HIV/AIDS COUNSELLING AND TESTING

GUIDELINES FOR MALAWI

SECOND EDITION

MINISTRY OF HEALTH

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FOREWORD

Malawi, just like other countries in Sub-Saharan Africa has been seriously affected by HIV/AIDS. The epidemic has affected every sector of the society to such an extent that is has been declared by the President of the Republic as "the single greatest challenge facing this nation today". Over the past ten years, the country has moved from a point of denial to a situation where there is almost universal awareness of HIV/AIDS. However, despite the country's success in raising awareness, behavioural change continues to lag behind as seen by the continued spread of the virus.

Prevention of new HIV infections remains the most important way of reducing the burden of HIV/AIDS. A key factor in prevention strategy is HIV/AIDS Counselling and Testing (CT). CT has also been recognised as an entry point to care and support as well as being an essential tool for behaviour change for people who test both HIV positive and HIV negative, hence contributing toward reduction of stigma.

CT has been integrated as one of the priority components of the National HIV/AIDS Strategic Framework for Malawi (2000-2004), in the National HIV/AIDS Policy (2004), and in the Health Sector HIV/AIDS Strategy (2003 – 2006). The aim is to offer high quality, gender equitable and youth-friendly psychosocial support to clients in order to assist them access care and affect behaviour change.

As Malawi scales-up CT service delivery, the MOH recognises the importance of guidelines to ensure standardisation of the services in terms of delivery approaches and quality standards. This guidelines document is a result of a wide consultative process with various stakeholders (policy makers, planners, counsellors, laboratory experts, physicians, social workers, NGOs, CBOs, PLWHAs etc) in the health sector and beyond.

The guidelines describe and define basic minimum requirements for establishing, providing and monitoring CT services in Malawi. They are intended to assist health managers and providers in developing and expanding CT for people at risk of HIV infection as well as those requiring treatment, care and support.

This document replaces the previous "Counselling Guidelines and Policies, AIDS Control Programme, Ministry of Health, Malawi, 1992". It is for use by all health service managers and providers and those who intend to provide CT services whether in integrated or stand-alone sites. This document should serve as the Ministry's policy instrument in guiding establishment, provision and scale-up of CT services in Malawi.

These Guidelines will be periodically reviewed based on stakeholder and provider observations and feedback, international experience and guidance and scientific/research development on intervention and delivery approaches.

Counselling and Testing remains the most potent weapon in tearing down the walls of silence and in removing stigma. I urge all health workers to constantly and vigorously promote it.

Dr. R.B. Pendame

SECRETARY FOR HEALTH

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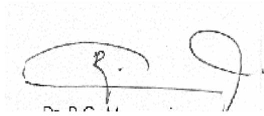
Furthermore, the Ministry wishes to thank all members of the CT Sub-group for their input in improving this document. Finally, the Ministry wishes to thank all officials and staff members of the Ministry for their contribution towards the development process and for editing and finalising this document.

Last but not least, the Ministry wishes to acknowledge all constructive contributions from various stakeholders not specifically mentioned above.



Dr. R.G Mpazanje

DIRECTOR OF CLINICAL SERVICES

LIST OF ACRONYMS

AIDS	Acquired Immune-deficiency Syndrome
ANC	Antenatal Clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral (drugs)
CBC	Community-based CT Counsellor
CBOs	Community Based Organizations
CDC	Centre for Disease Control
CHBC	Community Home Based Care
CMS	Central Medical Stores
CHSU	Community Health Science Unit
DAC	District AIDS Coordinator
DACC	District AIDS Coordinating Committee
DCT	Diagnostic Counselling and Testing
DHMT	District Health Management Team
EIA	Enzyme Immuno Assay
FHI	Family Health International
HIV	Human Immuno-deficiency Virus

HMIS	Health Management Information Systems
M&E	Monitoring and Evaluation
MIS	Management Information Systems
MOH	Ministry of Health
NAC	National AIDS Commission
NORAD	Norwegian Aid for International Development
OI	Opportunistic Infection
PLWHAs	People living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infection
TB	Tuberculosis
TWG	Technical Working Group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
CT	HIV/AIDS Counselling and Testing
DCT	Diagnostic Counselling and Testing
RCT	Routine Counselling and Testing

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Chapter 1

Introduction

1. INTRODUCTION

1.1. HIV/AIDS SITUATION

At the end of 2002, an estimated 42 million people globally were living with HIV, most of whom did not know they carry the virus, while those not yet infected knew nothing or too little about HIV to protect themselves. While about one third of those currently living with HIV/AIDS are aged 15-24, young women continue to be more vulnerable to HIV than their male counterparts1.

Sub-Saharan Africa is the most affected by HIV/AIDS. The region has less than 10 percent of the world's population, yet is home to almost 70 percent of the people living with HIV/AIDS. The Government of Malawi acknowledges that the impact of HIV/AIDS is severe in Malawi with16 percent of the population between 15 and 49 years of age being HIV positive. The cumulative number of orphans since the beginning of the epidemic is approximately 400,000 while over 60,000 might be added to this pool annually as the number of AIDS deaths increases during the current decade and beyond.

CT provides important information about a person's sero-status and encourages reduction of risk behaviour while at the time assisting with linkages to medical care. Currently, it is estimated that there are more than nine million people in Malawi who are not HIV infected. CT aims to assist them to reduce risk behaviour.

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[1] UNAIDS AIDS epidemic update Dec 2002

Although many of them (the 9 million) are at risk of exposure to and infection with HIV, there is good evidence that people will change their behaviour when provided with proper information through counselling services, motivation and support.

The Ministry of Health hence recognises CT as an essential part of the nation's response to the HIV/AIDS crisis and is, therefore committed to the implementation of quality CT services nation-wide.

1.2. DEFINITION OF HIV/AIDS COUNSELLING AND TESTING (CT)

HIV/AIDS Counselling and Testing (CT) is the process through which an individual is confidentially counselled and tested for HIV. CT encompasses encouragement counselling for testing, behaviour change counselling, on-going supportive counselling for those who already know their HIV status and care counselling for those requiring or attending treatment, care and support.

In Malawi, there are three models of CT approved by the Ministry of Health namely; Voluntary Counselling and Testing (VCT), Routine Counselling and Testing (RCT) and Diagnostic Counselling and Testing (DCT). Other forms of HIV testing such as life insurance eligibility, pre-employment screening, eligibility for pre-education scholarship, and legal purposes are not included in CT.

1.3. VOLUNTARY COUNSELLING AND TESTING (VCT)

Voluntary Counselling and Testing is one model of CT where the individual to be counselled and tested voluntarily seeks to know his/her HIV status and without coercion or proxy proceeds to receive confidential counselling and testing for HIV.

VCT involves pre-test counselling to prepare and encourage the client for testing; HIV testing to determine the client's serostatus; and post-test counselling to tell the client of his/her serostatus as well as helping the client make future lifestyle plans. Consent is always sought for testing while pre-test and post-test counselling are mandatory to all who choose to be tested. VCT being voluntary, clients can decide not to be tested if not ready even after being pre-test counselled, or not to know their result even after being tested.

In VCT, pre-test counselling focuses on information giving on HIV infection, implication of a positive or negative result, risk assessment and obtaining consent for testing. Post-test counselling on the other hand reinforces behaviour change, provides support and discusses appropriate referrals. There may also be supportive counselling focused on some clients who may come to VCT for information on HIV/AIDS or for ongoing counselling support.

In Malawi, VCT services should be offered to both individuals and couples voluntarily seeking to be tested for HIV. Shared confidentiality through partner disclosure and couple counselling is

encouraged in order to promote partner protection and encourage mutual support.

1.4. ROUTINE COUNSELLING AND TESTING (RCT)

Routine Counselling and Testing is a model of CT where the individual is counselled and tested routinely, and in this case HIV counselling and testing is considered to be one of the routine interventions of the service being provided. RCT is most suited to the delivery specific preventive health interventions, such as HIV testing for the prevention of mother-to-child transmission and for the management of sexually transmitted infections.

In PMTCT, RCT follows public health principles in making HIV testing a routine component of obstetric practice, including rapid HIV testing during labour for women whose HIV status is unknown, so that all HIV-exposed infants can be offered preventive ARV therapy. In this approach, the emphasis is on providing standard information about HIV testing, offering it to all pregnant women unless they actively refuse and emphasize post-test counselling for those who are HIV-positive.

In patients with STIs, RCT ensures that HIV infection being an STI infection is managed alongside other STIs in order to prevent its further transmission. Routine HIV testing of patients with STI, with provision of prevention services and medical referral, provides an opportunity for high-risk individuals to adopt risk reduction behaviours and benefit from follow-up medical care, if necessary.

In RCT, standard information about HIV testing is routinely provided as part of a health talk or group counselling session with emphasis being made that HIV testing is part and parcel of the services provided unless, the client actively opts out. After testing, post-test counselling is routinely provided alongside other services for those who test positive.

1.5. DIAGNOSTIC COUNSELLING AND TESTING (DCT)

Diagnostic Counselling and Testing is a model of CT where the individual is tested for HIV as part of a diagnostic workup. This approach is used in such situations where HIV serostatus has a bearing on the treatment being provided or to be provided for the diagnosed condition.

Routine diagnostic HIV testing is, in this case, considered a standard medical care practice. In line with these guidelines, DCT should only be used for general medical patients with WHO Stage III or IV HIV/AIDS related medical conditions or opportunistic infections who are being considered for ARV treatment or being considered for other medical interventions that are solely for HIV positive clients.

DCT should, therefore, be offered to all patients who present with serious HIV/AIDS related conditions such as TB, Kaposi's sarcoma, cryptococcal meningitis, etc. who are potential candidates for ART. All patients offered DCT will have an option to opt-out by not consenting for the test as standard policy and those who test

positive will be provided with post-test counselling and medical/ prevention support.

For patients on the ward, arrangements will be made for a counsellor to post-test counsel those patients with a positive result and referred by a clinician or nurse for counselling. Post-test counselling can be done in single bed wards or using nearby counselling or treatment rooms in order to maintain patient confidentiality.

DCT should not be used for reasons other than direct patient management. Clinicians, nurses and all other health workers are encouraged to use universal precautions to protect themselves.

1.6. THE GOAL OF CT

The goal of CT is twofold. First, CT facilitates behaviour change, hence, preventing acquisition and transmission of HIV. Second, CT serves as an entry point to HIV/AIDS care and supportive services.

1.7. RATIONALE FOR CT GUIDELINES

The rationale for formulating these guidelines is:

- Standardisation of CT services nationwide
- Provision of nationwide monitoring and evaluation systems and tools
- Provision of guidance on program operations

- Standardisation capacity requirements for the implementation of CT services
- Regulation of CT services and provide for its accreditation system
- Regulation of HIV testing approaches and technology for HIV sero-diagnosis
- Protection of the human rights of people seeking CT services
- Setting down a code of ethics for counselling as related to CT

Chapter 2

Guiding Principles

2. GUIDING PRINCIPLES FOR CT SERVICES IN MALAWI

2.1. CT SERVICE DELIVERY MODELS

Currently there exist two basic CT service delivery models in Malawi: stand-alone sites (also termed 'free standing') and integrated sites. 'Stand-alone' refers to sites located outside of a health facility and not directly linked to other health services, while 'integrated' refers to sites incorporated into health facilities with the CT service being directly linked to the health services delivered by the facility. Providers of either model may offer outreach services to encourage clients to come for CT or to bring testing and counselling services closer to potential clients who have no access to CT.

2.2. COMMITMENT TO PROTECTION OF CLIENTS' HUMAN RIGHTS

Providers of CT services will be required to subscribe to an ethical code of conduct consistent with principles of human rights as outlined in the *Malawi Constitution* and the *Universal Declaration of Human Rights and Professional Ethics*. These principles include: the right to privacy, the right to non-discrimination, equal protection and equality before the law, the right to establish a family, the right to the highest attainable standard of physical and mental health, and the right to informed consent before a medical procedure. Every effort should be made to deliver CT services in

such a way as to reduce stigma, to guarantee and to protect clients' privacy and confidentiality.

2.3. COMMITMENT TO CODE OF ETHICS AND PRACTICE

The CT counsellor's role is to work with the client in ways that respect client's values, personal resources and capacity for self-determination. CT counsellors should uphold the basic values of integrity, impartiality and respect. They should apply the principles of autonomy, beneficence, avoidance of harm, taking into account specific situations within the legal and cultural context of Malawi.

2.4. VOLUNTARY TESTING

The acceptance of HIV testing should be voluntary and free of coercion. Advocacy for CT through Information Education and Communication (IEC) should encourage but not force people to accept HIV testing. Full CT services can be offered after the counsellor's assessment of client's willingness and readiness.

Examples of inappropriate use of CT services include: life insurance eligibility, pre-employment screening, eligibility for a pre-education scholarship and legal purposes. Such clients should be informed that CT is voluntary and does not normally provide written results. Clients attending CT sites for mandatory, PMTCT or diagnostic testing should be counselled and tested and given a written result in line with the provision specifically made in this manual for such type of testing.

2.5. INFORMED CONSENT

Clients must be given the opportunity to understand that they are being tasted for HIV so that they can provide informed consent. Client consent cannot be implied or presumed. It should be obtained before blood is drawn for testing.

The client can provide consent in writing on a purposely-designed form where possible. Consent can also be given orally with no need for signature indicating the name of the client. Where consent is provided orally, documentation of the informed consent should be undertaken using the informed consent form.

2.6. ANONYMOUS TESTING

CT should be done anonymously without a client's name or information being linked to HIV status, service or medical records. The request for HIV testing and test results are provided using unique identifiers (code numbers) rather than client names. This form of identification adds to clients' confidence in and acceptance of the services. No written result should be provided to clients after testing, except where CT service is being used as an entry point for other medical services provided for in the guidelines document.

2.7. CLIENT CONFIDENTIALITY

CT services should adhere to the ethical principles of confidentiality governing clinical care that protect and promote the privacy of clients. Personal information obtained in the CT setting regarding a client's use of CT services, medical condition or HIV

status should not be divulged in ways inconsistent with client's original consent. Although CT services are anonymous in principle, when CT services are an entry point for other medical services, such as PMTCT, TB treatment and prevention, prevention and treatment of other opportunistic infections or sexually transmitted diseases clients' names and results might be recorded on the specific referral form. This should only be done with the knowledge of the client.

2.8. RELATED SERVICES

Because co-infections are commonly encountered with HIV in clinical practice, CT providers are encouraged to ensure that clients have access to screening for sexually transmitted infections, blood-borne infections, assessment for tuberculosis or other co-infections. Where these services are not available on-site, providers should have established relationships with programs that would offer these services to clients. Clients should be given the right to consent to the related testing.

2.9. MINIMUM AGE FOR CT

Any person aged 16 years and above requesting CT should be considered mature enough to give full and informed consent. Youth between 12 and 16 who are married, pregnant or engaged in behaviour that puts them at risk or are sex workers are regarded as mature minors and should be considered eligible to give consent for CT. The counsellor should make an assessment of their

readiness for CT. HIV testing for youth below 12 years of age should be done with the knowledge and consent of their parents or guardians unless this is impossible and the testing is for care services provision purposes.

2.10. PERSONS OF UNSOUND MIND

Persons under the influence of alcohol or illegal drugs and persons whose mental judgement is temporarily impaired can be offered counselling but not testing due to the fact that they cannot give informed consent. They should, therefore, be encouraged to return for CT when they are no longer mentally impaired if the testing is not for care purposes. Persons whose mental judgement is impaired due to mental illness can be offered testing with the knowledge and consent of their parents or guardians only where the test result serves as an entry point for other medical services, or where he/she rapes someone or has been raped and the testing is necessary for determining need for pos-exposure prophylaxis.

2.11. YOUTH-FRIENDLY CT

Young people between the ages of 12 to 24 are especially vulnerable to HIV. They often lack information regarding their sexual and reproductive health. In addition, they experience physical and psychosocial changes at the time of their first exploration of sexual activity.

It is recommended that CT services be relevant, accessible, attractive, appropriate and acceptable to young people. Both the

site and the staff should be youth friendly, understanding, non-judgemental and comfortable with adolescent language, dress and behaviour and respectful of the feelings and emotional turmoil that adolescents commonly experience.

2.12. Gender equity and CT

Women and men have equal rights to information regarding their lives and have equal responsibility towards prevention of further transmission and infection of HIV. Several gender-related factors put women at greater risk of HIV infection than men and also make it less likely for women to access information and seek or access CT services in Malawi. Service providers should ensure that gender based violence, sex disaggregated data and post rape services are offered alongside with CT services.

2.13. Cost of CT services

CT services are part of the Essential Health Package (EHP) that the Ministry of Health will implement with its partners. Therefore, CT should be provided free of charge in all publicly funded health facilities. For non-governmental and private sector sites operating on a cost-recovery basis, fees can be charged but there is a need to ensure that the fees are affordable and do not constitute a barrier to accessibility of services and that a system of waivers is provided for clients unable to pay.

2.14. Responsiveness to community needs and culture

Providers of CT services should ensure the delivery of services that are responsive to client and local community needs, priorities, education and culture. Therefore, CT sites should be readily accessible to target populations needing or desiring CT. Media campaigns and local community mobilisation should take into consideration the specific needs of the Communities. Effective community mobilisation on CT is a prime responsibility of every service provider.

2.15. Community networks for care and supportive services

People living with HIV/AIDS have multiple needs that may not be adequately addressed by a CT facility. Providers of CT services should actively work to establish effective and confidential, referral protocols that assist clients link to and from needed services. Such support services include social, psychological, spiritual, health care and other support services.

2.16. Quality services

The provision of quality services is critical to Community confidence in CT. Effective support counselling, supervisory structures, quality assurance, well-trained and motivated staff, monitoring and evaluation are fundamental provider responsibilities that ensure appropriate and professional care to clients. Organisations offering CT services should adhere to

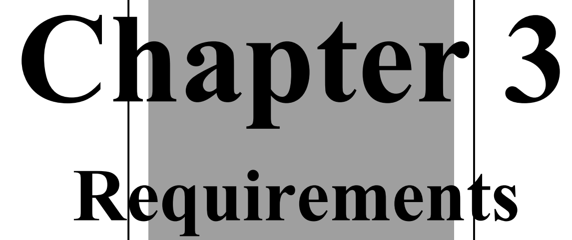
standardised programs, protocols/tools and procedures consistent with this CT Policies and Guidelines Manual.

Service providers should monitor and evaluate the performance and competency of CT personnel and the counselling services provided to ensure consistency, inter-agency linkages for client referral to medical care and other important services. Client and staff satisfaction should be gauged trough a variety of methods including client exit interviews.

Laboratory HIV testing procedures and quality control of HIV test kits should be done through existing district and national structures (see section 4.6).

2.17. INFECTION PREVENTION

All CT staff should at all times observe infection prevention measures according to guidelines for infection control and prevention standards set by the MOH. Protective equipment, especially gloves, must always be in stock, and utilized. Counselling rooms must be well ventilated. It is desirable that CT staff be offered Hepatitis B immunization. It is also desirable to offer anti-retroviral (ARVs) to HIV negative staff should accidental occupational exposure occur in line with the MOH care for carer guidelines and ARV guidelines.



Chapter 3

Requirements

3. REQUIREMENTS FOR CT SERVICES

3.1. AUTHORIZATION

The Ministry of Health and/or the Medical Council of Malawi or its authorised agent in accordance with the laid out principles in this manual and any supporting documents must officially register organizations offering CT services. The Ministry, in collaboration with the Council will put in place an accreditation process and assessment tools (see annexe 1 and 2) for fulfilling this requirement. MOH or any of its delegated partners will carry out an inspection and determine whether the prospective CT provider site meets the required standards.

3.2. LOCATION OF CT SERVICES

The District Health Officer has the responsibility to inspect potential CT providers and sites before approving and recommending locations for authorization by MOH. Locations should be selected considering factors such as: population density, high transmission areas, easy geographical access, distance from other services, potential for linkages to a network of providers for essential care and support services, inexistence of any other site in the immediate catchment area of 10,000 people in urban areas, and an 8 kilometres radius in the rural areas. In special circumstances, for the specific purpose of a project and where there is adequate infrastructure and demand, several sites within the catchment area may be authorised and registered.

3.3. REQUIRED FACILITIES AND INFRASTRUCTURE

Organizations planning to offer CT services must ensure adequate infrastructure and offer services in an environment that guarantees privacy, confidentiality, and reasonable comfort. ***A minimum package includes:***

- Reception and waiting area
- Minimum of two counsellors per site (1 counsellor for 8 clients per day)
- Minimum of one counselling room that ensures privacy (with a desk and three chairs and an adequate lab area, if testing is done in the room)
- Testing space in the counselling room if testing is done by the counsellor
- Laboratory room (if testing is done by a different person other than the counsellor)
- Lockable file system or lockable drawers
- Secure storage facilities for reagents and consumables
- Ability to appropriately dispose of infectious waste including sharps disposal

In sites where CT Counsellors provide testing, the counselling room should have adequate space, facilities including sharps disposal container, and other appropriate infection control

equipment as outlined in chapter six of the *Handbook for Clinician and Nurses*.

3.4. CT EQUIPMENT AND SUPPLIES

Equipment and supplies necessary to operate CT services could include:

- Laboratory supplies as described in Chapter 5
- Other consumable office supplies
- Male and female condoms, condom demonstration model
- Standardised data collection registers, forms, monitoring and evaluation tools, emergency tray and first aid kits

Other/additional resources could include computer, radio, and fire extinguisher, video or cassette player, television, telephone and fax machine, transport, and flip charts. An inventory and ordering system should be in place to ensure ongoing supplies.

3.5. IEC MATERIALS

It is recommended that all CT sites provide IEC materials in different and cost effective channels including stigma-free messages on following aspects:

- The services offered by the site
- HIV/AIDS related conditions preventive therapies

- Family planning, STD and other reproductive health
- Condoms and condom use
- Positive living
- Updated list of medical care and support services including community based counsellors and post-test clubs available in the community.

3.6. HUMAN RESOURCES

Each CT site should have staff with the following minimum competencies: pre-test counselling, HIV testing using approved rapid test kits, post-test counselling, infection prevention & bio hazardous waste disposal, resuscitation including handling shock, care pathway counselling and data handling capacity. In addition to the above listed competencies, the site should also have access to staff with the following competencies: site supervision (on all aspects of the CT service offered on the site) and on-site HIV test validation.

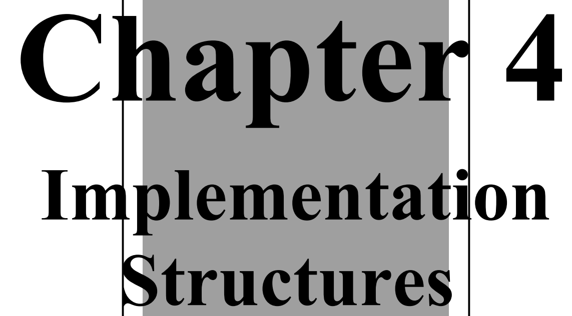
CT sites should ensure adequate staffing levels in accordance with the demand of the services and the resources available for effective service delivery. The emphasis should be on building a multidisciplinary and gender balanced team for CT services if possible. All staff serving in CT should receive adequate training specific to their work. Plans should be in place for ongoing capacity building to ensure staff receive ongoing training that will improve their skills and enhance both client and staff satisfaction.

CT sites should ensure that all CT counsellors attend regular support supervision

3.7. MANAGEMENT INFORMATION SYSTEMS (MIS)

Core data collection at CT sites should be restricted to those required to measure the indicators specified in the Health Management Information System (HMIS) by MOH and CT sites will be required to adopt the standardised data collection tools for site registers, client data, and laboratory results as determined by the HMIS and the HIV/AIDS Clinical Unit of the MOH so that consistent, standardised data can be obtained at national, district and local levels.

Additional guidance related to data management, monitoring and evaluation is provided in Chapter 6 on Monitoring and Evaluation.



Chapter 4

Implementation Structures

4. CT POLICY MAKING AND SERVICE IMPLEMENTATION STRUCTURE

4.1. POLICY MAKING AND IMPLEMENTATION

4.1.1. National HIV policies and strategies

CT being a health service and an EHP intervention, its implementation will be within the context of the health sector's policies and strategies. Specifically, CT will be implemented within the context of the Health Sector Programme of Work (2003 – 2009) that encompasses both the Essential Health Package and the Strategy for the Health Sector Response to HIV/AIDS in Malawi, 2003 – 2006. The strategy also provides for coordination mechanisms for various health sector HIV/AIDS interventions, including CT at national and district levels.

4.2. SERVICE IMPLEMENTATION STRUCTURE

4.2.1. MOH HIV/AIDS Unit

The HIV/AIDS Unit in the Ministry has responsibility for the overall coordination of CT services in Malawi. This unit serves as the primary point of contact for all National CT related issues.

The HIV/AIDS Unit, HMIS Unit and SWAPs Secretariat will have prime responsibility for coordination of monitoring and evaluation activities, collecting and analysing data, writing and dissemination of reports. The three units will ensure among them adequate and updated information systems and service provider adherence to

standardised reporting systems, including maintenance of a reliable reference base for research and development on CT issues.

4.2.2. National Reference Laboratory

The National Reference Laboratory has the responsibility of coordinating all issues relating to quality assessment, quality assurance, evaluation and approval of new test kits in the country. Central Hospital Laboratories will assist with quality assurance and quality control of HIV testing at CT facilities within their respective catchment areas with authorisation from the National Reference Laboratory.

4.2.3. The District CT Coordination Arrangements

The District Health Officer is responsible for the overall coordination of the implementation of HIV/AIDS health sector interventions at district level. For CT, this would include selection, appraisal and supervision of CT sites, translation of national health policies and guidelines for the development and implementation of an overall district CT strategy within the context of the District Implementation Plan (DIP).

The DHO will serve as a member of the AIDS Coordinating Committee of the Local Government Assembly (DACC) and may appoint a CT Coordinator or Supervisor within the District Health Office to coordinate all CT activities in the district.

The CT Coordinator or whoever is responsible for coordinating CT activities in the district, in liaison with the District Health Management Team will:

- Ensure adequate equipment, supplies and personnel for CT services in the district
- Set up district capacity building programs in coordination with the Ministry headquarters.
- Develop and coordinate networks of providers and hold regular meetings
- Sort out CT district administrative issues in consultation with DHMT and the district CT Supervisors and CT site staff
- Compile and submit monthly and quarterly reports to the HMIS.

4.3. CT Implementing Staff

4.3.1. The District CT supervisor

The District CT Supervisor is responsible for overall supervision, monitoring and evaluation of all CT activities in the district, the compilation of regular reports and coordination of the development of provider networks facilitated by monthly provider meetings. The District CT supervisor must have a health background. Attributes include counselling, support, supervision skills, administrative and management skills, and interpersonal skills to effectively supervise

and support CT experienced staff. The holder of this position should have completed the nationally recognized training in CT Counselling, CT Counsellor Supervision and continuing education to effectively support client referral needs. District CT Supervisors should have a minimum of a year's experience providing CT counselling, and may be a practicing counsellor in their daily work. The District CT Supervisor reports to the District AIDS Coordinator if one exists or directly to the DHO (refer to CT supervisor's handbook).

4.3.2. The CT laboratory technician

The CT laboratory technician must have supervisory skills and should have completed a CT Whole Blood HIV Rapid Testing training course certified by MOH. This technician will assist the CT supervisor in ensuring availability of test kits and other supplies in the district for CT. He/She will also ensure availability of test kits and other supplies in the district for blood screening and laboratory HIV testing and quality assurance. Other responsibilities will include:

- Providing laboratory supervision
- Testing specimens for quality assurance and quality control purpose in coordination with the central reference laboratory.

4.3.3. CT trainers

The CT trainers provide recognised training using the National CT Training manual as coordinated by the District CT Supervisor in liaison with the MOH HIV/AIDS Unit. CT trainers should have

experience in CT Counselling and Whole Blood Rapid Testing and should be available to teach when required. Incumbents should have an MSCE certificate and will be selected by individual organisations, government departments or ministries in liaison with the HIV/AIDS Unit. They could be health or non-health personnel who have successfully completed the Training of Trainer's Course for CT Training, authorized by the MOH. Responsibilities include:

- Conducting of CT training using the nationally certified training manual for nationally certified training courses
- Writing of reports documenting training to MOH HIV/AIDS Unit through the district AIDS coordinator, including the lists of participants
- Planning and conducting refresher courses
- Conducting observed practice
- Certifying participants according to objective criteria of assessment

4.3.4. Site CT supervisor

It is anticipated that large stand-alone sites may need a CT site supervisor. Where applicable, the site CT supervisor is responsible for counselling support supervision of CT counselling staff and is in charge of on-site or outreach activities. This position reports to the Director or Manager of the CT facility.

The Site CT Supervisor should have administrative and management skills and experience and interpersonal skills and qualities to effectively supervise, support and develop CT staff and should be a practicing counsellor in his/her daily work. The holder of this position should have completed the nationally recognized certificate course in CT Counselling, the CT Supervisor certificate, and have continuing education to effectively support client referral needs and counsellor professional growth. Site CT Supervisors should have a minimum of one year's experience in providing CT counselling, and could be health or non-health personnel.

The site CT supervisor should be in a position to dedicate enough time to regular support supervision. The person in this position may see clients, but his or her counselling work should not interfere with his/her supervisory responsibilities. Specific responsibilities include (refer to Supervisor's Handbook for detailed description of responsibilities):

- Monitoring and coordination of activities
- Staff supervision and development
- Counselling support supervision
- Ensuring adequate and consistent supply of reagents and consumables

4.3.5. CT counsellors

CT counsellors must provide counselling services consistent with these guidelines and the national training manual and must have

completed the nationally recognised CT Counsellor Training Course before practising. All CT Counsellors should be recruited by the CT service-implementing organisation in liaison with the MOH HIV/AIDS Unit.

4.3.5.1. Selection criteria for CT counsellors

CT Counsellors should be at least 21 years old, have a MSCE certificate or junior certificate. Those with additional related professional qualifications (clinical, teaching, social work, etc.) will have an added advantage. CT councillors need to be fluent in English and be familiar with the culture of the community they are to work with. They should have at least one year's experience working in Malawi and have no criminal record. Attributes include maturity, interest in providing CT services, listening skills, patience, understanding and respect of peoples' values and attitudes, interest in continuous education related to HIV/AIDS and CT. They may be health or non-health personnel. When selecting CT counsellors and trainees, those who are HIV positive should be encouraged to participate.

4.3.5.2. CT counsellors' responsibilities

Counsellors' responsibilities include:

- Conducting client and group education, pre-test and post-test counselling for individuals or couples. Details of pre and post test counselling protocols may be found in unit 6

of the training manual and unit 7 of the site counsellor handbook

- Performing rapid HIV testing when certified,
- Effective client referral and linkage to other services,
- Data collection, record keeping and report writing,
- Attending regular support supervision,
- Networking with community-based counsellors, and serving as a role model and resource for community mobilization.
- Client and group education on ART, PMTCT, care and support

4.3.5.3. HIV testing by CT counsellors

CT Counsellors with clinical background or those with basic qualifications of Junior Certificate and above should be trained to provide whole blood rapid HIV testing to clients in addition to counselling in order to enable continuity in the counselling session and maintain a friendly counsellor-client relationship, thus increasing confidentiality and privacy of counselling sessions. This is well backed by research, which has shown that providing a one-stop service increases client satisfaction, client acceptance of test result and overall efficiency.

4.3.5.4. The use of volunteers as CT counsellors

Volunteers who meet the selection criteria and have been trained in CT counselling in accordance with the national CT training manual may offer CT services at registered sites. However, the use of volunteers may affect the sustainability of services in the government sector and careful consideration should be given to long-term incentives and benefits given to volunteer counsellors.

4.3.5.5. CT community-based counsellor

Community-based Counsellors provide an important link between the community and the CT site. They also network with other stakeholders, including community home-based care (CHBC) providers and may be instrumental in implementing outreach or mobile CT services.

They should have a minimum of Standard Eight education and be able to read and write and communicate in Chichewa or any other local language. Responsibilities include: community education and information about HIV/AIDS and related health issues, promotion of CT services, supportive and positive living counselling, client referral and linkage to support groups and other services, record keeping and report writing.

4.3.6. Laboratory technicians

The laboratory technician must be familiar with CT principles and must have gone through an orientation of use of Whole Blood Rapid Tests certified by MOH. The laboratory technician or the

certified counsellor responsible for testing should ensure availability of test kits at the CT site, accurate record keeping and the collection of specimens for quality assurance.

Where counsellors who are not laboratory technicians do testing, the testing and laboratory practices should be supervised and monitored by a qualified laboratory technician on a regular basis. The site laboratory technician reports to the district laboratory technician supervisor.

4.3.7. CT support staff and volunteers

Individual providers of CT may set more stringent eligibility criteria for staff supporting CT services at their site(s) and have the responsibility to ensure all staff understands CT services. These positions include data entry clerk, receptionist, driver, messenger and watchmen who have received an orientation in CT. Volunteers working in technical positions will be required to receive the same orientation to view CT like any other personnel mentioned in this document.

4.4. TRAINING AND PROFESSIONAL ADVANCEMENT

Appropriate training and certification of staff is critical to the provision of quality services. The MOH HIV/AIDS Unit will provide certificates. Likewise, the HIV/AIDS Unit will serve as the certifying authority and will coordinate the development of training courses.

- The CT Counsellor Training is composed of a three-week session followed by, one week of supervised observed practice at a recognised site. An experienced counsellor or supervisor for a minimum of ten clients seen in addition to submitting one case study from the week of observed practice would perform observation.

- CT supervisors will be trained for a period of one week followed by field experience of conducting supervisory visits for a period of at least 3 months. This initial one-week training and the practice experience gained will be reinforced through ongoing experience sharing meetings to be conducted regularly.

- The CT Training of Trainers module will be covered in a period of a one-week session followed by trainees doing training on CT issues. Trainees should accumulate a minimum of 20 hours in session, within a time allowance of two months. An experienced CT trainer who will write a report on the trainee should observe at least one session. Where possible, it is preferable that the trainee co-train with an experienced trainer in CT counsellor training. One week in class will follow the practical session and the trainee should submit reports and participants evaluations form on all completed training.

- The curriculum for training of CT community based counsellors is intended to be a five week course, composed

of one week in class followed by 3 weeks practical and placement in the community where the trainee is going to serve. One week will follow the practical for sharing experiences and trouble shooting on experiential cases. At the time of going to press, this curriculum has not been yet developed.

As providers develop CT services, they are encouraged to institute staffing structures that enable career development. Staff members who demonstrate interest and skill in CT work should be given appropriate consideration for professional advancement and training opportunities. CT counsellors should have opportunities to maintain and expand current knowledge and skill for advancement in their field, such as additional training in counselling methods, supervision, and training of trainers.

4.5. ROLES AND RESPONSIBILITIES

Roles and responsibilities as stipulated in this chapter should be developed by implementing partners into position descriptions for staff and volunteers, which are written and communicated to all CT workers during their orientation. Management of the CT site must also define working hours for each position. If, as in an integrated site, the CT counsellor or laboratory technician is dedicated only part time to CT services, the timing of when these services should be provided should be clearly communicated to the public and other health professionals working at the facility. CT counsellors and laboratory technicians assigned to CT should not be drawn

away from CT responsibilities during hours dedicated to CT activities. In order to ensure quality service delivery, site supervisors or managers should establish policies to provide guidance on the amount of time staff are permitted to be away from their posts for professional development.

Chapter 5

Service Provision

5. CT SERVICE PROVISION

5.1. OPERATIONAL PROCEDURES FOR COUNSELLING

5.1.1. Forms of Counselling in CT

5.1.1.1. Individual counselling

Involves counselling of an individual by a counsellor on HIV testing and HIV/AIDS care and support. Individual counselling is the most prevalent form of counselling that will enable strict maintenance of the individual's confidentiality.

5.1.1.2. Couple counselling

Involves counselling of a couple by a counsellor on HIV testing and HIV/AIDS care and support. Couple counselling should be encouraged for those planning to get married, as well as for those already in a relationship who wish to make informed decisions about having children, selecting family planning methods, attending antenatal care, attending STI or other care services or planning for the future.

Couples should not be coerced into being counselled together but should be given an opportunity to make informed decisions about it. Confidentiality of each individual should be maintained whether they chose to be tested together or individually. There is a need to obtain clear consent (e.g. during pre-test counselling) about whether or not the couple agrees to receive their results or results of one of the spouse together.

5.1.1.3. Group pre-test education

If demand at a CT site is very high, sometimes pre-test education can be provided in groups. This will be mostly the case for antenatal mothers accessing antennal care services with RCT being provided as one of the ANC interventions. It is, however, important that before group pre-test counselling is done, the following conditions should be met:

- Measures for privacy should be adequate
- The number of people in the group should not impede two way communication
- The group should be homogeneous with regards to age and sex

In some circumstances, the person requesting CT will ask for a guardian, partner, relative, friend or significant other to be present. This is especially provided for in ART guidelines for Guardian Supported Therapy (GST). This shared confidentiality is appropriate and often very beneficial for ongoing care and support. However, upon the counsellor's assessment if it is understood that the client does not want the guardian, relative or friend to be present, the counsellor can ask the person accompanying the client to leave the room if his/her presence infringes the client's confidentiality.

5.1.2. CT protocol

The CT protocol involves three components and these are: pre-test counselling, testing and post-test counselling. Details of pre and post test counselling protocols may be found in unit 6 of the training manual and unit 7 of the site counsellor's handbook.

5.1.2.1. Pre-test counselling

Before performing an HIV test, counsellors must ensure the clients have basic pre-test information, provide informed consent and receive HIV risk reduction counselling. This is, however, not strictly required when the testing to be performed is for diagnostic purposes. In DCT obtaining of an informed consent for the test is adequate. In DCT, risk reduction counselling is delivered as part of post-test counselling. In RCT, pre-test counselling often takes the form of group counselling and health education on the ANC interventions and what each means or involves.

5.1.2.2. Testing procedures

Where the client is referred to a separate room for a laboratory testing, the counsellor should accompany the client where feasible. Providers should ensure appropriate protection of client anonymity and confidentiality, even while the client is in the laboratory. Once the test is completed, the counsellor should collect the results and make them available to the client as soon as possible.

Clients should be empowered by counsellors to read their results as it reinforces client ownership of results. In cases where clients are

unable to read their results or where the client wishes to see the test components physically, the counsellor may bring the tests themselves back to the CT room. The client may then check their numbers against the kit and interpret the results themselves. The counsellor should then reconfirm the results verbally. Where the counsellor provides the testing, the client may be invited to remain in the counselling room as the counselling session continues while waiting for test results.

Where a blood sample is taken for a battery of laboratory tests in addition to HIV testing, the test request form for the HIV test should only contain the patient's unique identifier and not the name.

5.1.2.3. Post-test counselling

Post-test counselling should be done after the test result and should be provided by the one who provided the pre-test counselling. One-on-one or couple counselling can be used to give results, depending on the clients' preference. Clients may specifically request that a family member, friend, or other supportive person be in the room when they receive results. However, the counsellor should make sure that this is truly desired by the client.

5.2. OTHER ISSUES TO BE CONSIDERED IN CT COUNSELLING

5.2.1. Referral and follow up

Referral services are services for all clients who need ongoing medical or psychological care and support. Counsellors should

undertake networking to inform themselves of location, accessibility, quality and cost of services before making referrals. They should have a basic knowledge of HIV care, including information on the availability and accessibility of antiretroviral drugs. If the counsellor is referring the client for ART eligibility assessment or opportunistic disease treatment, the HIV result will need to be written and an assessment made on whether the patient is symptomatic or asymptomatic. Only HIV positive symptomatic patients can be referred for ART eligibility assessment or opportunistic disease treatment (see ART guidelines).

Counsellors should have a directory of services available for referral of clients. When such referral resources are not available locally, providers should identify service providers outside their catchment area. For all other referrals, other than to certified ART clinics, the counsellor should not document clients' names and HIV status unless the Ministry of Health approves the requirement for inclusion of such information as a requirement of the receiving facility.

HIV negative clients may need referral to:

Medical evaluation

- For treatment of sexually transmitted infections (STI)

Reproductive health services

- For information related to family planning

Counselling services and support groups

- For mental health and crisis counselling
- Pastoral counselling
- Bereavement counselling
- Post-test clubs and other peer support

Other support

- For post-rape care following gender based violence
- For legal services.

HIV positive clients may need referral to:

Medical evaluation

- For treatment and prevention of HIV/AIDS related diseases
- For treatment of sexually transmitted infections (STI)
- For treatment of life-threatening infections including malaria and sepsis
- For antiretroviral therapy (ART)

Reproductive health services

- For information related to family planning

- For interventions to reduce mother-to-child-transmission including advice on infant feeding and antiretroviral drugs (refer to *Guidelines for Health Workers Implementing Interventions To Reduce Mother to Child Transmission of HIV in Malawi, February 2002*)

Counselling services and support groups

- For mental health and crisis counselling
- Pastoral counselling
- Bereavement counselling
- Post-test clubs and other peer support

Nutrition counselling

- For information about the basics of a healthy diet.

Other support

- For post-rape care following gender based violence
- For legal services.

5.2.2. Repeat testing and the window period

The period from exposure to production of detectable antibodies to HIV is often called the window period. Antibodies can confidently be detected in the blood three months after HIV infection. Thus clients who test HIV negative but have had recent risk of HIV

infection should be advised on safer sex and asked to return for repeat testing at least three months after their last exposure.

Clients who have not been exposed to the HIV virus in the three months before testing and test negative, are considered to be HIV negative. They do not need to return for testing and should be encouraged to follow their risk reduction plan.

Some clients will repeatedly return to CT sites to confirm positive or negative results. The counsellor should explore with the client reasons for seeking repeat testing including lack of confidence in the results or repeated exposure to HIV infection. Counsellors will then be able to assist clients to make appropriate future plans and evaluate whether repeat testing is actually beneficial to the client.

5.2.3. Accessibility of condoms and educational materials

All providers of CT services should offer condoms free of charge to all clients, married or unmarried couples or singles. In addition, condoms may be socially marketed in CT sites. Condom demonstration and education should be part of every CT post-test counselling session.

5.2.4. Discordant couples

Counsellors working with discordant couples (couples where one partner is HIV positive while the other is HIV negative) should be sensitive to issues related to the window period, the difficulties of condom negotiation and the confidentiality of the individual's results. Sometimes, this requires prevention counselling with the

couple together, as well as offering prevention counselling for the individuals privately.

5.2.5. Quality assurance

Quality assurance is a critical responsibility of administrators and supervisors of CT services and requires the cooperation and participation of all CT staff. A written checklist consistent with these guidelines and made available to all staff providing services must be adhered to.

Continuous quality improvement based on the results and analysis of regular client exit interviews is recommended.

5.3. PROCEDURES AND STANDARDS FOR LABORATORY AND HIV TESTING IN CT

5.3.1. Laboratory standards

Provision of HIV testing services follows standards and requirements that are consistent with those of the Medical Council of Malawi.

- Test kits and supplies must be stored securely.
- Storage area temperatures should be within range of manufacturer recommendations.
- Running water for hand washing and infection prevention should be available in or near the testing room.
- Adequate lighting and ventilation is required.

- Dust bins and sharps boxes should be labelled and disposed in compliance with government infection control standards.
- Each room where testing is done should contain a table for testing, two chairs (one for the client and one for the technician) and a bench outside the testing room for waiting clients.
- The site must clearly display its license from the Medical Council of Malawi.

5.3.2. Characteristics and applications of the HIV test

Only HIV tests approved by the Ministry of Health may be used for CT. These should be rapid, whole blood HIV tests that detect HIV-1, HIV-2 and HIV-1 group O infection, give same day results and are simple to use. EIA and Western blot tests should be reserved for clinical diagnostic purposes, quality assurance testing and for ongoing evaluation of new upcoming technologies.

HIV test kits to be used for CT must meet the following specifications:

- Approval by the Ministry of Health
- Use of whole blood
- Testing completed in less than 25 minutes
- Little or no addition of reagents required
- In-built performance control.

- Storage without refrigeration at temperatures consistent with manufacturer specifications
- Require no electricity
- Easy transportation

As new technologies are developed and new test kits become available they must be evaluated by the Community Health Sciences Unit and approved by the Ministry of Health before being used for CT services. The Ministry of Health will inform CT sites about the new technologies.

5.3.3. Procurement and distribution of test kits

A regular and reliable supply of rapid HIV test kits is critical to effective CT services in the country. The Central Medical Stores (CMS) is responsible for the purchasing and distribution of test kits and other supplies nationwide through the District Aids Co-ordinators and district CT supervisors. However, this should not prevent capable NGOs or other organizations from procuring test kits. All kits purchased must be authorized for distribution by the MOH after testing for quality control by the Pharmacy Medicines and Poisons Board Laboratory. All new batches of test kits not passing the Pharmacy Medicines and Poisons Board Laboratory testing should be returned to the manufacturer for replacement.

All newly purchased batches of test kits should have expiration dates longer than one year from the date of purchase and delivery, and kits should not be used beyond their expiry date.

The MOH will be responsible for coordinating resources for procurement of an uninterrupted supply of test kits.

5.3.4. Testing algorithms

Testing algorithms outline the sequence in which tests should be performed. Parallel testing (where every test is confirmed with a second different test) is recommended but serial testing (where only HIV positive results are confirmed) is acceptable in the presence of a quality assurance and control mechanism for HIV testing. In both cases, the selection of test kits must be based on Ministry of Health approved protocols and standards and be based on the available reagents. CT providers should be aware that testing algorithms might change as new testing technologies are approved for use. Supervisory staff must update their site protocols accordingly.

Parallel testing: All clients must be tested using two whole blood rapid HIV tests simultaneously or *in parallel.* One of the tests must be highly sensitive and another must be highly specific. If the tests are discordant — which is estimated to occur less than one percent of the time — a third type of rapid test is used as a tie breaker.

Serial testing: All clients are tested with a highly sensitive rapid HIV test. If the test is negative the result should be reported as negative. If the test is positive a second, different, highly specific rapid HIV test is performed. Discordant test results are further tested with a third type of rapid HIV test or tie breaker, which

should be highly sensitive, and different from the first one used. The tests are performed *in series*.

5.3.5. *Who should perform the tests*

Laboratory technicians, laboratory assistants or CT Counsellors with clinical and nursing background who have been trained to perform whole blood rapid HIV tests are allowed to do testing for CT. Non-health personnel may only perform whole blood HIV rapid tests in the context of an operational research study at sites carrying out quality assurance measures for HIV testing. All non-laboratory personnel doing testing must be trained and supervised by experienced laboratory technicians.

5.3.6. Quality control

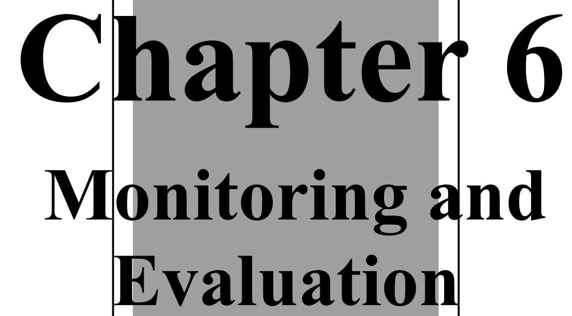
The National Reference Laboratory will mandate the Central Hospital Laboratory technicians to provide on site quality control and quality assurance for staff performing HIV testing. Dry blood spots are to be collected from all clients, using unique client codes, and transferred to the lab for quality control testing. 5% of these will be selected randomly as guided by Community Health Sciences Unit.

Proficiency testing is to be conducted by the Community Health Sciences Unit of the National Reference Laboratory on a quarterly basis by sending a blind pre-tested blood specimen to each testing

site. Providers conducting testing should consult with supervising laboratory technicians to resolve any problems and questions.

5.3.7. Laboratory safety

Universal precautions must be adhered to as recommended by the MOH. These universal precautions are listed in chapter 6 of the *Handbook for Clinicians and Nurses*. One of the staff members should be appointed by the CT management in liaison with the site supervisor, where available, to serve as a bio-safety officer at each CT site. The role of the bio-safety officer is to ensure site compliance with infection control guidelines and that safety precaution measures are observed on a daily basis.



Chapter 6

Monitoring and Evaluation

6. MONITORING AND EVALUATION

6.1. MONITORING OF CT IN THE CONTEXT OF CT SCALE-UP STRATEGY

CT scale-up will be monitored by the Ministry of Health within the context of the Essential Health Package and SWAps using the HMIS as the main tool.

6.2. CT MONITORING TOOLS

Although some CT providers may choose to have or maintain their own internal monitoring tools, all CT providers should use recommended national standardised tools and indicators across the country, as provided by the MOH from time to time, in line with the national monitoring and evaluation plan to facilitate national monitoring of CT services.

Client data forms should ideally be filled in duplicate for every client, with a copy remaining at the site. Activity reports should be submitted through the HMIS specified schedules to the District Health Office and Ministry of Health Headquarters.

Laboratory report forms: the laboratory technician or certified CT counsellor should fill the standard CT laboratory protocol form for every client and submit to the District Laboratory supervisor who should then compile and submit the quarterly report to HMIS, National Reference Laboratory and the District AIDS Co-ordinator.

Reagents Inventory Forms should be filled as part of reagents ordering process to the district pharmacy, laboratory and CMS. The District laboratory supervisor should compile and submit a quarterly report on reagents inventories to the Central Medical Stores and the District AIDS Coordinator.

6.3. DATA ANALYSIS, REPORTING AND FEEDBACK MECHANISMS

CT data should be used for the purposes of understanding CT demand and utilisation, for surveillance and for improving management of CT services. Strategies and policies should be based on actual and supported data. A proper data recording and analysis system should serve as a basis for research and development on HIV/AIDS prevention.

An appropriate software package and scanning systems should be developed and installed at both national and district levels to facilitate data collection and analysis. Horizontal and vertical flow of processed information at all levels will ensure quality of collected data before data reporting or publication. MOH will design and update feedback mechanisms to ensure that each level of services and management is informed adequately regarding CT services. Thus, data analysed should be submitted back to the District AIDS Co-ordinator who will then dispatch it to each CT site, which in turn may ensure greater community access to information.

Personnel involved in data entry, data analysis and data publication should be trained on the specific requirements of their roles. They

should understand the linkage between the work of the different levels and its effect on quality data information and, thus, on policy and strategy implementation. The Health Management Information Systems office should ensure appropriate human resource development in case there is a change of system, of software package or of personnel.

6.4. PUBLICATION OF CT SERVICE DATA

The MOH will publish quarterly and annual service statistic reports and HMIS bulletins on CT services. These publications will ensure easy accessibility by all stakeholders and researchers. Published data will be sex disaggregated and will include data on care and referral and other social issues related to CT.

Further Reading

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Annexes

Malawi VCT Site Assessment Tool

Purpose:

1. To assess how well the VCT site complies with minimum national standards stated in the VCT Guidelines
2. To create a plan for strengthen the VCT site

Objectives:

3. Assess availability of trained personnel
4. Assess adherence to VCT and safety guidelines
5. Assess physical infrastructure for VCT service delivery

General Instructions:

Districts must use this form to assess currently operating VCT Sites in a district. The tool can be self-administered as long as objectivity is maintained. It can also be used by someone (such as the VCT supervisor or site counsellor of a different VCT site within the district). The counsellors who work at the site should be involved in the assessment.

The final general comments and immediate action items should be done with those responsible for managing the site, so that the proposed actions are agreed and owned by those who will be responsible for implementing them.

If additional space for comments and action plan is needed, please use the back of the form.

Instructions: ***Complete the following table using the following scoring system.*** *Essential criteria are shaded. If the answer to any items is "No" (minimum standard not met), the action plan column must be completed. If the answer is yes, a comment and action plan is not required.*

SCORING SYSTEM

No	Minimum standard not met at the time of the visit
Yes	Minimum standard met at the time of the visit

	Human Resources	**Yes**	**No**	**Comments**	**Action Plan**
1	Two VCT trained and certified counselors (in accordance with National VCT Guidelines) available				
2	At least one trained lab technician or counselor able to do rapid tests available				
3	Catchment 10,000 people (urban), 8 km from other VCT site (rural)				

	Policy, Standards and Guidelines	**Yes**	**No**	**Comments**	**Action Plan**
4	National VCT guidelines easily accessible				

		Yes	No	Comments	Action Plan
5	VCT counseling protocols available and on display				
6	VCT testing protocols available and on display				
7	Safety guidelines available and on display (including advice on needle stick injuries)				
8	Registered by Medical Council of Malawi and certificate visibly displayed				
	Infrastructure	**Yes**	**No**	**Comments**	**Action Plan**
9	Adequate sign posting and directions for VCT room/s				
10	Opening hours clearly posted				
11	Door tags available (please enter/counseling in progress)				
12	One adequate counseling room available (well lit, spacious, ventilated, and private)?				

13	Room/s adequately equipped with 3 chairs, 1 table and separate testing surface (if testing in the room)				
14	Adequate waiting area (chairs and space)				
15	Room/s and waiting area well maintained and clean				
16	Secure lockable cupboard for storing client records available (counselor access only)				
17	Supply of test kits approved by MOHP and in date. i. Screening test ii. Confirmatory test iii. Tie breaker				
18	Provision for storing test kits at $< 30^{o}$ C				
19	Penile model available				

		Yes	No	Comments	Action Plan
20	Male and female condoms freely available and on display				
21	IEC materials available				

	Safety (for testing area)	**Yes**	**No**	**Comments**	**Action Plan**
22	Running water and soap for hand washing				
23	Sharps container available for disposal of lancets and needles				
24	Separate bin in testing room for disposal of contaminated waste (gloves, cotton wool etc.)				
25	Pit or incinerator available for disposal of contaminated waste				
26	LATEX DISPOSABLE GLOVES				
27	Cotton Wool				
28	Methylated Spirit				
29	Antiseptic Solution				

	Laboratory Technician/ Counselor trained in testing	Yes	No	Comments	Action Plan
30	Tester adheres to all standard operating procedures				
31	Ensures blood samples are labeled with client's number				
32	Samples recorded in laboratory registers				

	Records and Information System	**Yes**	**No**	**Comments**	
33	Client register available				
34	System for anonymous client coding in place				
35	Laboratory log book available				

36 Written referral list for care and support of people living with HIV. At least TB and STI referral must be functional				
37 Quality assurance system for testing in place or being developed?				
38 Quality assurance system for counseling in place or being developed?				

General Comments (including existing plans for expansion)**:**

____

____

____

____

____

Immediate Action Items:

1.

2.

3.

Application to Develop VCT Services

1. Institution Contact Details

Name of Institution ______________________________

Location ______________________________

Name of Officer in Charge ______________________________

Governing Organization ______________________________
(eg MoHP, CHAM, private – give details)

Postal Address ______________________________
____
____

Phone ______________________________

Email (if available) ______________________________

Will the site receive assistance from a Donor/ Implementer/ Partner? If Yes please;

1. Give Name of Donor: ______________________________

2. Describe type of assistance:
____
____
____

Services Planned

Voluntary Counselling and Testing ☐

Opening hours Day(s) ____________ Times __________
Day(s) ____________ Times __________
Day(s) ____________ Times __________

Estimated number of clients to be tested per month__________
(maximum)

Human Resources

Names of identified VCT Counsellors for the VCT site.

Name	Cadre

Do you have replacement for the proposed councillors in their normal duties whilst the VCT site is running? Explain

____

Other staff members to be assigned to the VCT clinic

Name	Cadre	Role

***Note**: the VCT guidelines provide for at least two trained and certified counsellors, must be assigned to the VCT site with at least one person, either one of the counsellors or r a laboratory staff member, being trained and certified to run whole blood rapid testing.*

Policy, Standards and Guidelines

Do you have copies of the following documents? (tick boxes if yes)

National VCT guidelines ☐
VCT counsellor's handbook ☐
Whole blood rapid testing manual ☐

Note: You may contact the MoHP HIV / AIDS unit (01) 789-400 if you require any of these documents.

Infrastructure

Please describe the rooms you intend to use for VCT. The following considerations should guide your choice of room.

You will need;

- One adequate counselling room available (well lit, spacious, ventilated, and private) adequately equipped

with 3 chairs or a bench for 2 and a chair, 1 table and separate testing surface if testing in the room
- Adequate waiting area (chairs/benches and space)
- Room/s and waiting area well maintained and clean
- Secure lockable cupboard for storing client records available (counsellor access only)

Describe rooms chosen for VCT service;

____

____

____

____

Whole Blood Rapid Testing

Please describe how you intend to perform whole blood rapid testing

Who will perform HIV Rapid Testing:

Name: ____________________ Cadre: ________________

Name: ____________________ Cadre: ________________

Note*: At least one person, either one of the counsellors or a laboratory staff member, must be trained and certified to perform whole blood rapid testing.*

Location of HIV Testing

At this site: In the VCT Room ☐ In the laboratory ☐

Testing will be done at another site ☐ Please describe

____

Other ☐ Please describe:_______________________________

Rapid Test Kits

Planned Source of Test Kits

MoHP ?CMS ☐ CHAM ☐ Other ☐ _____________

Type of Kits to be used (Tick box for each test to be used)

	Parallel	First	Second	Tie-break
Determine	☐	☐	☐	☐
Unigold	☐	☐	☐	☐
Hemastrip	☐	☐	☐	☐
Other	☐	☐	☐	☐

If other, please specify :

1. Kit ______________ Source ______________
2. Kit ______________ Source ______________

Will there be any cost to the client?

Free ☐
Other ☐ (eg cost sharing, targeted discounts etc)

For Other please describe

____

____

Location

Please indicate two nearest other VCT sites

Site Name	Owner	Distance from this site

Form Submitted by

Name ________________________________

Position in Institution ________________________________

Signature ________________________________

Date: ________________________________