

**ASSESSMENT OF COUNSELING SERVICES IN
ADDIS ABABA MOBILE VOLUNTARY
COUNSELING AND TESTING CENTER**

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**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
INSTITUTE OF PSYCHOLOGY**



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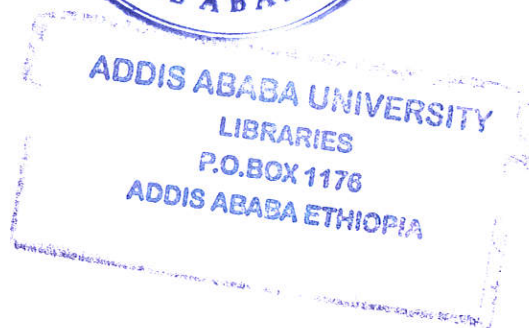
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**THESIS SUBMITTED TO THE INSTITUTE OF
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ABSTRACT

This research was conducted to identify the major achievements and problems of counseling given in the mobile VCT center to satisfy the needs of the clients. For this study, descriptive survey method was used and data were collected from available five counselors, two coordinators, a supervisor and 160 voluntary Clients through questionnaires, structured interview and observation checklist. As a result, Addis Ababa OSSA mobile van has functioning laboratory, separate narrow counseling room, inadequate tent waiting area, infection control and waste disposal practices as well as it is well structured and has adequate stuff. But the study found out that; there is a referral service problem, specially care and support service, problems of follow up and networking and promotion about the mobile VCT services were not adequate. Besides, contents of pre-test counseling session were covered but the contents of post-test counseling sessions were not fully covered during the counseling sessions. Furthermore, the study indicated that counselors did not possess some of the basic counseling skills, the training given to them was neither standardized nor adequate and the majority counselors were not well experienced. In addition, counselors face the presence of workload, lack of on-going training, lack of technical support, administrative support, lack of emotional support, staff turn over, staff moved to other posts and lack of waiting area. Nevertheless, most of the clients and counselors of the mobile VCT center have positive attitude towards counseling services. Finally, Based on the problems recommendations were forwarded such as; provide further standardized training and refreshment training for Counselors, provide strong support and supervision, referral system should be strengthen, counselors' need of incentive and shift work should be addressed, the contents of post-test counseling should be covered, the counseling and waiting room should be improved in order to provide quality Mobile VCT services.

TABLE OF CONTENT

CONTENTS	PAGE
ACKNOWLEDGMENTS	i
LIST OF TABLES	v
ABBREVIATIONS	vi
ABSTRACT	vii
CHAPTER ONE	
INTRODUCTION	1
1.1. Background of the Study -----	1
1.2. Statement of the Problem-----	4
1.3. Objectives of the Study-----	5
1.4. Significance and Justification of the Study-----	5
1.5. Delimitation of the Study-----	6
1.6. Limitation of the Study-----	6
1.7. Operational Definition of Terms-----	6
CHAPTER TWO	
REVIEW OF RELATED LITERATURE	8
2.1. The Concept of Counseling-----	8
2.2. The Nature and Concept of HIV Counseling-----	10
2.3. The Models of VCT Service-----	11
2.4. Characteristics of a Good VCT Sessions and Counselor-----	14
2.4.1. Characteristics of a Good VCT Counselor-----	14
2.4.2. Characteristics of a Good VCT Session-----	14
2.4.3. Clients of VCT Services-----	15
2.4.4. Counselor Training-----	15
2.4.5. Operational Aspects of VCT Service-----	16
2.4.5.1. Counseling Room and Waiting Area-----	16
2.4.5.2. Referral Linkage-----	16
2.4.6. Elements of HCT -----	17

2.4.6.1. Pre-test Counseling-----	17
2.4.6.2. Post-test Counseling-----	17
2.4.6.3. Follow-up Counseling -----	18
2.5. The Nature and Characteristics of Mobile VCT-----	18
2.5.1. Advantages and Disadvantages of Mobile VCT Services-----	19
2.5.1.1. Advantages of Mobile VCT Services-----	19
2.5.1.2. Disadvantages of Mobile VCT Services-----	20
2.5.2. Operational Requirements for Mobile VCT-----	21
2.5.2.1. Venues and Equipment-----	21
2.5.2.2. Staffing-----	22
2.5.2.3. Promotion-----	22
2.6. General practice of Addis Ababa OSSA Mobile VCT Center-----	23

CHAPTER THREE

METHODOLOGY AND DESIGN OF THE STUDY.....	24
3.1. Description of the Study Area-----	24
3.2. Participants of the Study-----	24
3.3. Instruments Used for Data Collection-----	25
3.4. Pilot Test-----	27
3.5. Data Collection Procedure-----	28
3.6. Data Analysis-----	28

CHAPTER FOUR

RESULT OF THE STUDY.....	30
4.1. Socio- Demographic Profile of Respondents by Type-----	30
4.2. General practice of Addis Ababa OSSA Mobile VCT Center-----	32
4.3. Contents of Mobile VCT Counseling Sessions-----	35
4.4. Training, Support, Supervision and Skills of Counselors-----	38
4.5. The Counseling Environment -----	40
4.6. Attitude of Clients and Counselors towards counseling-----	44
4.7. The Problems Counselors and Clients Faced and Their Suggestions towards improvement of Addis Ababa OSSA Mobile VCT center-----	45

Currently, most people remain unaware of their HIV status due to various reasons. However, with the development of affordable and effective medical care for people living with HIV, demand for testing is increasingly rapid, creating urgent need to increase access.

Moreover, many people are still reluctant to learn their HIV status unless medical care for HIV related illness and psychological supports does not exist and in the absence of community support and legal protection when they face discrimination and social marginalization (FDRE HPCO and MoH, 2007).

Thus, counseling has become a catchword associated with HIV infection and AIDS. It has entered the arena from the start of the epidemic as a direct result of the need for information transfer, behavior change, and as a possible solution to action in the face of ignorance and uncertainty. Yet now, with the hindsight of over a decade of experience with HIV infection and AIDS, the nuances of counseling, psychological intervention, and client care need to be carefully scrutinized (Bennett and Erin, 2001).

Since the national HCT guideline was published in 2002, new information as well as evidence based best practices have become available to make counseling and testing more effective and accessible and revise the existing to steer counseling and testing services to increase access and improve quality more effectively.

To achieve this, it is necessary to implement various counseling and testing approaches and services delivery models that can appropriately address facility and human related needs while maximizing utilization of existing resources. These counseling and testing approaches and service delivery models are Integrated Services, Stand-alone Services, Outreach and Mobile Services, and Work Place Services (FDRE HPCO and MoH, 2007).

According to FDRE HPCO and MoH, 2007 HCT guideline, Integrated Services are provided in public, NGO and Private Health Facility Settings, as designated VCT units or under other programs, such as TB, STI, PMTCT, Pediatrics, OI and Antiretroviral drug management.

Stand-alone Counseling and Testing Services are provided at sites outside health facilities, sometimes linked with care and support services.

Outreach HCT Services should be considered for special populations such as people in remote areas, pastoralists, refugees and prisoners. Outreach HIV Counseling and Testing can be provided in mobile vans or in other premises, such as kebeles, churches and schools. These services can be integrated with existing primary health care services. Mobile VCT should be linked to the nearest care and support organization through a strong referral system.

Because of policy support and it is one of the priority areas for HIV intervention, HIV Counseling and Testing Guideline is prepared by FDRE HAPCO, the Ministry of Health and different stakeholders in 2007. As a result, Governmental Organizations, Non Governmental Organizations, Private Clinics, Health centers and Hospitals are giving HIV counseling services.

Besides, Addis Ababa OSSA introduced a special Mobile VCT service which was officially launched and began its services in September 9, 2005. The main objective of the service is to make HIV counseling and testing services easily accessible to the community and to promote the importance of VCT in the society. Since its start, an average of 40-50 people takes this advantage per day (Addis Ababa OSSA brochure, 2008).

According to Organization for Social Service for AIDS (OSSA) Addis Ababa branch 2004 project proposal, Mobile VCT, just like other mobile health services, is an outreach approach that has been used to make the service more accessible for the social group that cannot get the service at the traditional site for various reasons.

According to OSSA (2004), the service package in the mobile VCT is based on policies and procedures outlined in the HCT procedures manual. It considered confidentiality, privacy, and anonymity as basic requirements. The counseling protocol and seating arrangements as recommended for counseling and observation of counseling session should be done to ensure quality just like it would done at the center. Furthermore, client satisfaction should be assessed equally.

Thus, this study attempted to assess the strengths and the weaknesses of the counseling service offered at the mobile VCT center conducted by Organization for Social Service for AIDS (OSSA) Addis Ababa branch and recommend some ways of improving the quality of counseling service.

1.2. Statement of the Problem

Addis Ababa OSSA provided mobile VCT services in order to make HIV counseling and testing services easily accessible to the community and to promote the importance of VCT in the society. However, very little work has been done to assess the quality of counseling in mobile VCT centers.

Based on the above rationales, this study was undertaken to assess the counseling service offered in Addis Ababa OSSA mobile VCT center. Therefore, the study attempted to answer the following research questions.

1. What seems the general practice of mobile VCT in Addis Ababa OSSA?
2. Do the mobile VCT counselors have adequate counseling training?
3. Do the counselors get necessary support and supervision?
4. Do counselors use basic counseling skills?
5. Are the essential contents of pre-test and post-test counseling sessions covered?
6. How conducive is the counseling environment (counseling room, seating arrangement and waiting area)?
7. What kind of attitude do clients and counselors have towards the counseling service offered in mobile VCT center?
8. What are the problems that affect the quality of counseling services and what are the solutions to overcome these problems?

1.3. Objectives of the Study

The objective of the study is to assess the counseling service offered in Addis Ababa OSSA mobile VCT center and identify major achievements and problems in rendering the service.

1.4. Significance and Justification of the Study

The researcher selected the counseling service because the researcher is a counseling student and he has involved in counseling activities. Thus, the need to examine whether or not counseling services are being offered effectively more attracted the researcher.

In addition to this, the researcher selects Mobile VCT center for the study with a rational that mobile VCT is one of the modes VCT service and it is one of the important strategies for the prevention of HIV/AIDS and the area might not be studied before.

According to the Federal Democratic Republic of Ethiopia /FDRE/ MoH and HAPCO (2007) HCT guideline, HCT is become increasingly available in Ethiopia but many people are still reluctant to be tested, this might be partly due to the quality of the services. Therefore, the researcher developed, among other things, a real concern for some of the counseling problems in mobile VCT center, which in time led to a decision to assess the situation at the mobile VCT center.

The importance of assessing the counseling service being offered in mobile VCT center is to examine whether or not quality counseling services are rendered at mobile VCT center. Thus, this study is intended to contribute the following significances:

1. It gives light on the theoretical frameworks by indicating the extent to which counseling is utilized and integrated with the existing HCT guideline.
2. Unfold major problems encountered in providing counseling services in mobile VCT centers.
3. Serve as one of crucial endeavors to enhance the quality of counseling in mobile VCT centers.
4. Encourage others to undertake further study on the topic in depth.

1.5. Delimitation of the Study

The scope of this particular study is delimited to assess the counseling service offered at the mobile VCT center organized by OSSA Addis Ababa. This is because the experience in the regions is very limited as it is recently introduced by OSSA, while Addis Ababa city administration OSSA mobile VCT service was launched before five years and provided the service for a significant number of populations. Thus, the findings of the research will reflect the situation of the study area. However, other regions also could learn the lesson from the study.

1.6. Limitation of the Study

Addis Ababa Organization for Social Service for AIDS (OSSA) starts Mobile VCT service in March 2005 by obtaining experience from Botswana. However, the OSSA mobile VCT project proposal was designed without adequate reference material and its protocol is the HCT Guide line of Ethiopia. This means specific guideline was not prepared for Mobile VCT service implementation. When this coupled with the insufficient literature on mobile VCT, the researcher was forced to use the Federal Democratic Republic of Ethiopia /FDRE/ 2007 HCT guideline and other VCT reference materials. In spite of this, the researcher has attempted to make the study as complete as possible.

1.7. Operational Definition of Terms

- Confidentiality:** Information shared is not revealed to anybody else, if necessary only with the expressed consent of the client.
- HIV Counseling:** A confidential dialogue between Addis Ababa OSSA client and a counselor aimed at enabling the client to cope with stress and make personal decisions related to HIV/AIDS.
- Mobile VCT:** The VCT service given with a mobile Van by Addis Ababa OSSA.
- Pre-test counseling:** HIV/AIDS counseling before someone has HIV tests in the mobile VCT center.

Post-test counseling: HIV/AIDS counseling after HIV test result is given in the mobile VCT center.

Voluntary Counseling and Testing /VCT/: A situation in which a client undergoes willingly through counseling to enable him or her to make an informed choice about being tested for HIV in OSSA mobile VCT center.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1. The Concept of Counseling

According to Taylor (1995), professional counseling is a process in which a trained counselor helps an individual, group of individuals, or family members gain self-understanding and understanding of others in order to solve problems more effectively to resolve conflicts in everyday living. This process involves a professional relationship in which counselors and clients jointly participate in problem resolution of the client. Therefore, both the experience and the personal qualities of the counselor and the characteristics and motivation of the client contribute to the development of client change.

Thus, counseling is a process / is not a single event but involves sequential actions and practices progressing toward a goal. The definition usually specifies that the relationship is characterized by warmth, permissiveness, understanding and acceptance, etc. Some definitions describe the counselor as professional, matured, possessing special knowledge and the client as troubled, anxious, upset, or frustrated. Most definitions indicate that the effect of counseling is improvement, or change in client behavior (Shertzer and Stone, 1974).

Colledge (2002) states that *those counselors who regard counseling as a mainly helping relationship usually describe to the theory and practice of the person-centered approach. It could be said that a helping relationship is enough to get constructive changes to occur in clients. The core conditions of such a relationship are empathetic understanding, congruence and genuineness, and respect for client's capacity to lead their own lives.*

In addition, Colledge (2002) said that *counseling theories provide counselors with conceptual framework that enable them to think systematically about human development and their practice of counseling. This is vital because counselors*

constantly have to make decisions and choices about how to view client's behavior and how to treat and respond to them during the counseling session.

According to WHO, Counseling may be defined as an interaction in which the counselor (helper) offers another person the time /attention/ respect necessary to explore, discover and clarify ways of living more resourcefully. In the context of HIV/AIDS, counseling is a confidential dialogue between a client and a counselor aimed at enabling the client to cope with stress and make personal decisions related to HIV/AIDS (FHI, 2004).

Counseling is an issue-centered and goal-oriented interaction and involves carrying on a dialogue and providing options for decisions making and behavior change. Good counseling helps another person to be autonomous (i.e. able to choose, make decisions, and be responsible for his or her own actions (FHI, 2004).

Psychologists, social workers, psychiatrists' physicians, nurse and other health workers, clergy, teachers and other to enable clients to cope with their problems can do counseling. As Carl Rogers and Albert Ellis cited in Corey (1984), the attitude and feelings of the counselor is more important than techniques and theoretical orientations. Carl Roger further illustrates that genuineness unconditional positive regard and understanding the client are important personal characteristics of counselors.

As Carl Rogers cited in Corey (1984), argues that if the above personalities are met, clients will become better integrated and able to function more effectively. On the other hand, Albert Ellis cited in Corey (1984), Ellis believed that personal warmth, affection and caring are secondary and good counseling can be done without them.

Counseling may take time to work, depending upon the nature and number of problems being presented by the client. Sometimes, a single or a few sessions are all that is needed. At other times, longer periods possibly months or up to a couple of years may be needed.

According to Corey (1984), the central responsibility of any counselor is to be genuinely concerned about the welfare of the client. This means that primary importance should be given to the need of the client and not to the counselor. According to MoH (2003),

code of ethics serves as general guide to every day conduct of counselors. It is also a brief standard of ethical behavior for counselors in their professional relationships with clients, colleagues, employees, the community and the society.

According to Corey (2005), effective counselors understand their own cultural conditioning, the conditioning of their clients, and the socio political system of which they are a part. Acquiring this understanding begins with counselors awareness of any cultural values, biases, and attitudes, they may hold. A big part of becoming a diversity competent counselor involves challenging the values we hold and how such values are likely to influence our practice with the diverse clients. Furthermore, becoming adversity- competent practitioner is not something that we arrive at once and for all, it is an ongoing process. It is important to deal about acquiring competence in multicultural counseling.

2.2. The Nature and Concept of HIV Counseling

According to FDRE MoH (2002), *HIV Counseling and Testing Guide Line, HIV counseling is defined as a voluntary dialogue between a counselor and client, couple or a group of clients. It is a process of enabling clients to understand and make informed decisions on whether to be tested for HIV, to understand the results and facilitate future planning.*

HIV/AIDS counseling is a recent phenomenon. According to FDRE MoH (2002), HIV counseling in Ethiopia begun in the late 1980s AIDS pandemic because of its total outcome, creates feeling of fear and resentment. Moral breakdown accompanied by ideas of guilt and punishment is initial response to the disease. Stigmatization, Ostracism, rejection and discrimination will exacerbate the already heavy stress the victim has development (FDRE, MoH, 1996) many of these problems may be minimized or solved through counseling the infected and affected individuals.

According to UNADIS (2002b) Voluntary Counseling and Testing Technical update guideline, VCT has become the most important cost-effective tool to prevent and control HIV/AIDS in the country. It motivates people to adopt safe sexual behavior and safe injecting practices. It encourages people with high-risk behavior to know their HIV

status, thus helping to break the chain of transmission of the infection. VCT is also a key entry point to care and support services for people living with HIV/AIDS (PLWHA).

VCT also include access to interventions to reduce mother-to-child transmission (MTCT) of HIV; interventions to prevent opportunistic infections (e.g. tuberculosis preventive therapy and prophylaxis for other infections); as well as other medical and supportive services, that can help HIV positive people to live longer and healthier lives. VCT enables PLWHA to better plan for their and their dependents' future. It helps lessen the stigma attached to the disease and the discrimination they have to face in the community. In general, VCT offers a holistic approach and addresses HIV in the broader context of people's lives, including the context of poverty and its relationship with risky practices (UNADIS, 2002b).

2.3. The Models of VCT Service

VCT can be delivered in the five identifiably distinct approaches as shown below. The five approaches to delivering VCT are the following: Freestanding services, Integrated into existing health-care services, Private sector, Home testing and Mobile/community outreach (WHO, 2010).

Freestanding services

Although freestanding services offer VCT away from health facilities, they may have links with other care and support services. Many freestanding services are run by local or international NGOs, and rely upon a high level of public awareness of the benefits of VCT. Publicity, understanding of VCT in the community, and concerted efforts to reduce the stigma associated with HIV, are therefore all important factors contributing to success. VCT sites that have been successful in attracting people have been supported by information, education and communication (IEC) campaigns, community mobilization and advertisements (WHO, 2010).

Individuals can undergo an anonymous HIV test, receive HIV testing and counseling and attend a peer support group. The service is located in a major shopping area and has access to public transport (WHO, 2010).

Integrated into Existing Health-Care Services

VCT services can be “integrated” into the established health-care setting across a range of services. In this approach, people attending primary health care services (including family planning), or those seeking more specific medical attention (for example by presenting at TB or STI clinics), can also receive VCT (WHO, 2010).

Counseling is usually carried out by clinic staff or by HIV/AIDS counselors. Established links with other medical services in the clinic may also facilitate cross-referral. A successful and properly integrated VCT service may require counseling staff, dedicated counseling time or time for staff to attend regular meetings, held between clinics, to ensure good liaison and cross-referral between services. This should be supported by a commitment to (and understanding of) VCT services by clinic management, and by the planning and development of VCT services (WHO, 2010).

Private Sector

In Asia, private health practitioners deliver much of the primary care. HIV testing in such settings is often carried out without adequate pre-test counseling or informed consent, and insufficient quality control of HIV-testing procedures. VCT (or more often HIV testing alone) is usually carried out as part of clinical care, often to confirm the clinical suspicion of HIV infection (WHO, 2010).

Although in many countries where Antiretroviral (ART) is available, patients may be able to access appropriate medical care, HIV prevention is often largely ignored. There is therefore great potential for improving VCT in the private setting. There have been some small-scale efforts to train private practitioners to offer better VCT services. For example, the Green Star Network in Pakistan is one of the largest developing country franchised private reproductive health networks in the world. The Green Star is a logo that symbolizes strict quality programmes are in place, standard operating procedures and staff training can be found within a clinic displaying logo (WHO, 2010).

Home Testing

Several different self-test kits are now available, allowing people to test themselves for HIV infection at home. Although the major regulatory authorities do not yet approve self-

test kits (which provide an instant result and can be used without assistance), they are widely available and can be bought directly from pharmacies in some countries or ordered on the Internet. Home collection kits are also available in some countries and have been approved for use in the USA (WHO, 2010).

These allow users to collect their own blood sample at home and send it to a testing facility. After about one week, clients telephone the centre for the test result, which if negative is communicated by a recorded message. If the result is positive the client is “counseled” over the telephone and referred for further follow-up if required. Experience from the USA has shown that 97% of people phoned for their results and 65% of those testing HIV positive accepted referral for counseling (WHO, 2010).

Provision of VCT through Mobile/Community Outreach

In order to make VCT more widely available to groups who do not routinely attend health facilities, mobile VCT clinics have been developed in some settings. The “mobile unit” can be a car van, which offers VCT and has a schedule of places which it visits at pre-advertised times (WHO, 2010).

This approach has been used to access “hard-to-reach” populations who do not visit formal health settings, such as homeless people, sex workers or Injecting Drug Users (IDUs). It may also be appropriate for increasing access to remote or rural areas. One variation of this model is to have a mobile “VCT team” which provides services at fixed times at a variety of sites such as community centers, religious centers or schools. Pre-advertising (via fliers and public announcements), can provide potential clients with information, maps and schedules for the mobile service. Using rapid tests makes it possible for results to be given to clients on the same day. However, in some settings it has been more feasible to ask clients to return the following day for their result (WHO, 2010).

One study from Australia has demonstrated that marginalized populations who received services from a mobile HIV/STI bus eventually used the associated permanent site. A key feature of the service that promoted this transfer of clients was that the outreach service employed the same staff at both the mobile site and the associated permanent

site. As trust grew between clients and staff of the mobile service, clients started to use the permanent site. There is, however, little published information on mobile VCT services beyond the description of small pilot projects. PSI India has established an HIV information, condom social marketing and VCT service at one of Asia's largest trucking terminus.¹⁸ Mobile sites are operated along the major highway in Rajasthan. In a 12 month period over 30,000 truckers received HIV information, 2000 reported for syndromes management of STI and over 500 presented for HIV testing. A mobile VCT/AIDS counseling in central and south Mumbai has proved to be a cost-effective alternative to fixed and integrated sites. The service has been well utilized with a high uptake of VCT (WHO, 2010).

2.4. Characteristics of a Good VCT Session and Counselor

2.4.1. Characteristics of a Good VCT Counselor

According to NACPGP and UNAIDS (2001) guideline, the Ideal VCT Center Counselors are must be trained on National VCT guidelines, have good know-how of VCT services and be motivated, must be accessible, available and reliable to their respective clients. They should have knowledge of psychosomatic and hypochondriac issues, must have basic communication skills, should be intelligent, and with an empathic character and both male and female counselors should exist at each VCT center.

2.4.2. Characteristics of a Good VCT Session

VCT sites must be easily accessible to target clients, ensure privacy and confidentiality, and have a reliable HIV testing facility and VCT sessions must be well organized and structured, and appropriate checklists should be used, be flexible in order to meet the requirements of individual clients and must have a goal-based strategy for each session (UNAIDS, 1997a).

According to WHO (1990), Client satisfaction and consequent positive changes in behavior are the two major outcomes that can be expected from a successful VCT session and A good VCT session can have the following characteristics. This are: confidentiality, time, acceptance, accessibility, consistency, accuracy, sensitivity, and tact.

Confidentiality forbids reference to, or discussion about a client or a test result, except with a professional relationships, and only then with the consent of the clients (FDRE MoH/HACPO, 2007).

2.4.3. Clients of VCT Services

According to NACPGP/UNAIDS (2001), VCT services should be available to the people who want to know their HIV status, including the relatives of PLWHA, patients who are referred by their physicians for clinical diagnosis, blood and body organ donors and people who need a HIV test for visa, insurance or other purposes.

In addition, about who needs HIV testing NACPGP/UNAIDS (2001) guideline stated that, not everybody needs to be tested for HIV. HIV testing can be considered, if a person who asks the following questions from himself answers yes to one or more.

- *Have you ever had unsafe sex outside a marital relationship?*
- *Have you or your regular sexual partner ever had a sexually transmitted infection?*
- *Have you ever received an unscreened blood transfusion?*
- *Have you ever injected illegal drugs?*
- *Have you ever been injured with a needle contaminated with HIV infected blood?*

2.4.4. Counselor Training

Providing culturally sensitive intervention that are effective both as primary and secondary prevention strategies, while enhancing coping care and support, is an evolving and challenging task. In most countries in sub Saharan Africa the initial national response to the HIV epidemic was to train as many people as possible to provide hospital, community, and home based counseling (FHI, 2004).

Counselors as well as their supervisors require adequate training and the training is not a one- time-event. It should be on going process (CDC, 1993).

According to UNAIDS (2000a) counselors in HCT services will need continuous training which should consist of basic information on HIV, transmission routes, risk factor possible and available interventions and the role and process of pre-test, post-test and

on going counseling. FDRE MoH (2002), suggest that any one selected to become a counselor should be given at least one month training on counseling.

2.4.5. Operational Aspects of VCT Service

According to UNAIDS 1997a, a VCT centre should have at least a well functioning laboratory, separate room for counseling, waiting area, trained laboratory technician, trained counselor and good infection control and waste disposal practices.

2.4.5.1. Counseling Room and Waiting Area

According to CDC (1994), counseling rooms must be private to ensure confidentiality of the counseling session. Similarly, UNAIDS (2000a) suggests that VCT to be carried out correctly and effectively, privacy must be ensured. Discussing risk factors and sexual relation is part of HCT for HIV infection and key information essential to the process will not be 'elicited' unless people can discuss these issues in private.

According to Shertzer and Stone (1974), the counseling room should be comfortable and attractive. Counseling facilities should be designed for comfort and relaxation. Therefore, from the above discussion, it is indicated that for effective counseling process private space is required. In addition to this to facilitate the counseling relationship, the counseling room should be comfortable and attractive.

Clients must feel as comfortable and relaxed as possible during their stay in the HCT center. The counseling office should be easy to access and yet not in a busy place of any center where every passer by knows that this is the counseling and testing for HIV. It is best if there is a waiting room or area, so that clients have somewhere to sit, out of the public gaze. UNAIDS (2000a) suggests that in HCT centers a well-ventilated waiting area is important.

2.4.5.2. Referral Linkage

In the context of HIV prevention, counseling and testing, referral is the process by which immediate client's needs for care, supportive services are assessed and prioritized, and clients are provided with assistance in accessing services (CDC, 2001).

According to WHO/UNAIDS (2001) HCT has been shown to be more effective when it is developed in conjunction with support services; such as medical, psychological, social and the like. Similarly, FDRE HAPCO/MOH (2007) describes that HCT service deliveries are required to be linked to local referral services, to be able to track referrals and to work cooperatively with internal and external post-test services.

2.4.6. Elements of HCT

According to FDRE HAPCO/MoH (2007), HIV Counseling and Testing Guide Line HIV counseling is defined as a voluntary dialogue between a counselor and client, couple or a group of clients. It is a process of enabling clients to understand and make informed decisions on whether to be tested for HIV, to understand the results and facilitate future planning. The common components are pre-test, post-test and ongoing counseling.

2.4.6.1. Pre-test Counseling

HIV counseling helps a person make informed choices. However, it is important to note that people who do not want pre-test counseling before taking the HIV test should not be required to do so. In addition, a decision to be tested should be an informed decision. Informed consent implies awareness of the possible implications of a test results, including and awareness of the window period (UNAIDS, 2000a).

2.4.6.2. Post-test Counseling

The post-test counseling session should begin by trying to put the client at ease. The room must be quiet, without any fear of being disturbed. The counselor should then tell the client the test result in a clear and direct manner. The result (either positive or negative) should be discussed while being sensitive to the client's feelings. Providing further information might be necessary, although, in case of a positive diagnosis, the client may be in shock, and may not fully take in all the information offered (UNAIDS, 2000a).

However, in some circumstances, this might be the only chance to counsel him and asking to repeat the information, or writing down some basic facts, will be helpful. It is important for the client to have time to reflect on the result and to understand the next

course of action. Ideally, couple and/or family counseling should be started when appropriate and further follow-up counseling arranged (UNAIDS, 2000a).

2.4.6.3. Follow-up counseling

The majority of people attending VCT, regardless of testing positive or negative, need follow-up counseling. It helps improve the quality of life and enhances the ability to cope and make informed decisions about ongoing care. Some PLWHAs, or those with a high-risk behavior, do not like to be referred for the fear of the disclosure of their identity, and prefer to avail follow-up counseling at VCT centers. Follow-up VCT counseling should therefore be flexible and provide ongoing counseling to all those who need it. A checklist was not developed because of the nature of the issue and it would be hard to address them in a rigid form. The follow-up should be flexible and compatible with the needs of each client (UNAIDS 2000a).

2.5. The Nature and Characteristics of Mobile VCT

Mobile HCT services are an important strategy for increasing accessibility to HCT services for key populations and people living in hard-to-reach areas. The principle behind mobile HCT services is to bring HCT out of health facilities and into the community. There are different approaches to providing mobile HCT services. A team of providers may offer the services to the general population, defined groups such as a church congregation, attendees at cultural and sports events, employees of a company, or hard-to-reach groups such as injection drug users, sex workers, truck drivers, street boys, or those with no fixed address (FHI, 2005). The temporary services site may be a tent, or existing community locations such as churches, schools, and administrative offices. In some cases, bicycles and motorcycles are used. A more expensive model involves the use of a mobile van, often equipped with video units. Provider's counsel and test clients inside the van, which remains in a designated location or drives to different locations to attract clients. Finally, HCT may be offered to clients within their homes (home-based HCT), with services providers going door-to-door to offer the service (Makoane, et al., 2008).

PSI/Zimbabwe (2009) states that, organizations providing mobile VCT should ensure that there are adequate follow-up services to provide posttest care and support. Creative and innovative approaches to providing follow up services may be required in rural settings. In view of the expenses involved in outreach services performed in the health sector, a package of services such as family planning, child health monitoring and immunization can be provided on the same day/s that the VCT outreach activity is carried out (to target as many people as possible with several interventions). Mobile VCT services should also be located where high-risk groups live and work (i.e. sex work areas, youth venues and military bases).

Mobile VCT Guidelines need to be implemented to clarify where mobile VCT should be conducted, who is responsible for setting it up and promoting it in the community (i.e. the Site Manager). And also how often mobile services should be provided and detailed follow up services to be provided (such as a 3 month return and referrals to post test care and support or establishment of a post test club in the community that would link to the central site (PSI/Zimbabwe, 2009).

2.5.1. Advantages and Disadvantages of Mobile VCT Services

2.5.1.1. Advantages of Mobile VCT Services

According to PSI/Zimbabwe (2009), the advantage of mobile VCT services are:

- Increases the number of people who can access and receive VCT services
- Increases and promotes concepts of living positively with HIV/AIDS to a wider spectrum of community
- Fights stigma and discrimination associated with HIV/AIDS in a wider spectrum of society
- Improves early detection and prevention of STDs and AIDS related diseases and conditions
- Increases access to one to one HIV/AIDS prevention approaches, such as STIs, access to condoms (and counseling on the consistent, correct usage), risk reduction and behavior change, appropriate information and education about HIV/AIDS
- Promotes counseling and care at a community and grassroots level

- It is easier and a cost effective for rolling out VCT services to a wider spectrum.

In addition, Morin (2006) said that, *we found acceptance of the mobile VCT approach in a high-density setting and a rural setting in Zimbabwe. Although we were concerned that testing in public settings would be a potential problem for women, 42% of those coming forward for VCT were women. Same-day rapid testing also seems to be an acceptable approach, with 99% of participants opting for same-day results. Mobile VCT was able to identify a large number of individuals with HIV infection. The 29% infected with HIV is higher than the 17% reported at fixed clinic-based sites in Harare. HIV infection was significantly higher in Epworth (31%) than in Seke (23%), suggesting that targeting mobile VCT to areas with higher migration like Epworth may be helpful.*

2.5.1.2. Disadvantages of Mobile VCT Services

According to PSI/Zimbabwe (2009), the disadvantage of mobile VCT services needs a large budget as resources easily get overstretched i.e. transport, personnel, maintenance, maintenance of cold chain storage for rapid test kits and blood samples, production of VCT materials.

As the number of mobile outreach communities increase in demand, the more deal there is to return to clients to provide support services and 3 monthly follow up (for window closers)

Counselors are not always there in communities to fulfill needs:

- Difficulties in accessing remote communities due to poor infrastructure, such as long distances and poor road conditions
- Insufficient counseling facilities and structures for optimizing privacy and comfort to the client
- Insufficient time spent with the clients as the counselor has to rush back to the central site to prepare for the next outreach services
- In case of problematic client case management, there is usually no established support systems such as other counselors or health professionals to help
- Referral can be challenging as there are no immediate systems and referral locations can be far or out of reach to mobile clients.

Besides, according to Narathius (2004), some of the weaknesses of the Mobile VCT, which need to be addressed to make the mobile VCT more appropriate are include:

- *Measures for continuity especially for taking care of those who test positive are not sufficiently developed.*
- *The challenge of HIV/AIDS in communities goes to 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.*
- *The level of the community education prior and during service delivery needs to be scaled up, issues of stigma to be addressed especially considering that the testing and counseling are conducted in open air or full view of others.*
- *Other issues that are important in developing a sustainable highly attractive mobile VCT system, that meets the demand for VCT within and across communities seem to be weak or are lacking in the current AIDS Information Center (AIC) mobile VCT delivery service.*

In addition, Zinabie (2009) recommended that the mechanism of follow up counseling should be designed such as ensuring transportation access to counselors, regular Outreach Voluntary Counseling and Testing (OVCT) service provision, tracing mechanism of needy clients or integrate with organization providing such services (Churches, CBOs, etc). Moreover, facilitative supervision followed by timely feedback should be mandatory for OVCT service delivery system and counselors who participate in OVCT service should get adequate incentives and in-service trainings or ongoing trainings.

2.5.2. Operational Requirements for Mobile VCT

2.5.2.1. Venues and Equipment

There are many options for providing mobile VCT services. VCT can be offered out of a stocked van, in tents or in premises in the community (such as schools, churches, health centers, and other youth facilities or community/NGO centers). Where cost is an option, it is recommended to work with the local community to provide VCT out of existing buildings with community support that will help with referrals and promotion of mobile VCT services. Tents and vans are not recommended as they are expensive and are not 'integrated' into the community like working out of a local school or health

center. They can be used where necessary (i.e. in very rural locations without available space) and where the budget permits. Rapid testing should be utilized where possible to ensure results are available on the same day. Where demand is high or distance is far from the central site, staff can stay the night to continue testing the following day (a budget should be allocated for such over night expenses) (PSI/Zimbabwe, 2009).

2.5.2.2. Staffing

Staff should not travel to locations alone. Where possible male and female staff members should travel together. Senior counselors or experienced staff should be the first to provide mobile VCT services and should train the newer team once systems are in place. The number of staff will depend on the demand for services. A receptionist should assist as well in the logistics and promotion of mobile VCT activities. The number of staff is reduced for such services where a counselor is trained to perform HIV rapid tests (i.e. no need for a nurse or lab technician). Staff from the central VCT site can be used if they are not at capacity. Counselors should be hired only when necessary (i.e. if the central VCT site is always at capacity and cannot spare the counselors). If the VCT site only has rooms for three counselors, additional counselor should never be on site (one counselor should be rotated through mobile VCT everyday) (PSI/Zimbabwe, 2009).

2.5.2.3. Promotion

Promotion of mobile VCT is very important and should not be neglected. Mobile VCT services should be promoted throughout the community or directly to the target group the week before the service is provided. Staff should work with the local community to gain support for mobile VCT and to promote the activities throughout their community. They should be provided with leaflets, invitations and posters to promote the services (complete with the date, time and location). The day of service provision there should be a banner set up outside of the location to show that VCT is offered in that location that day (PSI/Zimbabwe, 2009).

Relationships with the local community are very important in gaining support for VCT, in setting up local referral networks (required for each mobile VCT activity) and for promoting VCT. Mobile VCT services should come back every 3 months to provide the

opportunity for those in the window period and to follow up with those that were tested in the last mobile service (PSI/Zimbabwe, 2009).

2.6. General Practice of Addis Ababa OSSA Mobile VCT Center

According to OSSA 2008 annual report, OSSA rendered mobile HIV volunteer counseling and testing (VCT) service for the first time at its mobile site in March 2005. The mobile VCT service has been successfully implemented in different segments of Addis Ababa and it was to reach different parts of the community. Such as factory workers, youth, long distance drivers, businesspersons, female CSW, etc.

According to OSSA 2009 annual report, after four and half years, it started the service to the end of the year 2009; about 36,321 clients came to mobile sites for the service. Out of those coming to the service, 36,321 clients gave test for HIV 1,819 clients were HIV positive. The mobile VCT site worked for three months and served 1,824 clients in its first open year. After the opening year, it has served about 8,624 clients per year on average.

Reasons of Clients to Request the VCT Service

According to OSSA 2008 annual report, the two predominant reasons of clients for requesting the VCT service are “plan for future” 40% and “client at risk/had risk” 32.2%. Premarital test, test for window period, exposure to others blood/body fluid and “partner at risk” are other noticeable reasons of clients to come to the service.

Referrals

According to OSSA 2008 annual report, from 2005 up to the end of 2008, about 828 clients from mobile site were referred from OSSA for different services. Most of the clients were referred for ART service. Others were referred for Follow up counseling, Social services, TB clinic, Hospital, APLWH/A, STI Clinic, Family Planning, Post-test club, PMTCT Service and ART Service.

CHAPTER THREE

METHODOLOGY OF THE STUDY

This study was aimed at assessing the counseling service offered by Organization for Social Service (OSSA) Addis Ababa mobile VCT center and to identify the major achievements and problems affecting the quality of mobile VCT counseling service. To carry out the study, descriptive survey research method was employed since it enables to collect several kinds of data related to the study.

3.1. Description of the Study Area

Mobile Voluntary Counseling and Testing service is an important strategy for increasing accessibility to VCT service for key populations and people living in hard-to-reach areas. The principle behind mobile VCT services is to bring VCT out of health facilities and making it more accessible to the community. Considering this, Addis Ababa OSSA mobile VCT center was providing voluntary counseling and testing service inside the mobile van and waiting area in a tent. Therefore, this study was under taken in Addis Ababa City Administration OSSA mobile VCT center.

3.2. Participants of the Study

In this study, three groups of respondents were involved in the study. These include clients, counselors, coordinators and supervisors in Addis Ababa OSSA mobile VCT center.

The available coordinators and a supervisor were included due to the emphasis given for the responsibility they hold in the mobile VCT counseling services. The investigator believed that they could provide rich information about the existing situation through interviews.

Client and counselor are the main participants in the counseling process and hence in the research since they have the capacity to provide rich evaluation information about the counseling process.

Generally, the type and the number of participants of the study are presented below on Table 1.

Table 1: Types and number of participants of the study

Types of participants	Number		
	Male	Female	Total
Clients	116	44	160
Counselors	1	4	5
Supervisor and coordinators	3		3
Total	120	48	168

Samples and Sampling Procedure

Selection of Clients

In this study, clients who come to Addis Ababa OSSA mobile VCT center and get the service (pre-test counseling, blood test for HIV and post-test counseling) were selected to participate in the study when they exit from the post-test counseling. Besides the consent of clients to fill the questionnaire completely was asked before the post-test and those voluntary and willing clients were selected.

Therefore, among the total population of 653 clients who came to mobile VCT center within 11 days, from March 10 up to March 20, 2010, 160 (24.5%) volunteer clients were selected and 154 clients responded to the questionnaire while the remaining 6 were rejected because of incompleteness.

Selection of Counselors, Coordinators and Supervisors

In the selection of counselors, coordinators and supervisors available sampling technique was used. So five counselors, two coordinators and one supervisor available at the mobile VCT center were included.

3.3. Instruments Used For Data Collection

Four types of data collection tools were used. These include questionnaire, interview and observation checklist.

A. Questionnaire

To collect information from clients and counselors, two sets of questionnaire were used. These questionnaires contained both close-ended and open-ended questions. The client questionnaire has 82 items with seven parts. The first part was prepared to get information about the client's personal data (i.e., sex, age, educational level, occupation and marital status).

The second part of the questionnaire was prepared to get information about the awareness of clients about Addis Ababa OSSA mobile VCT counseling services.

The third and fourth part of the questionnaire was adapted from UNAIDS (2000a) to get information about the contents of each counseling sessions, i.e., pre-test counseling and post-test counseling sessions.

The fifth part of the questionnaire was adapted from UNAIDS (2000a) to get information about counseling skills of the counselors (i.e. interpersonal relationship, information gathering, information giving and handling special circumstances).

The sixth part of the questionnaire was prepared in the form of rating scale. The rating scale was designed to measure client's attitude to wards counseling service offered in mobile VCT center.

The seventh part of the questionnaire was prepared to obtain information about the facilities and constraints of the counseling services in the mobile VCT center. With this perspective, the questionnaire addresses the counseling room, waiting area, the time allotted for each counseling session, the number of sessions, confidentiality and information about a set of possible comments and lists down those factors that affect the provision of counseling services.

The counselor's questionnaire consists of four parts, which has 49 items. The first part deals with personal information of counselors. The second part was prepared to get information about training, supervision and support given to the counselors. The third part of the questionnaire was prepared in the form of rating scale. The rating scale was designed to measure counselor's attitude towards counseling. The fourth part of the

questionnaire was designed to get information about the problems faced by counselors in rendering the service and about counselor's general comments on the counselor's problems and their comments to improve the services.

B. Interview

To collect data from supervisor and coordinators a structured interview was used. The interview was mainly focused on gathering information about mobile counseling service general practice, achievements and problems.

C. Observation Checklist

Observation checklist was used to observe the counseling room, waiting room/area, the supply and availability of other office furniture's and recording materials as well as the filing system of counselors.

3.4. Pilot Test

Pilot test was conducted to collect information that helps to screening the items. That is to find out if wording and instructions of the instruments as a whole were clear to respondents. The questionnaires of clients and counselors were first developed in English then checked and confirmed by my advisor and ethical committee of Addis Ababa Health Bureau to ensure appropriateness and ethical considerations. After this for understandability and message consistency, they were first translated into Amharic and again into English by two Addis Ababa university literature students. The final questionnaires were submitted to my advisor and the comments were included before piloting the instrument.

The respondents who took the pilot-test were taken through available voluntary sampling method among the clients of Addis Ababa OSSA mobile VCT center. The pilot test was conducted on 40 voluntary clients of mobile VCT clients.

Before the questionnaires were distributed the respondents were told to note down any ambiguous word, phrase, or sentence. After the questionnaires were administered discussion was held with clients and the only comment given was the items of questionnaire were too much and time consuming and it is also found out that only 36 of

the clients responded to all the questions out of the 40 voluntary clients. Based on this observation and the comment of respondents the researcher decided to stick only to voluntary and willing clients. Since the counselors were few in numbers, piloting was not conducted where as they responded to the questionnaire by the researcher close follow up.

3.5. Data collection procedure

Before data collection begins, cooperation letter was asked from the Institute of Psychology in order to write supporting letter for Addis Ababa Health Bureau to cooperate on data collection. Addis Ababa Health Bureau wrote ethical license to Addis Ababa OSSA Bruhe Hiwet mobile VCT center to give necessary information, data and facilitate the activity.

To conduct the survey on clients, data collectors were recruited based on the following criteria: 12th grade completed and above and data collection experience. Based on these criteria one male and one female data collectors were selected. Necessary training was given for the data collectors for a day before the pilot test and a day after pilot test totally for two days. The training focused on briefing on the general objectives of the study; discussing the questions one by one; how to approach the respondents; how to keep confidentiality and privacy; how to keep close follow up to help the clients to complete all of the questions. The researcher closely monitored the activities of data collectors. The entire questionnaire was submitted by data collectors after counter checked by the researcher for complete clarity.

The researcher administered the questionnaire developed to the counselor. During the time of questionnaire delivery, the counselor told to go through each item if there is any unclear statement or word. In addition, observation was made in their counseling room.

3.6. Data Analysis

Depending on the nature of data received, different statistical techniques were employed. For the closed-ended questionnaire items upon which clients and counselors are required to choose among the given alternatives, the values first tallied with the

respective category. Then after summarized the data obtained, simple frequency counts and percentages was used.

In the professional skill and attitude measurement scale, each response has three and five categories respectively. Thus, an individual score was determined by the sum of the point values given for each statement. Then scores categorized into high and low professional skill and positive and negative attitude.

Generally, this study followed descriptive survey research method. In this regard, Best and Khan (1989) stated that *the use of multiple data collection instruments as a rule is useful, since each reveals different aspects of practical reality.*

Table 3: Clients source of information about the Mobile VCT Service

Awareness and Information Sources	Frequency	Percentage (%)
<i>Having information</i>		
Yes	121	78.57
No	33	21.43
Total	154	100.00
<i>Information sources</i>		
TV	38	24.68
Radio	9	5.84
News paper	2	1.30
Magazine	2	1.30
Leaflet	13	8.44
Friends	24	15.58
Community mobilizes	17	11.04
Others	49	31.82
Total	154	100.00

Clients were asked about their source of information on the mobile VCT service (see appendix A). Out of the total 154 respondents 78.57%, respondents were having information about the mobile VCT services and the remaining 21.43% were not having information about the service. Among different sources mentioned above, others (along the roadway) were the source for 31.82% of clients, TV were the source for 24.68% of clients, Friends were the source for 15.58% of clients and community mobilizes were the source for 11.04% of clients.

All coordinators and a supervisor also mentioned that the community is aware of mobile VCT service and promotion was given to the community. Even though the coordinators and supervisors noted that promotion was given by community mobilizer, by car and other different sources about 31.82% of clients did not have prior sources of information about mobile VCT service but they got information along the road way.

4.3. Contents of Mobile VCT Counseling Sessions

VCT counseling session contents were considered in terms of pre-test and post-test counseling whether clients agree or disagree on coverage of the contents of the counseling sessions at OSSA Addis Ababa mobile VCT center.

Table 4: The Response of Clients about Pre-test Counseling Content Coverage (N=154)

Variables	Pre-test counseling contents	Categories	Frequency	Percentage
Introduction / orientation	Reasons for attending discussed	Yes	137	88.96
		No	17	11.04
	Knowledge for HIV and modes of transmission explored	Yes	135	87.66
		No	19	12.34
	Misconceptions corrected	Yes	116	75.32
		No	38	24.68
Information concerning the process of HIV testing given	Yes	140	90.91	
	No	14	9.09	
Risk assessment	Assessment of personal risk profile carried out	Yes	123	79.87
		No	31	20.13
	Discussion of possible test results and meaning of HIV positive & negative results	Yes	139	90.26
		No	15	9.74
Risk exploring options for risk reduction	Capacity to cope with HIV positive results discussed	Yes	140	90.91
		No	14	9.09
	Discussion of potential needs and available support	Yes	98	63.64
		No	56	36.36
Preparation for the test / plan partner disclosure	Discussion of personal risk reduction plan	Yes	121	78.57
		No	33	21.43
	Time allowed to think through issues	Yes	106	68.83
		No	48	31.17
	Informed consent/ dissent given freely	Yes	132	85.71
		No	22	14.29
	Follow-up arrangements discussed	Yes	115	74.68
		No	39	25.32
Adequate time for question and clarification given	Yes	116	75.32	
	No	38	24.68	

The content coverage of pre-test counseling session at Addis Ababa OSSA mobile VCT center by client respondents were indicated in Table 4. Among 154 respondents 88.96% respondents reported the reason for attending the session was discussed and 87.66% of the client respondents assured knowledge about HIV/AIDS and its modes of transmission was explored. Of all respondents 75.32% clients reported that

misconception about HIV/AIDS was corrected, 24.68% of clients reported that misconception about HIV/AIDS was not corrected and 90.91% of clients reported that Information concerning the process of HIV testing was given.

Regarding risk assessment, among the total 154 of clients 79.87% responded that during the pre-test counseling session assessment of personal risk profile carried out and 90.26% responded discussion of possible test results and meaning of HIV positive and negative results carried out.

Concerning risk-exploring options for risk reduction, among the total 154 clients, 90.91% responded that the capacity to cope with HIV positive results was discussed during the pre-test counseling session. In addition, 63.64% of respondents responded that discussion of potential needs and available support was carried out and 36.36% responded discussion was not carried out during the pre-test counseling session at Addis Ababa OSSA mobile VCT center.

In respect to personal preparation for the test / plan partner disclosure, among the 154 the total respondents 78.57% of clients were responded that discussion of personal risk reduction plan was carried out and 21.45% was responded discussion was not carried out. About 68.83% responded that time was allowed to think through issues and 31.17% of client's responded time was not allowed to think through issues. Regarding adequate time for question and clarification given 75.32% of the client's responded adequate time was given for questioning and clarification but 24.68% was responded adequate time was not given. About follow-up arrangements discussion is concerned 74.68% the clients responded that follow-up arrangement was discussed but 25.32% of the client follow up arrangement was not discussed. Regarding informed consent/dissent given freely concerned 85.71% of the client was responded informed consent/dissent was given freely during pre-test counseling session in Addis Ababa OSSA mobile VCT center. This shows that the content of pre-test counseling coverage was generally good.

Table 5: The Response of Clients about Post-test Counseling Content Coverage (N=154)

Variables	Post-test counseling contents	Categories	Frequency	Percentage
Informing the result	Results given simply and clearly	Yes	137	88.96
		No	17	11.04
	Time allowed for the results to sink in	Yes	129	83.77
		No	25	16.23
	Checking for understanding	Yes	128	83.12
		No	26	16.88
	Discussion of the meaning of the result for me/ partner	Yes	77	50.00
		No	77	50.00
	Discussion of personal, family and social implications including who, if any to fell	Yes	99	64.29
		No	55	35.71
Risk reduction plan	Discussion of personal risk reduction plan	Yes	108	70.13
		No	46	29.87
	Dealing with immediate emotional reactions	Yes	98	63.64
		No	56	36.36
	Checking availability of immediate support	Yes	90	58.44
		No	64	41.56
	Discussion of the HIV/AIDS policy	Yes	100	64.94
		No	54	35.06
	Discussion of follow-up care and support	Yes	102	66.23
		No	52	33.77
	Options and resources identified	Yes	78	50.65
		No	76	49.35
	Immediate plans, intentions and actions reviewed	Yes	83	53.90
		No	71	46.10
	Follow-up plan discussed	Yes	85	55.19
		No	69	44.81
Referrals discussed when necessary	Yes	83	53.90	
	No	71	46.10	

As Table 5 shows, out of the total 154 Addis Ababa OSSA mobile VCT center client respondents, 88.96% clients reported that HIV test result was given simply and clearly. Among the total 154 the client respondents, 83.77% of the clients reported that enough time was allowed for the HIV test result to sink in. In addition, 83.12% clients reported that understanding for test result was checked. 50% of client responded that the meaning of test result discussed for me or partner. While 50% of clients responded that the meaning of test result was not discussed for me or partner. Among the total respondents, 64.29% reported that discussion of personal, family and social implication

was made while 35.71% responded that personal, family and social implication was not discussed.

Regarding to personal risk reduction plan among the total 154 of Addis Ababa OSSA mobile VCT clients 70.13% of clients responded that personal risk reduction plan was discussed. Among the total clients 58.44% of respondents reported that availability of immediate support was checked; 66.23% of clients reported discussion was made about follow up care and support and follow up plan. Of all the clients, 50.65% reported identification of options and resources was made; and 53.90% of clients responded that immediate plans, intention and action were reviewed. Respondents of 53.90% reported that discussion about referral was made.

The majority of Addis Ababa OSSA mobile VCT clients agreed on that result was given simply and clearly; time was allowed for the result to sink in; understanding for the result was checked; the meaning of test result was discussed; discussion of personal; family and social implication and personal risk reduction plan were discussed. On the contrary, some of the clients disagree with the coverage of these contents in post-test counseling session.

The majority of mobile VCT clients reported that issue concerning the meaning of results for me/partner, availability of immediate support, Identifications of options and resources, revision of immediate plans, intention and actions, follow up plan and referral were not discussed during the post-test counseling session. This shows that the contents of post-test counseling were not well covered at the mobile VCT center.

4.4. Training, Support, Supervision and Skills of Counselors

4.4.1. Training of Counselors

Table 6: Training of Counselors (N=5)

Training duration	Frequency
15 days	1
21 Days	1
25 Days	1
1 Month	2
Total	5

As indicated on Table 6, out of the total five counselors who participated in the study one counselor reported he has 15 days counseling training, one counselor has 21 days training, another counselor has 20 days training and two counselors have one month training. These shows that councilors training were not standardized.

Table 7: Counselors Further Training Need (N=5)

Area of training	Frequency
Couple counseling	3
ART	3
PMTCT	2
TB/HIV	1
New findings of HIV/AIDS	1
Family planning	1

From the total number of five counselors who participated in this study, all counselors reported that they needed additional training in different areas (As it is shown in Table 7). Out of five counselors three responded that they need additional training in couple counseling; three responded that they need training in the area of Antiretroviral Treatment (ART); Two reported that they need additional training in the area of Pregnant Mother to Child Transmission /PMTCT/ of HIV/AIDS.; one of the respondent responded that he need training in the area of TB/HIV; one of the respondent responded that he needs training on New findings of HIV/AIDS and another one respondent reported that he needs training on Family planning. This shows that there is a need to organize additional training based on the need of the counselor and the importance of the training.

4.4.2. Support

Out of the total five counselors asked whether they had attended counselors support group three counselor reported that they never attended a counselor support group, while two counselors responded that they attended a support group. Furthermore, those counselors who attended a support group were rated work of the support group was good.

4.4.3. Supervision

Items on part two (see Appendix B, question number 8 and 9) in a counselor questionnaire asked the counselor whether their work have been supervised or not and to rate the work of the supervisors. As a result, out of the five counselor respondents all of them reported that their work has been supervised and the work of supervisor was good.

4.4.4. Skills of Counselors

Four main areas of counseling skills that are inter-personal relationship, information gathering, and information giving and handling special circumstances were taken and clients rated the counselors' skill, as shown below in Table 9.

Table 8: The Responses of Clients Rating on the Counseling Skills (N=154)

Category	Respondents	
	Frequency	Percentage
Above Median	77	50
Below Median	77	50
Total	154	100

Here, 154 clients in Addis Ababa OSSA mobile VCT center rated skill of the counselors. The Median score was 45.5, therefore 50% of the clients score above the median score that is high professional skill and the remaining 50% of clients score below median score that is low professional skill of counseling. This shows that almost half of the respondents reported that the professional skills of counselors low then there is a need to improve the professional skills of counselors.

4.5. The Counseling Environment

4.5.1. Private Counseling Room

To assess the availability of separate space or room for counseling session, (see Appendix A part seven item number one in the questionnaire) clients were asked to rate the counseling space. Among the total 154 Addis Ababa OSSA mobile VCT clients, 72.08% agree with the presence of separate room to ensure privacy. While 25.97% clients reported, there was separate room but it was not adequate to ensure privacy.

Table 9: The Response of Clients to the Availability of Private Space for Counseling

Response	Client respondents	
	Frequency	Percentage (%)
Yes, there is adequate space to ensure privacy	111	72.08
Yes, there is some but not adequate to ensure privacy	40	25.97
No, there is no private space	3	1.95
Total	154	100

Observation revealed that the mobile center have separate room for counseling. However, the mobile VCT counseling room is narrow spaced and it is not ventilated so it caused stress to the counselor and clients.

4.5.2. Waiting Area

Table 10: Responses of Clients to the Availability of Waiting Area

Item	Response	Clients respondents	
		Frequency	Percentage (%)
Is there a waiting area?	Yes, there is adequate area	103	66.88
	Yes, there is some but not adequate	48	31.17
	Not at all	3	1.95
	Total	154	100
How do you rate the waiting area?	Very good	46	29.87
	Good	97	62.99
	Not good	11	7.14
	Total	154	100

In Table 10, it is indicated that 66.88% of the mobile VCT clients responded there was adequate waiting area while 31.17% clients reported there was some waiting area but not adequate. Out of 154 clients 29.87% is rated the waiting area was very good, 62.99% was rated that the waiting area was good, the remaining 7.14% rated the waiting area was poor.

Respondents were asked why they said the waiting area was poor as it is shown on part seven on item four (Appendix A). The respondents responded that the waiting area had no important films and drama; the room was not attractive. The waiting room had no TV, no music, no coffee and soft drinks, no adequate separate waiting room for males and females, no provision of education until the result received. In addition, the waiting room

was not clean, the waiting room was not comfortable and it was crowded and disturbing ideas.

The observation revealed that there was a waiting area in Addis Ababa OSSA mobile VCT center while the waiting area in this center was not adequate. In this mobile VCT center, information about HIV/AIDS was not adequately given to the clients using different ways (this include poster, leaflets, movie or video drama) while the clients are waiting for pre-test and post-test counseling.

4.5.3. Counseling Sessions and Counseling Time

Clients were asked to respond about counseling sessions and counseling time (see table 4.7 in Appendix A). Among 154 clients 71.43% responded that the number of counseling session was adequate while 28.57% were responded that the number of counseling session was not adequate. Regarding the counseling time for each counseling session among 154 clients 73.38% responded the time of each counseling session was adequate and 26.62% were responded the time of each counseling session was not adequate. This shows that there is a need of improvements the counseling time in each counseling session.

4.5.4. Seating Arrangement

Clients were asked about seating arrangement and ensuring privacy (see Table 4.7 in Appendix A). Among 154 clients 88.96% responded that there was a typical office seating arrangements ensuring confidentiality, 11.04% responded that there was no seating arrangement ensuring confidentiality.

The observation revealed that the seating arrangement was effective office seating arrangement in Mobile VCT center; it was across the table while the room is narrow.

Table 11: Observation Checklist

No.	Criteria	Yes	No	Remark
1	Is there sufficient counseling rooms?	✓		
2	Is there conducive waiting rooms?	✓		
3	Is there necessary office equipment?			
	Chair	✓		
	Table	✓		
	Telephone		✓	
4	Other details			
	Client registration	✓		
	Pre-test counseling	✓		
	Post-test counseling	✓		
	Follow up counseling		✓	
	Referral linkage	✓		
5	Data collection tools			
	Client in take Record	✓		
	CT log book		✓	
	CT data: monthly reporting form	✓		
6	Reports and documents			
7	Others: ventilator, refreshment like highland water		✓	

The purpose of this checklist was to observe the counseling room and waiting room/area, and the supply and availability of other furniture and recording materials as well as the filing system of the counselors. In this regard, they have separate but narrow counseling room and inadequate waiting area. Moreover, not all counselors have telephone. Regarding counseling, there is no follow up counseling and concerning data collection tools there is no CT logbook. In general, the room is hot; the counselors need ventilator and refreshment like spring water. In addition, among the three counseling rooms one counseling room is very narrow and it has single chair then they cannot provide couple counseling.

4.6. Attitude of Clients and Counselors towards Counseling

Clients were asked to rate statements that are intended to measure their attitude towards mobile VCT counseling services. The rating scale was constructed in the form of Likert scale. As a result clients have five alternatives to select, ranging from strongly disagree up to strongly agree. Eleven items (see appendix A part six) of opinion statements were used as a measuring device. See Table 13 for the summary result of client's responses.

Table 12: Clients' Attitude towards Mobile VCT Counseling Service

Category	Client respondents	
	Frequency	Percentage (%)
Above mean	135	87.66
Below mean	19	12.34
Total	154	100

As it is indicated from Table 12, the questions were asked to know the attitudes of clients categorized by their mean score i.e. above mean and below mean score. The expected mean score was 33, therefore 87.66% of clients score is above mean and 12.34% of client score is below mean. This shows that the majority of clients have positive attitude towards HIV/AIDS mobile counseling service.

Table 13: The Response of Counselors about their Attitude towards Mobile VCT

Category	Frequency	Percentage (%)
Above mean	5	100
Below mean	0	0
Total	5	100

Counselors were asked 13 questions in order to know their attitude towards counseling (see Appendix B). The attitude of the counselors was categorized based on the mean score. The expected mean score was 39. As it shown above in Table 14, all of the respondents fall above the expected mean. Therefore, all of the counselors have good attitude towards counseling.

4.7. The Problems Counselors and Clients Faced and their Suggestion towards Improvement of Addis Ababa OSSA Mobile VCT Service

Table 14: The Response of counselors about the problems encountered in provision of counseling (N=5)

Problems	Frequency
Presence of workload	4
Lack of ongoing training	4
Lack of emotional support	2
Lack of technical support	3
Lack of administrative support	3
Lack of supervision	0
Staff moved to other posts	2
Staff Turn over	3
Lack of privacy	0
Lack of confidentiality	0
Lack of waiting area	1

As it is indicated In Table 14, among the total five respondents four counselors reported the presence of workload and lack of ongoing training. Three counselors reported the presence of lack of technical support; administrative support and staff turn over. Of the total counselors, two respondents reported the lack of emotional support and staff moved to other posts and one counselor reported the problem of lack of waiting area.

Counselors were asked to specify other problems of the mobile VCT centers. As a result, the repeatedly mentioned problems are lack of drinking water, latrine, poor sanitation of some sites. The main Problems of the mobile VCT center responded by the counselors were high transportation cost, since it is mobile this cost was not proportional to our income.

On the other hand, the main constraints faced by counselor's were handling the behavior of different clients and shortage of care and support referrals.

In addition counselors were asked to give the main recommendations to improve the quality of the mobile VCT service and they recommended that introduction of new findings, ask and solve the problem of counselors, salary increment, provision of training, shift working and motivation of counselors.

Finally, counselors were asked to give additional recommendation to improve the quality of mobile VCT services and they responded strongly that the program should continue because it addresses different groups of the community and it serves the clients near by their area.

Clients were asked to respond their overall opinion about their interaction with the counselor during pre-test and post-test counseling (see Table 7 in Appendix A). Some of the clients responded that they were happy and it was very good. Others also responded that counselors were given unclear response; counselors did not provide adequate counseling; the counseling time was short; the skill of counselors was not adequate; the counselors do not give adequate time for counseling; counselors need local language translators for those who came from regions hence counselors have communication problems.

Clients were asked to list the problems they faced in the Addis Ababa OSSA mobile VCT center and during the counseling process. Among the 154 clients, 39.61% reported lack of adequate waiting area, and the problem of getting service according to their coming order while the remaining 60.39% respondents responded they did not face problems.

Clients were asked to list the problem they faced during the counseling sessions. Among the 154 clients, 18.18% reported counselors was abstract; counselors did not ask direct questions; counselors did not show smile; shortage of the counseling time and the test result was not given. While the remaining 81.82% respondents responded that they did not face any problems in the mobile VCT center.

Clients were asked what they were thinking for good quality counseling service. Among 154 respondents, 36.36% clients reported there is a need of community mobilization; provision coffee and tea service in the waiting room; In addition, assign appropriate

professional and mature counselors; counselors should make detail discussion with the clients; provision of adequate counseling time; assign female counselors; provision of strong counseling; provision of education and adequate training to counselors; counselors should wear white gown or proper closing. In addition, the counseling room was not attractive; improve the waiting area; the site selected should be private and clean area; education should be available and supported by video in the waiting room; and suggest to establish additional mobile VCT centers. While the remaining 98 (63.64%) respondents responded that it was very good and continue the service.

More over, clients were asked to give their general comments about the mobile VCT service. Among the 154 respondents, 81.82% reported that it was good but they claimed that the test result paper did not given. Besides this, it is time saving and located in appropriate place; the service is important to weak and poor; it is useful for those who are busy or do not have time; it is good because it is free of charge and provide the service in weekends. While the remaining respondents did not respond.

Finally, Clients were asked to give additional suggestion to improve the counseling service in the mobile VCT center. Among the 154 respondents 62.98% reported that the location /the site/ selected should be free from car crowded place; provide adequate counseling; provide education for PLWHIV; raise the awareness by distributing leaflets, magazines, cassettes, pens and other gifts for clients; films should be available; the laboratory and counseling room gates are not comfortable for disabled clients. while the remaining respondents left to respond.

Coordinators and supervisor also were interviewed about the problems they faced to provide quality mobile VCT counseling services. The respondents reported that they faced referral follow up and getting feedback problems. In addition, mobilization problem in factories, repeated testers without expected risk or within the window period, over flow of clients/ inability to respond clients sometimes, the mobile service is expensive /it is costly/, different behavior of clients, insufficient motivation (few salary and motivation), proportion of skilled counselors and clients are the problems they were faced.

The coordinators and supervisor were interviewed about the measures to be taken to provide quality mobile VCT counseling services. They reported that the allocation of

trained workers, involvement of other stakeholders, refreshment/burn out/ management training per six months. HCT guideline protocol followed by session observation, client satisfaction questionnaire, client suggestion sample crosscheck implementation, other mobile VCT center establishment, continuation of program budget and stakeholder sensitization for stability of the program particularly government and community are required.

CHAPTER FIVE

DISCUSSION OF THE RESULT

Mobile HCT services are an important strategy for increasing accessibility to HCT services for key populations and people living in hard-to-reach areas. The principle behind mobile HCT services is to bring HCT out of health facilities and into the community. There are different approaches to providing mobile HCT services. A team of providers may offer the services to the general population, defined groups, such as a church congregation, attends at cultural and sport events, employees of a company, or hard-to-reach groups such as injection drug users, sex workers, truck drivers, street boys, or those with no fixed address (FHI, 2005).

The temporary service sites may be a tent, or existing community locations such as churches, schools, and administrative offices. In some cases, bicycles and motorcycles are used. A more expensive model involves the use of a mobile van, often equipped with video units. Provider's counsel and test clients inside the van, which remains in a designated location or drives to different locations to attract clients (Makoane, et al., 2008).

Thus, Addis Ababa OSSA mobile VCT service uses counseling and testing inside the mobile van and a waiting area in a tent. However, the use of a van is expensive as it is mentioned above and the researcher obtained information during interview with the program coordinator. Therefore, it is better to use other mobile HCT models which are less expensive to expand the service and reach vulnerable groups of the community.

Regarding mobile HCT staffing PSI/Zimbabwe (2009) mentioned that, staff should not travel to locations alone. Where possible a male and female staff member should travel together. Senior counselors or experienced staff should be the first to provide mobile VCT services and should train the newer team, once systems are in place. The number of staff will depend on the demand for services. A receptionist should assist as well in the logistics and promotion of mobile VCT activities.

In addition, according to UNAIDS 1997a, a VCT center should have at least a well functioning laboratory, separate room for counseling, waiting area, trained laboratory technician, trained counselor and good infection control and waste disposal practices. VCT sites must be easily accessible to target clients, ensure privacy and confidentiality and have a reliable HIV testing facility. VCT sessions also must be well organized and structured, appropriate checklists should be used, be flexible in order to meet the requirements of individual clients and must have a goal-based strategy for each session (UNAIDS, 1997a).

In this respect, Addis Ababa OSSA mobile VCT center has its own coordinators and a supervisor at the center, one male and one female laboratory technicians, four female and one male counselor, one community mobilizer, one receptionist and one cleaner at the site. Moreover, the mobile van has a functioning laboratory, three separate rooms for counseling, a tent waiting area, and infection control and waste disposal practices. However, the client's responses and observation of rooms conformed that the counseling rooms are too narrow and the waiting area is inadequate.

According to Makoane, et al. (2008), the United States Agency for International Development (USAID) in Ethiopia has identified the following as priority at-risk populations for HIV/AIDS interventions. These are sex workers, females involved in cross-generational and/or transactional sex, males engaged in transactional sex including male clients of sex workers, young men having multiple sexual partners, highly mobile workers, separated/divorced individuals, and pregnant women. In addition, these are referred as the key population for HIV/AIDS interventions.

According to Makoane, et al. (2008), the three rounds of assessments conducted to inform the design of mobile HCT services indicated that these key populations do not utilize facility-based HCT services due to barriers related to access and confidentiality.

As to them, the hours of operation and location of health facilities are often not convenient for key populations. Clients also perceive a lack of confidentiality and privacy at health facilities they fear being recognized by the counselor or other clients when seeking services. At times, existing HCT sites cannot provide services due to

shortages in staff and necessary testing supplies. They added, the travel time and transport costs required to visit clinics pose a barrier to clients wanting to access HCT. As a result, the July 2007 national HCT guidelines clearly indicated the need for outreach and mobile HCT service delivery.

PSI/Zimbabwe (2009) indicates that mobile units can offer greatly increased access over a wide area, vulnerable and marginalized groups can be reached through mobile and community outreach.

Morin (2006) also said that, *we found acceptance of the mobile VCT approach in a high-density setting and a rural setting in Zimbabwe. Although we were concerned that testing in public settings would be a potential problem for women, 42% of those coming forward for mobile VCT were women. Same-day rapid testing also seems to be an acceptable approach, with 99% of participants opting for same-day results. Mobile VCT was able to identify a large number of individuals with HIV infection. The 29% infected with HIV is higher than the 17% reported at fixed clinic-based sites in Harare. HIV infection was significantly higher in Epworth (31%) than in Seke (23%), suggesting that targeting mobile VCT to areas with higher migration like Epworth may be helpful.*

Accordingly, the information obtained from document investigation shows that, the mobile VCT service has been successfully implemented in different segments of Addis Ababa. And was to reach different parts of the community such as factory workers, youth, long distance drivers, businessmen female CSW and etc. from the initiation of mobile service activity to date, the number of clients get the service (OSSA, 2008).

According to Addis Ababa OSSA 2009 report, from 2005 half year in the end of the year 2009, about 36,321 clients came to mobile sites for the service. Out of 36,321 clients gave test for HIV 1,819 clients were HIV positive. Therefore, Addis Ababa OSSA mobile VCT can reach the key population that do not utilize facility-based VCT services due to barriers related to access and confidentiality.

In addition, according to OSSA 2008 annual report, the predominant reason of clients request VCT services are "plan for future" 40% and "client at risk/had risk" 32.2%.

Similarly, according to WHO/UNAIDS (2001) HCT has been shown to be more effective when it is developed in conjunction with support services, such as medical, psychological, social and the like. Similarly, FDRE HAPCO/MoH (2007) describe that HCT service deliveries are required to be linked to locale referral services, to be able to track referrals and to work cooperatively with internal and external post-test services.

Organizations providing mobile VCT should ensure that there are adequate follow-up services to provide post-test care and support. Creative and innovative approaches to providing follow up services may be required (PSI/Zimbabwe, 2009).

Therefore, there is a need to strengthen the referral system to providing referral service and mobile VCT should ensure the existence of adequate follow-up services to provide post-test care and support. As well as creative and innovative approaches to providing follow-up services.

Promotion of mobile VCT is very important and should not be neglected. Mobile VCT services should be promoted through out the community or directly to the target group a week before the service is provided. Staff should work with the local community to gain support for mobile VCT and to promote the activities throughout their community. They should be provided with leaflets, invitations and posters to promote the services (complete with the date, time and location). The day of service provision there should be a banner set up outside of the location to show that VCT is offered in that location that day (PSI/Zimbabwe, 2009).

Coordinators and a supervisor mentioned that, promotion was given to the community and they were aware of mobile VCT service. Even though, coordinators and a supervisor noted that promotion was given by community mobilizer, by car and other different sources, 31.82% of clients were not have prior sources of information about mobile VCT service. Nevertheless, they got information along the roadway. Therefore, there is a need of strong promotion about the mobile VCT service including the objective and who should be tested because the clients need prior information to decide for voluntary counseling testing.

HCT counseling contents were considered in terms of per-test, post-test counseling and follow-up counseling. In other words, the process of HCT counseling consist of at least two sessions, pre-test and post-test counseling and each session has several elements that makes up the prevention intervention (FDRE MoH, 2007).

According to UNAIDS (2000a), pre-test counseling is offered before HIV testing. Ideally, the counselor prepared the clients for the test by explaining HIV/AIDS and its modes of transmission, what HIV test is and its importance, as well as myth and misconception about HIV/AIDS. The counselor also discussed the clients personal risk profile and HIV prevention method, the implication of knowing one's HIV status, the way to cope with new information (HIV test result), and potential needs and available support. The findings of this study indicates that the majority of clients reported that almost all the issues or contents of per-test counseling session were covered in Addis Ababa OSSA mobile VCT center.

UNAIDS (2000a) states that, post-test counseling should always be offered after the HIV test. The main objective of post-test counseling session is to help clients understand their test result and initiate adoption to their HIV negative or HIV positive status.

To attain those objectives, the counselor should give test result simply and clearly, allowed time for the result to sink in, check the understanding of test result, explain the meaning of test results, and discuss the implication of test results. Besides the counselors deal with personal risk reduction plan, manage clients immediate emotional reaction, checking availability or support, discuss follow up care and support and discusses about referral when necessary.

The result of study indicates that out of the total 154 Addis Ababa OSSA mobile VCT center clients, 88.96% reported that HIV test result was given simply and clearly. Among the total 154 respondents, 83.77% of them reported that enough time was allowed for the HIV test result to sink in. In addition, 83.12% clients reported that understanding for test result was checked. 50% of clients responded that the meaning of test result was made clear while 50% of clients responded test result was not made

clear. Among the total respondents 64.29% of the respondents reported that discussion of personal, family and social implication was made while 35.71% of respondents respond that personal, family and social implication were not discussed.

Regarding to personal risk reduction plan among the 154 mobile VCT clients 70.13% responded that personal risk reduction plan was discussed. Among the total clients, 58.44% respondents reported availability of immediate support was checked, 66.23% of clients reported discussion was made about follow up care and support and follow up plan. Of all the respondents, 50.65% reported that identification of options and resources were made, and 53.90% of clients responded that immediate plans, intention and action were reviewed. It was indicated that 53.90% respondents reported that discussion about referral was made.

As it is indicated in the above result the majority of Addis Ababa OSSA mobile VCT clients agreed on that the result was given simply and clearly, time was allowed for the result to sink in, understanding for the result was checked, and the meaning of test result was discussed. In addition, issues of personal, family and social implication and personal risk reduction plan were discussed. On the contrary, some of the clients disagree with the coverage of these contents in post-test counseling session.

The majority of Addis Ababa OSSA mobile VCT clients reported that issues concerning the meaning of results for me/partner, availability of immediate support, Identifications of options and resources, revision of immediate plans, intention and actions, follow up plan and referral were not discussed during the post-test counseling session. This shows that the contents of post-test counseling were not well covered at Addis Ababa OSSA mobile VCT center.

According to UNAIDS (2000a), HIV counseling helps a person make informed choices. However, it is important to note that people who do not want pre-test counseling before taking HIV test should not be required to do so. In addition, a decision to be tested should be an informed decision. Informed consent implies awareness of the possible implications of a test result, including the awareness of the window period.

In addition, access to pre-test counseling is not always available, and some people might refuse this option. However, in case the test is positive, there are considerable benefits to the client having taken part of pre-test counseling. Which include: improved acceptance of HIV status and ability to cope, empowerment, involvement in the care and support to people living with HIV/AIDS, higher probability of change of behavior, reducing the risk of mother to child transmission, early management of opportunistic infections and information on safe sexual practices and the use of contraceptive devices. In addition, provision of early social and peer support, normalizing and destigmatizing HIV/AIDS, instilling hope and addressing the quality of life issues for people living with HIV/AIDS. Also planning future care, making a will considering future childcare and each counselor should have a checklist form for each client in order to be sure that all relevant issues have been discussed (UNAIDS, 2000a).

Similarly, the post-test counseling session should begin by trying to put the client at ease. The room must be quiet, without any fear of being disturbed. The counselor should then tell the client test result in a clear and direct manner. The result (either positive or negative) should be discussed while being sensitive to the client's feelings. Providing further information might be necessary, although, in case of a positive diagnosis, the client may be in shock, and may not fully take in all the information offered. However, in some circumstances, this might be the only chance to counsel him and asking to repeat the information, or writing down some basic facts, will be helpful. It is important for the client to have time to reflect on the result and to understand the next course of action (UNAIDS, 2000a).

Ideally, couple and/or family counseling should be started when appropriate and further follow-up counseling arranged. It is often difficult to tell someone bad news. However, most people with a positive result know before the result that they have HIV; a positive test result may be less of a surprise than the counselor thinks. Prepare yourself by thinking carefully about what you are going to say, and what the client's responses might be, before revealing the test result. This will make the experience better both for you and for your client (UNAIDS, 2000a).

Ask the client what she/he has been thinking about since taking the test. Find out what worries or questions she/he might have. Arrange for enough time to talk about the issues she/he raises. When you give the result, use a neutral tone of voice. You might say, "Your HIV test result was positive", and then wait for the client to respond. A neutral tone and a moment of silence allow the client to feel his own feelings rather than respond to yours (UNAIDS, 2000a).

The first feelings that a person has after finding out that she/he has HIV may include denial, anger, fear, sadness, hopelessness, and/or guilt. Most people will be upset, and some may talk about harming themselves. Help avoid a crisis. Be supportive. Let the client know that strong emotions are understandable, and she/he should not give up hope. Acknowledge feelings by using simple statements such as "This is probably a frightening time for you" (UNAIDS, 2000a).

Sometimes a person will not accept the result of a positive test. He will insist that she/he is negative and that there has been a mistake in the results. Do not argue with her/him. Tell him that tests are verified several times, but show your willingness to repeat the test if the client insists. People who deny the truth are often those most in need of support; ask them to return for another meeting (UNAIDS, 2000a).

While you should not deny the client's feeling of worry, it is helpful to talk about things positively. For example, many people believe that having HIV means that they will die very soon. Talk about how long it usually takes to become ill. Some people have lived for over fifteen years with the virus. Teaching people ways to stay healthy will help build a feeling of strength at a time when they may feel powerless. Try to help your client overcome harmful thoughts and focus on solving problems. Help people plan for the future and remind them that they are not going to die tomorrow (UNAIDS, 2000a).

Breaking the news and give results simply and clearly, allow time for the result to sink in, check that the client has understood the situation, discuss the meaning of the result and its implications at personal, family and social level, and explore who to tell and how to tell among the family, friends and employers. And if applicable, manage immediate

emotional reactions, check for immediate follow-up and referral support, review options and resources and review immediate plans, intentions and actions (UNAIDS, 2000a).

According to UNAIDS, 2000a, the majority of people attending VCT, regardless of testing positive or negative, need follow-up counseling. It helps improve the quality of life and enhances the ability to cope and make informed decisions about ongoing care. Some PLWHAs, or those with a high-risk behavior, do not like to be referred for the fear of the disclosure of their identity, and prefer to avail follow-up counseling at VCT centers. Follow-up VCT counseling should therefore be flexible and provide ongoing counseling to all those who need it. And a checklist was not developed because of the nature of the issue and it would be hard to address them in a rigid form. The follow-up should be flexible and compatible with the needs of each client.

Therefore, the contents of pre-test and post-test counseling should be covered in mobile VCT center and flexible and compatible follow-up counseling with the needs of clients should be given regardless of testing positive or negative.

According to Shertzer and Stone (1974), state that counseling is a process /is not a single event but involves sequential actions and practices progressing toward a goal. The definition usually specifies that the relationship is characterized by warmth, permissiveness, understanding and acceptance, etc. Some definitions describe the counselor as professional, matured, possessing special knowledge and the client as troubled, anxious, upset, or frustrated. Most definitions indicate that the effect of counseling is improvement, or change in client behavior.

In addition, according to Colledge (2002), *those counselors who regard counseling as helping relationship usually describe to the theory and practice of the person-centered approach. It could be said that a helping relationship is enough to get constructive changes to occur in clients. The core conditions of such a relationship are empathetic understanding, congruence and genuineness, and respect for client's capacity to lead their own lives.*

Colledge (2002), *further added counseling theories provide counselors with conceptual framework that enable them to think systematically about human development and their*

practice of counseling. This is vital because counselors constantly have to make decisions and choices about how to view client's behavior and how to treat and respond to them during the counseling session.

Furthermore, according to UNAIDS (2000b), guideline, a counselor must have the following qualities to conduct effective VCT sessions: ability to keep counseling on the emotional and intellectual level of the client, capacity to create an atmosphere where the client feels safe, and to establish a supportive, non-judgmental relationship, confidence to feel at ease. And in discussing intimate topics usually avoided in ordinary social life or during medical consultations, skill to help clients talk about sensitive topics, skill to focus the discussion on risk practices and behaviors and understanding how one's own beliefs, feelings, attitudes and prejudices can negatively affect the counseling relationship.

The counselor-client relationship and interaction are vital element in the counseling process. Therefore, the researcher found out the professional skill of the counselors regarding interpersonal relationship skill of counselors, information gathering skill, counselor's information giving skill and handling special circumstances skill of counselors.

A result obtained from 154 clients in Addis Ababa OSSA mobile VCT center 50% of the clients score was above the median score that is high professional skill and the remaining 50% of clients score was below median score that is low professional skill of counseling. This shows that almost half of the respondents reported that the professional skills of counselors are low; this is because of inadequate training and the presence of workload on the counselors.

Psychologists, social workers, psychiatrists, physicians, nurse and other health workers, clergy, teachers and others enable clients to cope with their problems can do counseling. As Rogers and Ellis cited in Corey (1984), the attitude and feelings of the counselor is more important than techniques and theoretical orientations. He further illustrates that genuineness; unconditional positive regard and understanding the client are important personal characteristics of counselors.

The attitude of an individual emerges from his knowledge and understanding of a particular thing or issue. In the same way, mobile VCT clients and counselors have attitude towards the counseling services, it is assumed that they have the necessary knowledge and understand of the service to benefit from.

Thus, the finding of this study indicated that of the total 154 clients 87.66% clients score above mean and 12.34% clients score below mean and all of the counselors have positive attitudes towards counseling. This shows that the majority of clients have positive attitude towards HIV/AIDS mobile counseling service and the entire counselor tends to show positive attitude towards counseling service.

Counselors in VCT services need training which should consist of basic information on HIV, transmission routes, risk factors, possible and available interventions, as well as the role and processes of pre-test, post-test and follow-up counseling. For the latter they will often need of acquire new skills. UNAIDS (2000a), suggests that there are several modes of counseling training for VCT services. A short course training modes usually have a duration or time scale of four weeks. Similarly according to FDRE MOR (2002), any one selected to be a VCT counselor should be given at least a four weeks (one month) training on counseling. However, other modes of training offer longer time and more in-depth training.

The results of this finding shows that out of the total five counselors who participated, one counselor reported she/he has got 15 days counseling training, one counselor has got 21 days of training, one counselor has got 25 days of training and two counselors have got 1 month of training. This indicated that the training offered to the counselors was not uniform; the duration varies from 15 days to one month training. Therefore, it is possible to say that the majority of counselors have not gotten adequate training and there is no standardized training for counselors.

From the total number of five counselors who participated in this study all counselors reported that they needed additional training in different areas. The result of the study indicated that of the total counselors three counselors reported that they need additional training in the area of couple counseling and Antiretroviral Treatment (ART). Other two

counselors reported they need additional training in the area of Pregnant Mother to Child Transmission /PMTCT/ of HIV/AIDS and one counselor responded that need additional training in the area of TB/HIV, one counselor responded that need training on New findings of HIV/AIDS and one counselor responded that need training on Family planning. This shows that there is a need to organize additional training based on the need of the counselor and the importance of the training especially general training including different theories of counseling.

Regarding support, three counselors reported that they have never attended a counselor support group, while two counselors responded that they have attended a support group and they rated work of the support group were good. Moreover, the entire counselor responded that their works have been supervised and the works of supervisor were good.

In counseling, perhaps more than in any other areas of service provision, service quality determine the out come. Poor quality counseling can result in misunderstanding and even resistance to behavior change. The result of this study indicates that the majority of counselors have not adequate training.

Counseling is a science and an art, as a science it requires knowledge, techniques and skill. As an art, it calls for intuition, some talent and creativity. Counseling requires a lot of work and experience to be effective. However, the result of this study in respect to counseling experience indicates that, two counselors had one year experience in total counseling and VCT counseling and three counselors had more than two years of experience in total counseling and VCT counseling. This shows that two counselors have lack of experience or the majority counselors are not well experienced.

To ensure privacy, VCT must be carried out correctly and effectively. Discussion of risk factors and sexual relationship is part of VCT counseling. However, key information to the process will not be elicited unless people can discuss these issues in private. Hence, for effective counseling private space is required. The finding of this study revealed that mobile VCT center has separate rooms for counseling. Even if there is a private counseling room, it is narrow and not well ventilated to maintain the comfort of

clients and counselors. Therefore, a well-ventilated separate counseling room is important for mobile VCT centers. In addition, the result of this study indicates that the mobile VCT center has a waiting area that is not adequate.

HIV infection is still a stigmatized condition in many areas. Therefore, counselors and all the staff involved to maintain confidentiality. Lack of confidentiality will result in reduction of clients who seek the service. The finding of this study indicates that discussion was made how confidentiality is ensured and this is done in mobile VCT center by anonymous testing and/or keeping clients secret but the selected sites are crowded so this reduces the comfort and confidentiality of some clients.

Seating arrangement is the other factor that affects effective counseling. The result of this study indicates that in mobile VCT center the seating arrangement was typically across the corner of the counselor table. According to Yusuf (1998) different seating arrangements have their own benefits and draw backs. However, the most effective is across the corner of the table. Hence, this study indicated that effective seating arrangement was observed but the room had no adequate space/narrow.

According to WHO (1990), client satisfaction and consequent positive changes in behavior are the two major outcomes that can be expected from a successful VCT session and a good VCT session can provide the client with time is important. Time is also necessary for the development of understanding and trust, both of which are indispensable. Some people may require a number of counseling sessions before they start to acknowledge the need to modify their behavior and to make difficult decisions concerning their life.

However, the result of the study indicates that counselors work 8 hours per day, 6 days per week and they counsel 16 up to 20 clients per day. This shows that each counseling session was not given adequate time so as to give clients satisfaction and positive changes in behavior which is the major outcomes of a successful VCT session and a good VCT session.

Regarding the problems of counselors, the findings of the study indicate that, about four counselors reported the presence of workload and lack of ongoing training three

counselors reported the presence of lack of technical support, administrative support and staff turn over. In addition, two respondents reported the lack of emotional support and staff moved to other posts and one counselor reported lack of waiting area. Moreover, the main constraints faced by counselors' were problems of handling the behavior of different clients and shortage of care and support referrals.

Besides, counselors were asked to specify other problems of the mobile VCT center. As a result, they repeatedly mentioned are lack of drinking water, latrine, poor sanitation of some sites, and high cost of transport. On the other hand, the main problem of counselors was high transportation cost.

The main recommendations of counselors to improve the quality of the mobile VCT service were the need to get new findings of HIV/AIDS, problem solving support, monitoring and supervision, salary increment, additional training, shift working and motivation.

This study has seen the overall opinion about clients' interaction with the counselor during pre-test and post-test counseling. As a result, some of the clients responded that counselors gave unclear responses; counselors did not provide adequate counseling; the counseling time was short; the skill of counselors was not adequate; counselors did not give adequate time for counseling and counselors have communication problems so they need local language translators for those who came from regions.

Besides, Clients were also face the problem of lack of adequate waiting area, and the problem of getting service based on to clients coming order in the mobile VCT center.

The problems that clients face during the counseling sessions were counselors did not counsel clearly; they did not ask direct questions; they did not show smile and did not give the test result.

To improve the mobile VCT service quality, clients reported that counselors should made detail discussion with the client, assign female counselors, counselors should wear white gown or proper closing, assign mature counselors, provide adequate counseling time, and provide adequate training to the counselors, establish additional

mobile VCT centers, and the counseling room should be attractive, improve the waiting area, the site selected should be private and clean area, and their should be education supported by video in the waiting room.

Clients were give additional suggestion that, the location/ the site/ selected should be free from car crowded, provide education for PLWHIV, raise the awareness by distributing leaflets magazines, cassettes, pens and other gifts for clients, films should be available and provide additional psychological support. The laboratory and counseling room gates is not comfortable for disables, use media for mobilization.

Finally, The suggestions given by clients of the mobile VCT are: it is time saving when it is located in appropriate place, the service is important to weak and poor, it is useful for those who are busy or don't have time, it is good because it is free of charge and provide the service in weekends.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1. Summary

Mobile VCT services are one types or models of VCT and an important strategy for increasing accessibility to VCT services for key populations and people living in hard-to-reach areas. The principle behind mobile VCT services is to bring VCT out of health facilities and into the community.

Hence, whether or not counseling service is effective for the intended purpose in the mobile VCT has motivated me to conduct this study. Thus, the present study was conducted with the following specific objectives: to assess what looks like the general practice of mobile VCT services, whether the counselors are trained or not, the supervision and support provided to the counselors, whether the counselors use basic skills of counseling, content coverage of pre-test and post-test counseling, the attitude of clients and counselors towards counseling, the counseling environment and to find out problems that affect rendering counseling services.

In this study, descriptive survey research methodology was employed. To obtain adequate information; questionnaire, interview and observation checklist data collection instruments were used.

A total of 160 voluntary clients were taken using convenient sampling method. The data were collected directly from the source through administration of questionnaire.

The available five counselors, two coordinators and one supervisor of the mobile VCT participated in this study through administration of questionnaire and interview. Observation was conducted using observation checklist in the mobile VCT center.

The data were tabulated for analysis, which included statistical application involving frequency counts, percentage, mean and median. Finally, clients and counselors identified problems, opinions, comments and suggestions were qualitatively analyzed and included in the conclusions and recommendations.

6.2. Conclusions

From the finding of this study, the following conclusions are drawn:

Addis Ababa OSSA mobile VCT had reached the key populations, those which do not utilize facility-based VCT services. The predominant reasons of clients for requesting VCT services are “plan for future” and “client at risk/had risk” while premarital test, test for window period, exposure to others’ blood/body fluid and “partner at risk” are other noticeable reasons of clients to come to the service. However, there is problems of repeater tester may be partly due to inadequate counseling and lack of instruction/guideline to identify the persons needs to be tested for HIV. In addition, there is a referral service problem, specially care and support service and problems of follow up and networking and promotion about the mobile VCT services including the objectives and who should be tested were not adequate.

Contents of pre-test counseling session were covered but the contents of post-test counseling sessions were not fully covered during the counseling sessions. Counselors do not posses some of the basic counseling skills, the training given to the counselors was neither standardized nor adequate, the counselors were supervised and the work of supervisor was good and the majority counselors are not well experienced. Nevertheless, most of the clients and counselors of the mobile VCT center have positive attitudes towards counseling services.

There is a narrow room for privacy counseling, inadequate waiting area and effective office seating arrangement in the counseling room. Confidentiality is ensured and this is usually done by anonymous testing and/or keeping clients secret but the sites selected are usually crowded and reduce clients’ confidentiality.

All of the counselors work 8 hours per day, 6 days per week and they counsel 16 up to 20 clients per day. Counselors face the workload, lack of ongoing training, lack of technical support, administrative support; staffs turn over, lack of emotional support, movement of staff to other posts and lack of waiting area.

Counselors in mobile VCT centers have faced problems of lack of drinking water, latrine, poor sanitation of some sites, and high cost of transport, and problems of handling the behavior of different clients and shortage of care and support referrals. Counselors need to get new findings, problem solving monitoring and supervision, salary increment, additional training, shift working and motivation.

Clients faced the problem of lack of adequate waiting area and the problem of getting service according to their coming order to the mobile VCT center. The problem clients faced during the counseling sessions are counselors counseling is not clear, counselors did not ask direct questions, counselors did not show smile and the test result was not given.

Comments given by clients to counselors are the need for local language translators for those who came from regions to solve counselor's communication problems. Few female clients recommended the assignment of female counselors at the mobile VCT center. Clients also recommended the site selected should be private and clean area; their should be education supported by video in the waiting room. In addition, few clients recommend that counselors should wear white gown or proper clothes; few clients comment the laboratory and counseling room gate is not comfortable for disabled clients and most client give comment to establish additional mobile VCT van to provide the service at different place around schools and to use media for mobilization.

6.3. Recommendations

In the light of the findings of the study, the researcher recommends the following points.

- The contents of post-test counseling should be covered.
- Provide adequate training in order to improve the professional skills of counselors.
- Since, the majority of counselors are not well experienced, provide strong supervision and technical support.
- The mobile VCT center should have adequate and ventilated counseling room to maintain the comfort of clients and counselors. Besides, for positive and emotionally unstable clients the counseling room should be arranged using a tent outside the van. Since the gate of the van is steeply, arrange the laboratory and counseling room out side the van for disable clients.
- Arrange adequate waiting area with sufficient chair, education material such as printing, audio and video materials. Besides, the site selected should be private and clean area.
- There is a need to revise the number of counseled clients per day by counselors to provide adequate time for each counseling session and bring positive changes in behavior of clients.
- The language of clients should be given attention in order to enhance communication between the clients and counselors.
- Assign female counselors for female clients who need to counsel by female counselors.
- The problems of repeated testing should be minimized by providing adequate counseling and the use of proper instruction/guideline to provide testing for the person needs to be tested for HIV.

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APPENDICES

4	Occupation (circle one)	a/ Student b/ Unemployed c/ Civil servant d/ Military e/ Housewife f/ Merchant g/ Commercial sex worker h/ Other specify _____
5	Marital status (circle one)	a/ Married b/ Single c/ Divorced Other specify _____

PART TWO: AWARENESS OF THE SERVICE

Instruction: The following questions are listed to know your awareness about the mobile VCT service. So read and circle the one you choose.

1	Do you know about HIV/AIDS mobile VCT service provided by Addis Ababa OSSA?	a/ Yes b/ No
2	If your answer is yes for question 1, from where did you get information?	a/ TV b/ Radio c/ Newspaper d/ Magazine e/ Leaflet f/ Friends g/ community immobilizers h/ other specify _____

PART THREE: COUNSELING CONTENTS

Instruction: indicate your responses with a tick mark (√) on the space provided

Pre-test counseling (During the session the following occurred)

Items		Yes	No
1	Reasons for attending discussed		
2	Knowledge for HIV and modes of transmission		
3	Misconceptions corrected		
4	Information concerning the process of HIV testing given		
5	Assessment of personal risk profile carried out		
6	Discussion of possible test results and meaning of HIV positive and negative results		
7	Capacity to cope with HIV positive results discussed		
8	Discussion of potential needs and available support		
9	Discussion of personal risk reduction plan		
10	Time allowed to think through issues		
11	Informed consent/ dissent given freely		
12	Follow-up arrangements discussed		
13	Adequate time for question and clarification given		

PART FOUR: COUNSELING CONTENTS

Instruction: Indicate your responses with a tick mark (√) on the space provided

Post-test counseling (During the session the following occurred)

Items		Yes	No
1	Results given simply and clearly		
2	Time allowed for the results to sink in		
3	Checking for understanding		
4	Discussion of the meaning of the result for me/ partner		
5	Discussion of personal, family and social implications including who, if any to fell		
6	Discussion of personal risk reduction plan		
7	Dealing with immediate emotional reactions		
8	Checking availability of immediate support		
9	Discussion of the HIV/AIDS policy		
10	Discussion of follow-up care and support		
11	Options and resources identified		
12	Immediate plans, intentions and actions reviewed		
13	Follow-up plan discussed		
14	Referrals discussed when necessary		
15	If you have other issues specify		

PART FIVE: COUNSELORS PROFESSIONAL SKILLS

Instruction: The questions below expresses the professional skills of counselors. Please put a tick mark (√) for each questions. Each question has three alternatives (i.e. 3= high, 2= medium, 1= low).

No.	Questions	Response		
		3	2	1
1	Greets me			
2	Introduce self			
3	Engage me in conversation			
4	Listens actively both verbally and non verbally			
5	Is supportive and non judgmental			
6	Uses of appropriate balance of open and closed questions			
7	Uses of silence well to allow for self expression			
8	Seeks clarification about information given			
9	Avoid premature conclusion			
10	Probes appropriately			
11	Summarizes main issues discussed			
12	Give information in clear and simple terms			
13	Give me time to absorb information and to respond			
14	Has up-to-date knowledge about HIV			
15	Repeats and reinforce important information			
16	Summarize main issue			
17	Accommodate language difficulties			
18	Talks about sensitive issues plainly and appropriate to the culture			
19	Use silences well to deal with difficult emotions			
20	Priorities issues to cope with limited time in short contacts			
21	Is innovative in overcoming constraints			
22	Manage clients distress/reaction			
23	Flexible in involving partner or significant other			

PART SIX: ATTITUDE OF CLIENTS TOWARDS MOBILE VCT COUNSELING

Instruction: Each of the statement below expresses an attitude towards counseling. Please put a tick mark (√) what your opinion is with respect to each statement in only one of five alternatives (i.e. 5= strongly agree, 4= agree, 3= uncertain, 2= disagree, 1= strongly disagree).

No.	Items	5	4	3	2	1
1	Counseling sessions are very interesting to me.					
2	I am under a terrible strain during counseling sessions so it scarce I to take a blood test.					
3	Counseling is fascinating and encouraging to take a blood test.					
4	Counseling sessions make me feel good and at the same time it is stimulating to take a test.					
5	In general I have a positive attitude towards counseling services.					
6	I enjoyed dealing with the counselor.					
7	I get more satisfaction and confidence from counseling than before.					
8	I have a feeling of dislike dealing with counselor.					
9	I have a problem in communicating with the counselor.					
10	The counseling session is threatening.					
11	The counseling environment is very stressful.					

PART SEVEN: FACILITIES AND PROBLEMS

Instruction: please circle what your response is with respect to each statement; expect the questions that require written response.

1	Is there a separate room or space to ensure counseling session to be private/?	a/ Yes, there is adequate space b/ Yes, there is some but not enough c/ No
2	Is there a waiting area?	a/ Yes, there is adequate space b/ Yes, there is but not adequate c/ No
3	How do you rate the waiting area?	a/ Very good b/ Good c/ Poor
4	If you say poor for question no.3, what is its weakness?	
5	Do you think the numbers of counseling sessions are adequate?	a/ Yes b/ No
6	Do you think the time given for each counseling session is adequate?	a/ Yes b/ No
7	Do you think the seating arrangement is ensuring confidentiality?	a/ Yes b/ No
8	What is your over all opinion of your interaction with the counselor during pre-test and post-test counseling?	
9	Please list the problems that you encountered in mobile VCT center?	
10	Please list the problems that you faced during the counseling sessions?	
11	What do you think be improved for "Good quality" mobile counseling services?	
12	What is your general comment about the mobile counseling services?	
13	Do you have additional suggestion to improve the counseling services in the mobile VCT center?	

ክፍል ሁለት :- ግንዛቤን ለማወቅ የቀረቡ ጥያቄዎች

መመሪያ:- ከዚህ በታች ስለተጠቀሱት ስፍራዎች ላይ የተመሰረተ የምክርና የምርምራ አገልግሎት ያለውን ግንዛቤ የሚመለከቱ ጥያቄዎች ተዘርዝረዋል፤ ጥያቄዎችን ካነበቡ በኋላ ምርጫዎን በማክበብ ይመልሱ።

1. በአዲስ አበባ ከተማ ተጠቃሚነት ስፍራዎች ላይ የተመሰረተ የምክርና የምርምራ አገልግሎት እንደሚሰጥ ያውቃሉ? ሀ/ አዎ ለ/ አላውቅም
2. በተራ ቁጥር 1 መልሰዎ አዎ አውቃለሁ ከሆነ ግንዛቤውን ከየት አገኙት? ሀ/ ከቴሌቪዥን ለ/ ከሬዲዮ ሐ/ ከጋዜጣ መ/ ከመጽሔፍ ሠ/ ከቦራሪ ወረቀቶች ሸ/ ከገገዥ ረ/ ከማህበረሰብ ቀስቃሾች ሰ/ ከሌላ ከሆነ ይግለጹ -----

ክፍል ሦስት:- የቅድመ ምርመራ የምክር አገልግሎትን በተመለከተ

መመሪያ:- ከዚህ በታች በተጠቀሱት ስፍራዎች ላይ የተመሰረተ የምክርና የምርመራ አገልግሎት ለማግኘት በሚሄዱበት ጊዜ በቅድመ ምርመራ የምክር አገልግሎት ወቅት በምክር አገልግሎት ሰጪው ሊነሱ የሚገባቸው ጉዳዮች ተዘርዝረዋል። ዐረፍተ ነገሮቹን ካነበቡ በኋላ በቅድመ ምርመራ አገልግሎቱ ወቅት ጉዳዮቹ መነሳት ያለመነሳታቸውን ከተሰጡት ሁለት አማራጮች መካከል በዚህ ምልክት(✓) ያሳዩ።

ተ.ቁ.	በቅድመ ምርመራ የምክር አገልግሎት ወቅት ሊካተቱ የሚገባቸው ጉዳዮች	መልስ	
		አዎ	አይደለም
1	ወደ ደም ምርመራው ሊመጣ የሚችልባቸው ዋና ዋና ምክንያቶችን በማንሳት ውይይት ተደርጓል?		
2	ስለኤች አይ ቪ ኤድስና የመተላለፊያ መንገዶች ውይይት ተደርጓል?		
3	ስለኤች አይ ቪ ኤድስ የተዛቡና የተሳሳቱ አመለካከቶች ማስተካከያ ተደርጎባቸዋል?		
4	ስለኤች አይ ቪ ኤድስ የምርመራ ሂደቶች በቂ መረጃ ተሰጥቷል?		
5	ለኤች አይ ቪ ቫይረስ ሊያጋልጡ የሚችሉ ባህሪያትን ለይቶ ለማውጣት ተሞክሯል?		
6	የደም ምርመራው ውጤት ምን ሊሆን እንደሚችልና ኤች.አይ.ቪ ፖዘቲቭ/ኔጌቲቭ ውጤትን ለመቀበል የሚያስችል የግል ዕቅድ ማውጣትን በተመለከተ ውይይት ተደርጓል?		
7	ኤች አይ ቪ ፖዘቲቭ/ኔጌቲቭ ውጤትን ለመቀበል የሚያስችል አቅምን በተመለከተ ውይይት ተደርጓል?		
8	ሊኖሩ ስለሚችሉ ድጋፎች ማለትም የጤና፣ የማህበራዊ፣ የሥነ ልቦና እና የኢኮኖሚያዊ ድጋፎች ማብራሪያ ተሰጥቷል?		
9	ያሉትን ስጋቶች/አደጋዎች ለመቀነስ የሚያስችል የግል ዕቅድ ማውጣትን በተመለከተ ውይይት ተደርጓል?		
10	በጉዳዮቹ ዙሪያ በጥልቀት ማሰብ እንዲቻል በቂ ጊዜ ተሰጥቷል?		
11	የደም ምርመራ ውጤቱን በተመለከተ በምን መልኩ ሊነገር እንደሚያስፈልግና ለማን ሊነገር እንደሚፈለግ በግልጽ ውይይት ተደርጓል?		
12	ከደም ምርመራ ውጤቱ በኋላ ሊኖር ስለሚችል የክትትልና ግንኙነት ሥርዓት ውይይት ተደርጓል?		
13	ለጥያቄና ለተጨማሪ ማብራሪያ በቂ ጊዜ ተሰጥቷል?		

ክፍል አራት፡- የድህረ ምርመራ የምክር አገልግሎትን በተመለከተ

መመሪያ፡- ከዚህ በታች በተንቀሳቃሽ በፍቃደኝነት ላይ የተመሰረተ የምክርና የምርመራ አገልግሎት ካገኙ በኋላ ውጤቱን ለመስማት በሚሄዱበት ጊዜ በድህረ ምርመራ የምክር አገልግሎት ወቅት በምክር አገልግሎት ሰጪው ሊነሱ የሚገባቸው ጉዳዮች ተዘርዘረዋል፤ ጉዳዮችን ካነበቡ በኋላ በድህረ ምርመራ የምክር አገልግሎቱ ወቅት መነሳት ያለመነሳታቸውን ከተሰጡት ሁለት አማራጮች መካከል በዚህ ምልክት(✓) ያሳዩ፡፡

ተ.ቁ.	በድህረ ምርመራ የምክር አገልግሎት ወቅት ሊካተቱ የሚገባቸው ጉዳዮች	መልስ	
		አዎ	አይደለም
1	የደም ምርመራ ውጤቱ ግልጽ በሆነ ሊገባ በሚችል መልኩ ተነግሯል?		
2	የደም ምርመራ ውጤት በሚሰማበት ወቅት መረጋጋት እንዲቻል ጊዜ ተሰጥቷል?		
3	የደም ምርመራ ውጤቱን በሚገባ መረዳትዎን ለማረጋገጥ ጥረት ተደርጓል?		
4	የደም ምርመራ ውጤቱ ምንነት ትርጉም ዙሪያ ከእርስዎ፣ ከቤተሰብዎ እና ከፍቅር ጋደኛዎ ጋር ውይይት ተደርጓል?		
5	የደም ምርመራ ውጤቱ በግል፣ በቤተሰብና በማህበረሰቡ ላይ ሊያሳድር የሚችለውን ተፅዕኖ እንዲሁም የደም ምርመራ ውጤቱ ለማን እንዲነገርልዎት እንደሚፈልጉና የመነገሩን ጠቀሜታ በተመለከተ ውይይት ተደርጓል?		
6	ያሉትን አደጋዎች መቀነስ እንዲቻል ስጋቶችንና አደጋዎችን መቀነስ የሚያስችል የግል ዕቅድ ማውጣትን በተመለከተ ውይይት ተደርጓል?		
7	በድንገት የሚፈጠሩ የስሜት መቀያየርና መረበሽን ለመፍታት ጥረት ተደርጓል?		
8	በወቅቱ ያሉትን የድጋፍ አማራጮችን ለማጣራት ጥረት ተደርጓል?		
9	ስለኤች አይቪ ኤድስ ፖሊሲ መረጃ እንዲኖርዎት ተደርጓል?		
10	ወደፊት ሊኖር ስለሚችል ክትትል፣ ድጋፍና እንክብካቤ ውይይት ተደርጓል?		
11	ያሉ የድጋፍ አማራጮች ምን ዓይነት እንደሆኑ ተለይተዋል?		
12	ዕቅዶች፣ ዕቅዶችን የማስፈጸም ሂደቶችና ሊከናወኑ የሚገቡ ተግባሮች ተፈትሸዋል?		
13	የክትትል ዕቅድን በተመለከተ ውይይት ተደርጓል?		
14	እንደአስፈላጊነቱ ከጉዳዩ ጋር አግባብ ካላቸው ግለሰቦችም ሆነ አካላት ጋር እንዴት መገናኘት እንደሚቻል ውይይት ተደርጓል?		

15. ከላይ ከተገለጹት ውጪ ውይይት የተደረገባቸው ጉዳዮች ካሉ ይግለጹ? _____

ክፍል አምስት፡- የሙያ ክህሎትን በተመለከተ የቀረቡ ጥያቄዎች

መመሪያ፡- ከዚህ በታች በተንቀሳቃሽ በፈቃደኛነት ላይ የተመሰረተ የምክርና የምርምራ አገልግሎት ሰጪውን ሙያዊ ክህሎት የሚመለከቱ ጉዳዮች ተዘርዘረዋል፤ ዐረፍተ ነገሮቹን ካነበቡ በኋላ በአገልግሎቱ ወቅት ከዚህ በታች የተዘረዘሩት ተገልፀው/ተንጸባርቀው ከሆነ፤ ከተሰጡት ሶስት አማራጮች መካከል ትክክለኛ ነው የሚሉትን ይምረጡ 3 = ከፍተኛ፣ 2 = መካከለኛ፣ 1 = ዝቅተኛ። ምርጫዎንም በዚህ (√) ምልክት ያሳዩ።

ተ.ቁ.	የካውንሰለርን ሙያዊ ክህሎት የሚገልፁ አረፍተ ነገሮች	መልስ		
		3	2	1
1	ከመቀመጫ በመነሳት እጅ በመጨበጥ በአክብሮት መቀበል			
2	ስለራስ ማንነት በግልፅና በሚገባ ማስተዋወቅ			
3	በመረጋጋት ወደ ውይይቱ እንዲገቡ ሁኔታዎችን ማመቻቸት			
4	የሰውነትዎን እንቅስቃሴ በንቃት መከታተልና በጥምና ማዳመጥ			
5	በርስዎ ጉዳይ እርስዎ እንዲወስኑ ማበረታታትና በውሳኔዎ ላይ ጣልቃ ያለመግባት			
6	በውይይቱ ወቅት ከቀረቡልዎት ጥያቄዎች ውስጥ ምርጫ ያላቸውና ምርጫ የሌላቸው ጥያቄዎች በቁጥር ተመጣጣኝ ነበሩ			
7	ራስዎን የመግለጽ እድሉ እንዲኖርዎት ጊዜ መስጠትን እንደአማራጭ ዘዴ መጠቀም			
8	ለተሰጠዎት መረጃዎች ተጨማሪ ማብራሪያ መስጠት			
9	ቸኩሎ ድምዳሜ ላይ ያለመድረስ			
10	እንዲናገሩና ሃሳብዎን ያለፍርሃት እንዲገልጹ ማደፋፈር/ማነሳሳት			
11	የተወያዩባቸውን ቁልፍ ነጥቦች በማጠቃለል ግልጽ ማድረግ			
12	የተሰጠዎትን መረጃዎች በግልጽ እንዲረዱ በሚገባ ቋንቋ በግልጽ ማስረዳት			
13	የተሰጠዎትን መልዕክት/መረጃ በሚገባ ተረድተው መልስ እንዲሰጡ በቂ ጊዜ መስጠት			
14	ስለኤች አይ ቪ ኤድስ በቂ መረጃና ግንዛቤ/አውቀት አለው/አላት			
15	ጠቃሚ የሆኑ መረጃዎችን ደጋግሞ መናገርና ማበረታታት			
16	የውይይቱን ፍሬ ሃሳብ በተመለከተ ማጠቃለያ መስጠት			
17	የቋንቋ ችግር እንዳይኖርና ለመግባባት ለቋንቋ ልዩ ትኩረት መስጠት			
18	ለባህላዊና ኃይማኖታዊ ጉዳዮች ጥንቃቄ ማድረግና በግል ጉዳዮች ላይ የሚደረጉ ውይይቶች ሙያውን ያገናዘቡ መሆን			
19	አስቸጋሪና ስሜታዊ የሆኑ ጉዳዮች ሲያጋጥሙ በትዕግስት ለመፍታት መሞከር			
20	ቅድሚያ የሚሰጣቸውን ጉዳዮች የግንኙነት ጊዜን በማሳጠር ቶሎ ለመፍታት መሞከር			
21	ችሮችን ለመፍታት እንዲቻል አዲስ አማራጭ የማመንጨት ችሎታ			
22	አለመረጋጋት ሲፈጠር ባፋጣኝ የተፈጠረውን ችግር ለመፍታት ጥረት ማድረግ			
23	እንደአስፈላጊነቱ ጠቀሜታ ሊኖራቸው የሚችሉ ግለሰቦችንም ሆነ አካላትን በጉዳዩ ውስጥ ለማካተት ፈቃደኛ መሆን			

6. በእያንዳንዱ የምክር አገልግሎት ክፍል ጊዜ የተሰጠው ሰዓት በቂ ነው ብለው ያስባሉ?

ሀ) አዎ

ለ) አይደለም

7. የምክርና የምርመራ አገልግሎት መስጫ ክፍሉ ሚስጥርን ለመጠበቅ የሚያስችል ነው ብለው ያስባሉ?

ሀ) አዎ

ለ) አያስችልም

8. በቅድመ ምርመራና በድህረ ምርመራ ወቅት ከምክር አገልግሎት ሰጪ ባለሙያ ጋር የነበረዎት ግንኙነት ላይ ያለዎት አጠቃላይ አስተያየት ምንድን ነው?

9. በተንቀሳቃሽ የምርመራና የምክር አገልግሎት መስጫ የገጠመዎትን ችግሮች ይዘርዘሩ?

10. በምክር አገልግሎት ጊዜ የገጠመዎትን ችግሮች ይዘርዘሩ?

11. የምክር አገልግሎቱን ጥራት ለማሻሻል ምን ቢደረግ ይሻላል ይላሉ?

12. ባጠቃላይ በተንቀሳቃሽ የምክር አገልግሎቱ ላይ ያለዎት አስተያየት ምንድን ነው?

13. ተጨማሪ የተንቀሳቃሽ የምክር አገልግሎቱን ለማሻሻል ይረዳሉ የሚሏቸው አስተያየቶች ካሉ ይዘርዘሩ?

ማሳሰቢያ:- ምላሽ ለመስጠት ያስቸገረዎት ጥያቄ ካለ ጥያቄው ያለበትን ክፍልና የጥያቄውን ቁጥር በመጻፍ ያስቸገረዎትን ዐረፍተ ነገር ወይም ቃል ይግለጹ። (ለሙከራ ጥያቄዎች የተሰጠው ይህ ማሳሰቢያ ከዋናው መጠይቅ ማሳሰቢያው ተነስቷል)

4	What is your educational back ground (circle one)	a/ From grade 1- 8 b/ From grade 9 -12 complete c/ Certificate d/ Diploma e/ Degree and above
5	Total year of experience in counseling	a/ Less than one year b/ One year c/ Two years d/ If more than two years please specify _____
6	Experience of counseling in VCT centers	a/ Less than one year b/ One year c/ Two years d/ If more than two years please specify _____
7	How many days per week do you do counseling	a/ 2 days b/ 3 days c/ 4 days d/ 5 days e/ 6 days f/ 7 days
8	How many hours per day do you do counseling	a/ 4 hours b/ 6 hours c/ 8 hours d/ if other please specify _____
9	How many clients do you see per day? (in average)	a/ 5 and less than b/ 6 -10 c/ 11- 15 d/ 16-20 e/ more than 20 please specify _____

PART TWO: TRAINING, SUPPORT AND SUPERVISION

Instruction: circle your response on the space provided, and describe for those questions asked to describe.

No.	Question	Response
1	Have you ever been trained in HIV counseling?	a/ Yes b/ No
2	If your answer is "yes" for question no.10 for how many days, weeks, months or Years of training	___days, ___weeks, ___months or ____years of training
3	How do you rate your counseling Training?	a/ Very good b/ Good c/ Fair
4	Are there any areas in which you need more training?	a/ Yes b/ No
5	If your answer is yes for question no.4 please specify?	_____ _____
6	Do you attend a counselor support group?	a/Yes b/ No
7	How do you rate the work of the support group?	a/ Very good b/ Good c/Fair
8	Do you have a counseling supervisor to provide you with support and supervise your?	a/ Yes b/ No
9	How do you rate the work of the supervisors?	a/ Very good b/ Good c/ Fair
10	Do you have an access to refer HIV positive clients to care and support services?	a/ Yes b/ No
11	If your answer is "yes" for question no.19 please list the type of care and support service given to the clients	1. 2.

PART THREE: ATTITUDE OF COUNSELORS TOWARDS COUNSELING

Instruction: Each of the statement below expresses an attitude towards counseling. Please put a tick mark (√) what your opinion is with respect to each statement in only one of five alternatives (i.e. 5= strongly agree, 4= agree, 3= uncertain, 2= disagree, 1= strongly disagree).

No.	Item	5	4	3	2
1	I feel positively valued by counselees in my counseling duties.				
2	I feel positively valued by colleagues/ the administrators in my counseling duties.				
3	I feel emotionally drained by my work as a counselor.				
4	My work is very stressful.				
5	My work environment is very stressful.				
6	I learn something in my work every day.				
7	I feel isolated in my work.				
8	I have problems in communicating with my clients.				
9	My work is very rewarding.				
10	I feel I can help my clients.				
11	I will go on with my counseling job for the future.				
12	I want to move to another job.				
13	In general I have positive attitude towards counseling.				

PART FOUR: CONSTRAINTS

Instruction: Indicate your response with a tick (√) mark on the space provided, and write your written response on the blank space.

No	Items	Yes	No
1	Is there work load		
2	Is there lack of ongoing training		
3	Is there lack of emotional support		
4	Is there lack of technical support		
5	Is there lack of administrative support		
6	Lack of supervision		
7	Is there staff moved to other posts		
8	Is there staff turn over		
9	Is there lack of privacy		
10	Is there lack of confidentiality		
11	Is there lack of waiting area		
12	Is there any other constraints please specify	1. 2.	
13	In your opinion what do you think are the main problems of the mobile VCT center? (In order of priority)	1. 2. 3 4.	
14	What are the main problems that you face as a counselor?	1. 2. 3 4.	
15	Give your main recommendations in which the mobile VCT center services could be improved?	1. 2. 3 4.	
16	You can give any additional comment	1. 2. 3. 4.	

በአዲስ አበባ ዩኒቨርሲቲ
የድህረ ምረቃ ትምህርት መርሐ ግብር
የሳይኮሎጂ ኢንስቲትዩት

በፈቃደኝነት ላይ የተመሰረተ የምክር አገልግሎት በሚሰጡ ባለሙያዎች የሚሞላ መጠይቅ።

ዓላማ፡- የዚህ መጠይቅ ዋና ዓላማ በአዲስ አበባ ከተማ አሳ በሚሰጠው ተንቀሳቃሽ በፍቃደኝነት ላይ የተመሰረተ የምክርና የምርመራ አገልግሎት የምክር አገልግሎት የሚሰጡ ባለሙያዎች በካውንስሊንግ አገልግሎት ላይ ያላቸውን አመለካከት የሥልጠና፣ የድጋፍ፣ የሱፐርቪዥን እና አገልግሎቱን ለመስጠት ያለባቸውን ችግር እንዲሁም አገልግሎቱን ለማሻሻል የሚረዱ ነገሮችን ለማጥናት የሚያስችል መረጃ መሰብሰብ ነው።

- ከዚህ መጠይቅ የሚገኘው መረጃ በሙሉ የሚያገለግለው ለዚህ ጥናት ብቻ ነው።
- በዚህ መጠይቅ አማካኝነት የሚሰጡት መረጃዎች በሙሉ ሚስጥራዊነታቸው የተጠበቀ ነው።
- ለምርምሩ ውጤት ተጠያቂ አይሆኑም።
- ሁሉንም ጥያቄዎች በተቻለዎት መጠን በግልጽነት አንዲመልሱ እጠይቃለሁ።
- ስምዎን በየትኛውም የመጠይቅ ገጽ ላይ መጻፍ አያስፈልግም።

አመሰግናለሁ!

ክፍል አንድ፡- አጠቃላይ መረጃ

መመሪያ፡- ከዚህ በታች አጠቃላይ መረጃ የሚጠይቁ ጥያቄዎች ተዘርዝረዋል፤ ለጥያቄዎች አስፈላጊውን መልስ በተሰጠው ክፍት ቦታ ላይ ይሙሉ፤ በምርጫ መልክ ለቀረቡት ጥያቄዎች ደግሞ መልስዎን ትክክለኛ ነው የሚሉትን አማራጭ ፊደል በማክበብ ይመልሱ።

1. ዕድሜ _____
2. የታ _____ ሀ/ሴት _____ ለ/ወንድ _____
3. ካውንስለር ከመሆንዎ በፊት ሙያዎ ምን ነበር? ሀ/ነርስ ለ/ጤና ረዳት _____
ሐ/ የጤና መኮንን መ/ ሶሽዮሎጂስት ሠ/ ሳይኮሎጂስት ረ/ ሌላ ከሆነ ይግለጹ _____
4. የትምህርት ደረጃ ሀ/ ከ1ኛ-8ኛ ክፍል ለ/ ከ9-12 ያጠናቀቀ _____
ሐ/ ስርተፍኬት መ/ ዲፕሎማ ሠ/ ዲግሪና ከዚያ በላይ _____

5. በካውንስሊንግ ሥራ ላይ ያለዎት አጠቃላይ ልምድ ሀ/ ከ1 ዓመት በታች ለ/ አንድ ዓመት ሐ/ ሁለት ዓመት መ/ ከሁለት ዓመት በላይ ከሆነ ዓመቱን ይጻፉ _____
6. በፈቃደኝነት ላይ በተመሰረተ የምክርና የምርመራ አገልግሎት ላይ ያለዎት አጠቃላይ የካውንስሊንግ አገልግሎት ልምድ ሀ/ ከ1 ዓመት በታች ለ/ አንድ ዓመት ሐ/ ሁለት ዓመት መ/ ከሁለት ዓመት በላይ ከሆነ ዓመቱን ይጻፉ _____
7. በሳምንት ለምን ያህል ቀን የካውንስሊንግ ሥራ ይሰራሉ? ሀ/ ሁለት ቀን ለ/ ሶስት ቀን ሐ/ አራት ቀን መ/ አምስት ቀን ሠ/ ስድስት ቀን ረ/ ሰባት ቀን
8. በቀን ለምን ያህል ሰዓት የካውንስሊንግ ሥራ ይሰራሉ? ሀ/ አራት ሰዓት ለ/ ስድስት ሰዓት ሐ/ ስምንት ሰዓት መ/ ከተጠቀሰው ውጭ ከሆነ ሰዓቱን ይጻፉ _____
9. በቀን በአማካይ ከምን ያህል ተጠቃሚዎች ጋር ይመንከራሉ? ሀ/ አምስትና ከዚያ በታች ለ/ ከ6-10 ሐ/ ከ11- 15 መ/ ከ16 - 20 ሠ/ ከ20 በላይ ከሆነ ቁጥሩን ይጻፉ _____

ክፍል ሁለት:- የስልጠና፣ የድጋፍና ሱፐርቪዥንን በተመለከተ የቀረቡ ጥያቄዎች

መመሪያ:- ከዚህ በታች በተንቀሳቃሽ በፍቃደኝነት ላይ የተመሰረተ የምክርና የምርመራ አገልግሎት መስጫ ለሚሰሩ ካውንስለሮች የሚሰጠውን የስልጠና ድጋፍና ክትትልን በተመለከተ ጥያቄዎች ተዘርዝረዋል። ጥያቄዎችን ካነበቡ በኋላ ምርጫዎን በማክበብ የሚሞሉትን በክፍት ቦታው በመሙላት ይመልሱ።

1. የኤች.አይ.ቪ.ኤድስ ካውንስሊንግ ስልጠና ሰልጥነዋል? ሀ/ አዎ ለ/ አልሰለጠንሁም
2. ለጥያቄ ቁጥር.1 መልስዎ አዎ ሰልጥኛለሁ ከሆነ ለምን ያህል ቀን/ወር /ዓመት እንደሰለጠኑ ይጻፉ? -----
3. የኤች.አይ.ቪ.ኤድስ ካውንስሊንግ ስልጠናውን እንዴት ይገመግሙታል? ሀ/ በጣም ጥሩ ለ/ ጥሩ ሐ/ ደህና ነው
4. ተጨማሪ ስልጠና የሚያስፈልገው አካባቢ አለ ይላሉ? ሀ/ አለ ለ/ የለም
5. ለጥያቄ ቁጥር.4 መልስዎ አዎ ከሆነ በምን ዙሪያ ተጨማሪ ስልጠና እንደሚያስፈልግ ይዘርዝሩ? -----

6. የምክር አገልግሎት ድጋፍ ሰጭዎች ቡድን ሥራን ተከታትለዋል? ሀ/አዎ ለ/ የለም

7. የምክር አገልግሎት ድጋፍ ሰጭዎች ቡድን ሥራን እንዴት ይገመገሙታል? ሀ/በጣም ጥሩ ለ/ ጥሩ ሐ/ ደህና ነው
8. ለምክር አገልግሎቱ ድጋፍ የሚሰጥና የሚቆጣጠር የምክር አገልግሎት ሱፐርቫይዘር አለ? ሀ/ አዎ ለ/ የለም
9. ለምክር አገልግሎቱ ድጋፍ የሚሰጥና የሚቆጣጠር የምክር አገልግሎት ሱፐርቫይዘር፥ን ሥራ እንዴት ይገመገሙታል? ሀ/በጣም ጥሩ ለ/ ጥሩ ሐ/ ደህና ነው
10. ኤች.አይ.ቪ. ኤድስ በደማቸው ለሚገኝ ተጠቃሚዎች የድጋፍና እንክብካቤ አገልግሎት እንዲያገኙ ለማድረግ የሚያስችል ሁኔታ አለ? ሀ/አዎ ለ/ የለም
11. ለጥያቄ ቁጥር 10 መልስዎ አዎ ከሆነ የሚሰጡትን የድጋፍና እንክብካቤ አይነቶች ይዘርዝሩ -

ክፍል ሦስት፡- ስለምክር አገልግሎት ያለዎትን አመለካከት በተመለከተ

መመሪያ፡-

በተንቀሳቃሽ በፍቃደኝነት ላይ የተመሰረተ የምክር አገልግሎት ላይ ያለዎትን አመለካከት በተመለከተ አስተያየቶች ተዘርዝረዋል በአስተያየቶች አንፃር የእርስዎን አመለካከት ከተሰጡት ምረጫዎች መካከል በመምረጥ በዚህ ምልክት(✓) ያሳዩ። ምርጫዎችም 5 = በጣም እስማማለሁ፣ 4 = እስማማለሁ፣ 3= እርግጠኛ አይደለሁም፣ 2= አልስማማም፣ 1= በጣም አልስማማም ።

ተ.ቁ.	አመለካከቶች	ምላሾች				
		5	4	3	2	1
1	በማማከር ሥራዬ ተገልጋዮች በጎ አስተያየት እንዳላቸው ይሰማኛል።					
2	በማማከር ሥራዬ ጓደኞቼና አስተዳደሩ በጎ አስተያየት እንዳላቸው ይሰማኛል።					
3	በማማከር ሥራዬ ስሜቴ እንደደከመ ይሰማኛል።					
4	ሥራዬ በጣም አስጨናቂ ነው።					
5	የሥራዬ አካባቢ በጣም አስጨናቂ ነው።					
6	ከሥራዬ በየቀኑ የተወሰነ ነገር እማራለሁ።					
7	በሥራዬ እንደተገለልሁ ይሰማኛል።					
8	ከተገልጋዮች ጋር የመግባባት ችግር አለብኝ።					
9	ሥራዬ በጣም አበረታች ነው።					
10	ተገልጋዮቼን መርዳት እንደምችል ይሰማኛል።					
11	በማማከር ሥራዬ ለወደፊትም እቀጥላለሁ።					
12	ሌላ ሥራ ለመቀየር እፈልጋለሁ።					
13	ስለምክር አገልግሎት ባጠቃላይ ጥሩ አመለካከት አለኝ።					

ክፍል አራት፡- ችግሮች/እጥረቶችን በተመለከተ

መመሪያ፡- በተንቀሳቃሽ በፈቃደኛነት የተመሰረተ የምክርና ምርመራ አገልግሎት መስጫዎች ዙሪያ ሊኖሩ የሚችሉ ችግሮችን በሚመለከት ለተዘረዘሩት ጥያቄዎች አማራጮችን በማክበብ፣ የሚዘረዝሩትን በመዘርዘር ምላሽዎን ይስጡ።

1. የሥራ ጫና አለ? ሀ. አዎ ለ) የለም
2. ተከታታይ የስራ ላይ ስልጠና እጥረት አለ? ሀ/ አለ ለ) የለም
3. የሰነ-ልቦና ድጋፍ እጥረት አለ? ሀ) አዎ ለ)የለም
4. የቴክኒክ ድጋፍ እጥረት አለ? ሀ/አዎ ለ/ የለም
5. አስተዳደራዊ ድጋፍ እጥረት አለ? ሀ) አዎ ለ) የለም
6. የሱፐርቪዥን ድጋፍ እጥረት አለ? ሀ) አዎ ለ) የለም
7. የስታፉ ሰራተኞች ወደ ሌላ የሥራ ዘርፍ የመሄድ ችግር አለ? ሀ/አዎ ለ/ የለም
8. የሰራተኞች ሥራ የመልቀቅ ችግር አለ? ሀ/አዎ ለ/ የለም
9. ተገልጋዮች ነፃነት እንዳይሰማቸው የሚያደርግ ችግር አለ? ሀ/ አዎ ለ/ የለም
10. ተገልጋዮች ኮንፌደንሻሊቲ እንዳይሰማቸው የሚያደርግ ችግር አለ? ሀ/ አዎ ለ/የለም
11. ለተገልጋዮች የመቆያ ቦታ ችግር አለ? ሀ/ አዎ ለ/ የለም
12. ሌሎች ችግሮች ካሉ ይዘርዝሩ?

13. በእርስዎ አስተያየት የተንቀሳቃሽ በፈቃደኛነት ላይ የተመሰረተ የምክርና ምርመራ አገልግሎት መስጫዎች ዋና ዋና ችግሮች የሚሏቸውን በቅደም ተከተል ይዘርዝሩ?

14. በካውንስለር ሥራዎ ያጋጠመዎትን ዋና ዋና ችግሮች ይዘርዝሩ?

15. የተንቀሳቃሽ በፈቃደኛነት ላይ የተመሰረተ የምክርና ምርመራ አገልግሎትን ለማሻሻል ይረዳሉ የሚሏቸውን ዋና ዋና ጉዳዮች ይዘርዝሩ?

16. የተንቀሳቃሽ በፈቃደኛነት ላይ የተመሰረተ የምክርና ምርመራ አገልግሎትን በተመለከተ አስተያየት ካለዎት ይዘርዝሩ?

**APPENDIX C: COORDINATORS AND SUPERVISOR INTERVIEW
GUIDE /ENGLISH AND AMHARIC/**

1. Age _____
2. Sex Male Female
3. Educational Status Diploma, Degree, Master, other _____
4. What is your field of specialization _____
5. What was your profession before you become a mobile VCT coordinator /supervisor?
6. How many years of service do you have in the mobile VCT center?
7. What is the structure of the mobile VCT?
8. What are the major activities you perform in the mobile VCT?
9. What are the general activities/ practices performed in the mobile VCT?
10. What are strategies used for information provision to the community about the service?
11. What referral linkages and follow up mechanisms are used?
12. What are the major problems encounters in order to provide quality Mobile VCT service?
13. What should be done in order to provide quality Mobile VCT service?

የቃለ መጠይቅ የመነሻ ሀሳቦች

ለተንቀሳቃሽ የምክርና የምርመራ አገልግሎት አስተባባሪዎችና ሱፐርቫይዘሮች የቀረበ ቃለ መጠይቅ የመነሻ ሀሳብ።

1. እድሜ -----
2. የታ ወንድ ሴት
3. የትምርት ደረጃ ዲፕሎማ / ዲግሪ / ማስተርስ/ ሌላ?
4. ያጠነ-ት የሙያ አይነት? -----
5. የተንቀሳቃሽ የምክርና የምርመራ አገልግሎት አስተባባሪ/ ሱፐርቫይዘር ከመሆንዎ በፊት የነበረዎት ሙያ? -----
6. በተንቀሳቃሽ የምክርና የምርመራ አገልግሎት መስጫ ምን ያህል የአገልግሎት ዘመን አለዎት? -----
7. የተንቀሳቃሽ የምክርና የምርመራ አገልግሎቱ ስትራቴጂ ምን ይመስላል? -----
8. በተንቀሳቃሽ የምክርና የምርመራ አገልግሎት መስጫው እርስዎ የሚያከናውኗቸው ዋና ዋና ተግባራት ምን ምን ናቸው?-----
9. የተንቀሳቃሽ የምክርና የምርመራ አገልግሎት አጠቃላይ አንቅስቃሴ/ፕራክቲስ ምንድነው? -----
10. ስለተንቀሳቃሽ የምክርና የምርመራ አገልግሎቱ ለማህበረሰቡ መረጃ ለማድረስ የምትጠቀሙበት ስልት ምንድነው? -----
11. ያሉ ሪፈራል ሊንኬጅ ዓይነቶች እና የክትትል ስልታቸው ምንድነው? -----
12. ጥራት ያለው የተንቀሳቃሽ የምክርና የምርመራ አገልግሎት ለመስጠት ያጋጠማችሁ ችግሮች ካሉ ችግሮች ምንድን ናቸው? -----
13. ጥራቱን የጠበቀ የተንቀሳቃሽ የምክርና የምርመራ አገልግሎት ለመስጠት ምን መደረግ አለበት ይላሉ? -----

APPENDIX D: OBSERVATION CHECK LIST

No.	Criteria	Yes	No	Remark
1	Is there sufficient counseling room			
2	Is there conducive waiting room			
3	Is there necessary office equipment			
	Chair			
	Table			
	Telephone			
4	Other details			
	Client registration			
	Pre- test counseling			
	Post test counseling			
	Follow up counseling			
	Referral linkage			
5	Data collection tools			
	Client in take book			
	Ct log book			
	Ct data : monthly reporting form			
6	Reports and documents			
7	Others			

APPENDIX E:



የአዲስ አበባ ከተማ አስተዳደር ሥነ ጤና ቢሮ
The Addis Ababa City Administration
Health Bureau

ቁጥር 2/2/ሠ/3190/227
ቀን 20/5/2008

በአዲስ አበባ ከተማ ሥር ለሚገኙ ተንቀሳቃሽ የኤች አይቪ ኤድስ የምክር አገልግሎት መስጫዎች አዲስ አበባ

ጉዳይ: የጥናት ትብብርን ስለመጠየቅ

በአዲስ አበባ ዩኒቨርስቲ ለሁለተኛ ዲግሪ በመመማር ላይ ያሉት አያሌው አቸንፍ "Assessment of Mobile voluntary counseling and testing (VCT) counseling service in Addis Ababa" በሚል ርእስ ያቀረቡት የጥናት ሰነድ ለቢሮው ኢትካል ኮሚቴ ቀርቦ የታየና የፀደቀ መሆኑን እያሳወቅን አመልካቹ ጥናታቸውን በአግባቡ ማከናወን እንዲችሉ አስፈላጊውን መረጃ በመስጠት ተገቢው ትብብር እንዲደረግላቸው እንጠይቃለን።

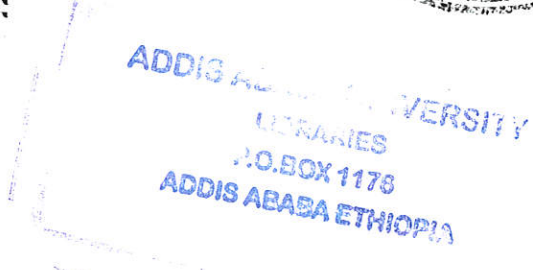
ከሠላምታ ጋር



Sehat
ሰ/ር ሰብሐወርቅ ታደሰ
ኢትካል ኮሚቴ ሰብላቢ

ግልጻጭ

- ለአቶ አያሌው አቸንፍ
- ለኢትካል ኮሚቴ
- አዲስ አበባ



ADDIS ABABA CITY ADMINISTRATION HEALTHBUREAU

ETHICAL REVIEW COMMITTEE

ETHICAL REVIEW FORM

Tel: 251 1 513911

P.O.Box 30738

Addis Ababa

CRITERIA/ITEM	RATING
1. consent form <ul style="list-style-type: none"> Does the consent contain all the necessary information that the subject should be aware of? 	<input checked="" type="checkbox"/> Yes -----Requires revision -----No -----Not applicable -----Not attached
2. Are the objectives of the study clearly stated?	<input checked="" type="checkbox"/> Yes -----No
3. Are provisions to overcome risks well described and accepted? <ul style="list-style-type: none"> Justice Beneficence Respect for a person 	-----Yes -----Not well described -----No <input checked="" type="checkbox"/> Not applicable
4. Are the safety procedures in the use of vaccines, drugs and other biological products acceptable?	-----Yes -----No <input checked="" type="checkbox"/> Not applicable
5. Are the procedures to keep confidentiality well described?	<input checked="" type="checkbox"/> Yes -----No -----Not applicable
6. Are the proposed researchers competent to carry out the study in a scientifically sound way?	<input checked="" type="checkbox"/> Yes -----No -----Not applicable -----Unable to assess
7. Does it have material transfer agreement?	-----Yes -----No <input checked="" type="checkbox"/> Not applicable
Recommendation	<input checked="" type="checkbox"/> Approved -----Approved on condition-----Not approved
Remarks	Approved with comment Add voluntary participants

Ethical Clearance Committee Members:

Name

1. Sr Seblework Tadesse
2. Sr Martha Wolde
3. Dr. Addis Akalu

Signature

