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS			
No	**Question**	**Answer Codes**	**Skip**
0	(***Probe with codes***)	….1 Trading centre…….2 Town……3	
SECTION 2: ACCESS TO MOBILE VAN FOR VCT			
200	How far is your home from here (***referring to point of service for Mobile VCT***)?	……Kms	
201	What mode of transport did you use to come here today?	Walking……..1 Bicycle……2 Motor-cycle…….....3 Bus/taxi……....4 Own Car……..5 Other (specify)……	
202	Did you pay any money in form of transport fares to reach this place?	Yes…….1 No……2	***to Qn 204***
203	How much have you/did you pay to reach this place? (***Clarify cost for one route***)	…….Ug.Shs	
204	How long did it take you to travel from your home to this place?	……minutes…… Hrs	
205	How do you feel about the time it took you from your home to this place?	Too long……..1 Long……2 Short……3	
206	Have you ever sought for VCT services before?	Yes…….1 No……2	***to Qn 208***
207	Where did you seek VCT services? ***If AIC specify these areas in the mentioned districts***…… ….	Hospital……...1 Health Facility…….2 AIC……..3 Mobile Van……4 Others (Specify)…….	

SECTION 1: IDENTIFICATION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS			
No	**Question**	**Answer Codes**	**Skip**
208	***For those who did not mention Mobile Van, ask;*** a) Did you know that you can get VCT services from a Mobile Van before? b) How did you come to know about Mobile Van VCT before?	Yes……..1 No……2 …… …… ……	***to Qn 300***
209	What category of people according to you, utilize the Mobile Van facility most?	Youth out of school…….1 Youth in school……...2 Married women……...3 Unmarried women……...4 Formal Working men……..5 Non working men……6 Others (specify)……	
210	What prompts people to use the Mobile Van rather than other places?	…… …… ……	
211	According to you, how do you compare the Mobile Van VCT services to the static site?	…… …… ……	
212	What particularly attracted you to seek VCT services from the Mobile Van?	…… …… ……	
213	In your view, what facilities should a good Mobile Van have? (***Write down all mentioned***)	…… …… …… ……	
214	Are the days or the day when the Mobile	Yes……	

SECTION 1: IDENTIFICATION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS			
No	**Question**	**Answer Codes**	**Skip**
	Van service is provided convenient to you?	…..1 No…… …2	
215	Is the time when the Mobile Van services are provided convenient to you?	Yes…… …..1 No…… …2	
	SECTION 3: QUALITY OF SERVICES		
300	What services did you come for? (***Multiple responses allowed; Interviewer may use codes to prompt the respondent***)	Pre-test counseling……1 HIV Testing……2 Post-test counseling……3 Information…… ….4 Post-test club services……5 Referral…… …..6 Treatment/drugs…… …7 Repeat testing……8 Other (specify)……..9.	
301	Have you received any VCT services from the Mobile Van today?	Yes…… …..1 No…… …2	***to Qn 304***
302	What services in particular have you received? (*Multiple responses allowed*)	Pre-test counseling……1 HIV Testing……2 Post-test counselling……...3 Information…… ….4 Post-test club services……5 Referral…… …..6 Treatment/drugs…… ….7 Repeat testing……8 Other (specify)……..9.	
303	a) How long did it take you to be attended	……Minutes……Hr	

SECTION 1: IDENTIFICATION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS			
No	**Question**	**Answer Codes**	**Skip**
	to? b) Would you say the time you spent here was: (***Interviewer read out options***)	s Too long……..1 Long……2 Short……3 Too short…….4	
304	***If did not mention HIV testing ask;*** What are the reasons you did not take an HIV test?	…… …… …… ……	***All go to Qn 400***
305	***If mentioned HIV testing ask;*** What are the reasons you took an HIV test?	…… …… …… ….	
306	With whom did you have the HIV test?	Alone……..1 Relatives…….2 Fiancé……..3 Girl/Boy friend……4 Spouse/partner……5	
307	***If mentioned alone, ask;*** Did you discuss with your partner/spouse before coming for the HIV test?	Yes……..1 No……2	
308	***If mentioned HIV testing ask;*** Have you received your test results?	Yes……..1 No……2	***→to Qn 310***
309	What are the reasons you have not received your results?	…… …… ……	***→to Qn 313***
310	Are you satisfied with the results from your HIV test?	Yes……..1 No……2	

SECTION 1: IDENTIFICATION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS			
No	**Question**	**Answer Codes**	**Skip**
311	With whom are you going to share your test results with?	Nobody……1 Relatives……2 Fiancé……..3 Girl/Boy friend……4 Spouse/partner……5	
312	What are the reasons you cannot share your results with your spouse/partner?	…… …… ……	
313	Whom would you feel comfortable consulting in case of problems related to sero-status?	…… ……	
314	How would you assess the sufficiency of information provided by the personnel on the Mobile Van? (***Probe with codes***)	Insufficient information……..1 Somewhat sufficient……2 Very sufficient……3 Did not receive any information……..4	
315	Are you satisfied with the services you have received?	Yes, very satisfied……..1 Yes, satisfied……..2 A little satisfied……..3 Not satisfied……4	
316	What do you like about the VCT services provided by the Mobile Van?	…… …… ……	
317	Is there anything you did not like about the counseling services provided by the personnel on the Mobile Van? ***If yes, what was it?***	Yes……..1 No……2	

SECTION 1: IDENTIFICATION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS			
No	**Question**	**Answer Codes**	**Skip**
	……... …… ……		
318	Did the place where you were attended to from offer sufficient privacy?	Yes…… …..1 No…… …2	***to Qn 320***
319	What was put in place to ensure privacy?	…… … …… …	
320	Did you feel comfortable with the staff who attended to you?	Yes…… …..1 No…… …2	
321	a) What particularly made you feel comfortable with staff attending to you? b) What particularly made you feel uncomfortable with staff attending to you?	…… … …… … …… … …… …	
322	Do you like the process you go through to be counseled and tested here?	Yes…… …..1 No…… …2	
323	How long does it take from testing to the time of getting the test results?	……..days	
324	How do you feel about the time it has taken you from testing to the time of getting results Would you say it (***Read Codes***)?	Took too long……..1 Took long……2 Took a short time…….3	
325	In your opinion, is the HIV education, and the pre & post-test counselling offered sufficient to enable you live positively in case you were found HIV positive?	Yes…… …..1 No…… …2	
326	What form of support should be extended to persons who have tested HIV positive?	…… … …… …	
327	What major challenges do you envisage that are likely to constrain positive living?	…… … …… … …… …	

SECTION 1: IDENTIFICATION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS			
No	**Question**	**Answer Codes**	**Skip**
	SECTION 4: ACCESS TO SERVICES		
400	Where else can you access Mobile Van VCT services from in this area?	…… … …… …	
401	Are there particular services that you required but are not available here?	Yes…… …..1 No…… …2	
402	Which particular services did you require but are not available here ?	…… … …… … …… …	
403	Did you pay/have you paid for the services?	Yes…… …..1 No…… …2	***to Qn 406*** →
404	How much did you pay/have you paid for services?	……Ug.shs.	
405	What is your opinion about the amount charged for the services you received?	Cheap…… …..1 Fair…… …..2 Expensive…… …3	
406	Apart from VCT, are there other services that were provided to you?	Yes…… …..1 No…… …2	→ ***to Qn 500***
407	What other services were provided to you?	Condoms…… ….1 Other family planning services…… …2 STI management…….3 TB management……..4	
	SECTION 5: INFORMATION EDUCATION COMMUNICATION (IEC)		
500	How did you know about the services provided here? (***Multiple responses allowed***)	Through friends……..1 Health workers……2 Radio…… ...3 Local officials…….4	

SECTION 1: IDENTIFICATION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS			
No	**Question**	**Answer Codes**	**Skip**
		Others (Specify)……	
501	On today's visit, were you given any information?	Yes…… …..1 No…… …2	
502	Were all your information needs addressed?	Yes…… …..1 No…… …2	***to Qn 504***
503	***If No, ask;*** What is it that you wanted information about but never got it?	…… … …… …… ……	
504	What kind of information were you given?	Leaflets…… …1 Brochures…… …2 News prints……3 Posters…… ….4 Booklets…… …..5 Others (specify)……..	
505	In what form was that information given to you?	Verbal health education……..1 Leaflets…… …2 Brochures……. ...3 News prints……4 Posters…… ….5 Booklets…… …..6 Others (specify)……	
506	Was the information presented to you in a language you understand?	Yes…… …..1 Fairly…… ...2 No…… …3	
507	Would you advise a relative or friend to	Yes……	

SECTION 1: IDENTIFICATION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS			
No	**Question**	**Answer Codes**	**Skip**
	come for VCT services provided by the Mobile Van?	…..1 No…… …2	
508	Do you intend to come back for VCT services in future?	Yes…… …..1 No…… …2	
509	What are the reasons you intend to come back for VCT services in future?	…… … …… … …… …… …….	

THANK YOU VERY MUCH FOR YOUR TIME

The Uganda Program for Human and Holistic Development (UPHOLD)

Feasibility Study of the Mobile Van for Voluntary Counseling and Testing (VCT) for HIV/AIDS

Observation Checklist

Mobile Van

1. Sitting capacity of the van
2. Number that sits in the van
3. Comfort with regard to sitting
4. Kind of equipment carried or transported
5. Adequacy of the van's capacity to carry all the necessary equipment at ago
6. Any occasional van break down resulting into rescheduling of the service
7. Suitability of the van to travel or rough roads

At the site:

1. Description of the site where VCT is provided:
    - Village/rural, trading center, town etc
    - Crowded with many people
    - Open ground
    - Private with few people
    - Under trees
    - How are the people mobilized?

2. Turn up of clients and potential clients
    - Head count of adults and children at the sites
    - Voluntary or involuntary interest in seeking VCT
    - Reaction of the people as soon as the van arrives
        - Excited
        - Indifferent
        - Move closer/Surround it
        - Start asking questions
        - Sneak away
    - Any interruption of some activities

Counseling Arrangements

1. Place where clients are counseled (pre & post test counseling)
2. Feeling of clients regarding the environment in which the services are being offered (i.e., are clients trying to sneak, reluctant to join or refusing to join)
3. Category of clients (i.e., females, males, youth, working class, students, children etc)
4. Procedures followed i.e., (i.e., general sensitization about HIV/AIDS etc)
5. Client service level (i.e., are all served, if no why?)

6. Duration the exercise takes (i.e., does it involve too much waiting? Evidence of some discontent due to the waiting?)

Other Observation Aspects

1. Availability of reception/receiving desk
2. Availability of a waiting place
3. Seats/mats available in at the waiting/waiting room
4. Availability of recreational facilities as people wait:
5. Availability of personnel for VCT at the site:
   - Counselors (No)_____
   - Laboratory personnel (No)_____
   - Clinicians (No)_____
   - Assistant Counselors (No)_____
6. Confidentiality of client information.
   - Client information/data well kept
   - Client consent forms exist
7. Condition/status of counseling place/room:
8. Availability of Behaviour Change Communication materials:
   - Materials on abstinence
   - Materials on faithfulness
   - Materials on condom use
   - Materials on family planning
9. Post-test clubs:

- Post test clubs available at the site
- Face to face counseling provided when giving out HIV test results to client
- Existence of a PTC drama group
- PTC linked to a comprehensive care and support service

10. Hours of work per visit:_____
11. On average, number of clients seen per visit by a counselor_____
12. VCT center opening time_____
13. VCT closing time_____
14. On average, number of clients seen per visit_____

The Uganda Program for Human and Holistic Development (UPHOLD)

Feasibility Study of the Mobile Van for Voluntary Counseling and Testing (VCT) for HIV/AIDS

Key Informant Guide with the AIC Management/Staff

1. How many communities have so far been covered by the Mobile Van?
2. How are the communities and districts selected?
3. Which target groups are served by the MVS?
4. Is there any criteria for selecting people who receive VCT
5. Who are the major clients/consumers of VCT services
6. What barriers or constraints do you think prevent or discourage people from using the Mobile Van VCT services?
7. Apart from the Mobile Van, what other options are available for serving the underserved communities?
8. What does it take to provide a full VCT service to a client using a Mobile Van? (estimates of costs in relation to items used—variable and fixed costs per capita, compared with other options of delivery)
9. How do the costs of providing full VCT services using a Mobile Van compare with other delivery options (i.e., direct site, indirect site etc)
10. What are the merits of using a Mobile Van to serve the underserved communities compared to other delivery options?
11. What are the demerits of using a Mobile Van for VCT compared to other delivery options?
12. What care or support is given to clients who test positive (i.e., probe on strengths and weaknesses)?
13. What should one consider in order to establish a mechanism of care for those who test positive at the community level?
14. What are the limitations or constraints of the Mobile Van approach?
15. How can these limitations be addressed?
16. Can you share with us any success stories of the Mobile Van?
17. How cost effective is the Mobile Van system?
18. How sustainable is the Mobile Van for VCT delivery?

The Uganda Program for Human and Holistic Development (UPHOLD)

Feasibility Study of the Mobile Van for Voluntary Counseling and Testing (VCT) for HIV/AIDS

Focus Group Discussion Guide for Users at the Site

1. Knowledge on VCT for HIV/AIDS
2. Attitude towards VCT for HIV/AIDS
3. Knowledge/awareness of other delivery options of VCT services
4. Community perception and attitude towards those who use Mobile Van services
5. Comparison of the Mobile Van and other options
6. Aspects liked most regarding the Mobile Van delivery service
7. Aspects not liked regarding the Mobile Van delivery system
8. Factors mitigating against use of Mobile Van VCT services by other community members
9. Ways of motivating people to use Mobile Van services
10. Provision of IEC materials
11. Parents views about children using Mobile Van VCT services
12. Any other suggestions and comments about Mobile Van VCT improvement.

The Uganda Program for Human and Holistic Development (UPHOLD)

Feasibility Study of the Mobile Van for Voluntary Counseling and Testing (VCT) for HIV/AIDS

Focus Group Discussion Guide for Community Members/Non-users

1. Knowledge on VCT for HIV/AIDS
2. Attitude towards VCT for HIV/AIDS
3. Knowledge/awareness of the Mobile Van for VCT for HIV/AIDS
4. Knowledge/awareness of other delivery options of VCT services
5. Comparison of the Mobile Van and other options
6. Factors mitigating against use of Mobile Van VCT services
7. Ways of motivating people to use Mobile Van services
8. Any other suggestions and comments about Mobile Van VCT improvement.

The Uganda Program for Human and Holistic Development (UPHOLD)

Feasibility Study of the Mobile Van for Voluntary Counseling and Testing (VCT) for HIV/AIDS

Key Informant Interview Guide for Local VCT Service Providers

1. What do you know about a Mobile Van VCT services?
2. How is it different from the regular VCT services?
3. Are there any advantages of the Mobile Van over other options of delivery (the regular services)?
4. Which groups of clients are targeted by this approach?
5. Is this group significant?
6. Is this the best option for accessing this group?
7. What conditions is the van convenient for delivery of VCT services?
8. Who benefits most from the Mobile Van service?
9. Is there any better way of reaching such people other than the Mobile Van? What are the other ways?
10. What are the people's views about the Mobile Van arrangement? (Probe for privacy, confidentiality and trust about the service?
11. How can the Mobile Van services be improved?
12. What else can the van do apart from VCT delivery services?
13. Comments and suggestions about the van.

The Uganda Program for Human and Holistic Development (UPHOLD)

Feasibility Study of the Mobile Van for Voluntary Counseling and Testing (VCT) for HIV/AIDS

Key Informant Interview Guide for UPHOLD Staff

1. What are the goals you would like to realize under VCT?
2. Is it possible to realize all these using the Mobile Van approach?
3. What other approaches would have been more cost effective than the Mobile Van?
4. Under what terms would you like to work with the Mobile Van?
5. What problems do you envisage when using the Mobile Van?
6. How can these be minimized?
7. What fears do you have about the Mobile Van system?
8. To what extent are you prepared to support the continuity of the Mobile Van services for VCT for HIV/AIDS?