HIV TESTING AND COUNSELLING (HTC)

THE 5 YEAR PLAN TO SCALE UP

HIV TESTING AND COUNSELLING SERVICES

IN MALAWI

2006 – 2010

Ministry of Health, Malawi

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1. EXECUTIVE SUMMARY

HIV prevalence in Malawi is high and has for the past five years stabilised at a high level of 14.6% with women being more infected than men and urban areas having HIV prevalence as high as 22.8%. HIV/AIDS continues to unleash severe impact on individuals, households and communities through high morbidity and mortality[1]. The National HIV/AIDS Action Framework [2005-2009] has put in place intensive efforts to bring down HIV prevalence and to scale-up treatment and care of people living with HIV. HIV Testing and Counselling is part of a comprehensive package of HIV prevention, care and treatment and a critical entry to accessing ARVs, treatment of opportunistic infections and prophylactic treatment to prevent vertical transmission from mother to child.

This 5 year HIV Testing and Counselling Scale Up Plan [2006-2010] is a planning tool setting out the framework and strategies within which HIV testing and counselling services will be scaled up. This plan has formulated eight strategies that if realised, could lead to *over four million Malawians* being tested for HIV from 2006 to 2010. The eight strategies are:

1. Enhancing equitable access to HIV Testing and Counselling by all Malawians
2. Scale Up Provision of HIV Testing and Counselling services
3. Strengthen Quality of HIV Testing and Counselling Services
4. Development of Human Resource Capacity for delivery of HIV Testing Services
5. Creation of Demand for HIV Testing Services
6. Development and Dissemination of HIV Testing and Counselling Resource Materials
7. Operational Research
8. Exchange of Experiences

There is a huge potential to scale up HIV Testing services in the health sector through integrating HIV Testing in all health care facilities. There is a further huge potential for NGOs and CBOs to introduce HIV testing and counselling either as a stand alone activity or integrated in their current HIV prevention and mitigation interventions. Workplace HIV/AIDS programmes, including government ministries as well as large private corporate organisations will be encouraged and supported to develop HIV testing services.

This plan is setting a target of 55% of all health facilities integrating HIV testing services by the end of 2007, and by 2010, 94% of all health facilities will have integrated HIV Testing services. As HIV Testing services are introduced in all health facilities, all patients will be offered and provided with HIV testing and counselling to facilitate their immediate referral for ARVs and treatment of opportunistic infections, etc.

Mobile and Outreach HIV Testing services will be introduced and it is planned that each DHO will have at least one Mobile HIV Testing Unit that will provide HIV Testing Services to communities that find it difficult to access HIV Testing provided by health care institutions or other NGOs.

The promotion and marketing of HIV Testing will be strengthened through introducing HIV Testing days in the annual calendar. During these days, there will be intense social marketing and promotion of HIV Testing through electronic and print media, drama and involvement of traditional authorities at community level. Printing of posters, pamphlets and drama will continue to inform members of the public and specific vulnerable groups on the benefits of HIV Testing.

[1] National HIV/AIDS Action Framework 2005-2006: Malawi Government

2. ACRONYMS

ADMARC	Agricultural Development and marketing Corporation
AIDS	Acquired Immune-Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BLM	Banja La Mtsogolo
CBO	Community Based Organisation
CHAM	Christian Health Association of Malawi
CT	Counselling and Testing
DHO	District Health Office
DCT	Diagnostic Counselling and Testing
HEU	Health Education Unit
HIV	Human Immuno-Deficiency Virus
HTC	HIV Testing and Counselling
HTSS	Health Technical Support Services
I.E.C	Information, Education and Communication
MACRO	Malawi AIDS Counselling and Resource Organisation
MANET +	Malawi Network of People Living with HIV/AIDS
MOH	Ministry of Health
MSCE	Malawi School Certificate of Education
NAPHAM	National Association of People Living with HIV/AIDS in Malawi
NGO	NON-Governmental Organisation
OIs	Opportunistic Infections
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
QA	Quality Assurance
RCT	Routine Counselling and Testing
STI	Sexually Transmitted Infections
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WBRHT	Whole Blood Rapid HIV Testing

3. INTRODUCTION

3.1 Situational Analysis

Malawi has one of the highest HIV/AIDS prevalence rates in the world, with 14% of those aged 15 – 49 years infected. The National AIDS Commission estimated that in 2003 there were about 900,000 adults and children living with HIV/AIDS in the country. Every year, it is estimated that a further 110,000 new HIV infections occur in the country. HIV/AIDS is now the leading cause of death in the most productive age group, resulting in an estimated 86,000 adult and child deaths annually. The cumulative number of orphans and vulnerable children, directly related to the AIDS epidemic, is approximately 700,000.

AIDS currently kills young adults in their most productive years, depriving the country of the skills and knowledge base so essential to human and economic development. AIDS leaves countless numbers of grandparents to bring up children. Many orphans cannot attend school; they suffer from poverty and malnutrition and become sucked into a spiral of crime, violence and commercial sex. AIDS retards development and creates the foundations for political instability.

HIV Testing and Counselling is one of the essential interventions in HIV/AIDS. It promotes prevention of HIV infection and is an entry point to care and support, including highly active antiretroviral therapy (HAART). In the estimated 9 million Malawians who are not HIV-infected, HIV Testing and Counselling should assist to reduce risk behaviour for HIV infection. In the 900,000 Malawian people estimated to be infected with HIV, there is a wide range of care and support services. These are initiated at both governmental and NGO/Community level, and should assist in improving the quality of life and health, access to treatment of opportunistic infections and other HIV-related diseases as well as access to life-saving antiretroviral drugs.

In 2003, there were 118 HIV Testing sites in the public health sector, CHAM institutions and in the NGO sector; and a total of 215,269 persons were tested for HIV and these included 60,561 blood donors (28%), 26,791 tests on pregnant women for Prevention of Mother to Child Transmission of HIV - PMTCT (12%), and there were 79,584 persons who were tested in the integrated health facility sites where the proportion of persons HIV-positive was 39%. There were 48,333 persons who were tested in the three MACRO sites where the proportion of persons HIV-positive was 14%.

In 2003 and in the 57 health facilities assessed that had an HIV testing site, there was a total of 420 active counsellors and 48 [11%] of them were full-time. 86 counsellors had been trained in rapid whole blood testing. In 13 (23%) of these health facilities, there was some form of external quality assurance for HIV testing[2].

In 2003, about 40,000 HIV-positive persons were identified through HIV Testing sites in the public health sector: i.e, about 1 in 20 persons who were HIV-positive found out their HIV status during that year. This implies that there is a need for massive scale up of HIV Testing services in the country for two main purposes:-

a) to motivate members of the public who are at risk to 'kick start' behaviour change and to access early care, counselling and community support, and

b) in the public, private and NGO health sectors for diagnosis of HIV-disease and early entry to appropriate treatment and ARV therapy.

Important pre-requisites in the scaling up of HIV Testing Services include national Policies and Guidelines. The HIV/AIDS Counselling and Testing Guidelines for Malawi [2004] and the National HIV/AIDS Policy [2003] guidelines provide policy directives and the principles and

[2] Report of the Country Wide Survey of HIV/AIDS Services in Malawi for year 2003 – NTP MOH

requirements for implementation of HIV Testing. Through these guidelines, minimum HIV Testing quality standards have been set. These are the foundation that will guarantee an effective HIV testing service delivery system.

3.2 Counselling and Testing 2 Year Plan[2004 – 2005] to Scale Up HTC
The 2 Year HIV Testing Plan [2004-2005], which was then entitled - The Counselling and Testing 2 Year [2004 – 2005] Scale Up Plan[3] - had an aspirational goal of testing 250,000 patients coming to health facilities for clinical care and testing 500,000 voluntary clients wanting to know their HIV status. Capacity of the health sector was sited as a major constraint to achieving the above targets. On a more realistic note, the plan estimated that 220,000 patients would be counselled and tested at health facilities and that 200,000 persons who voluntarily want to know their status would be tested mainly by the NGO sector in 2004 and 2005.

Reports of the Country Wide Situational Analysis for 2004 indicated that 283,467 persons were tested and counselled and a similar situational analysis for 2005 indicated that 467,831 persons were tested, making a total of 765,831 persons tested for 2004 and 2005. Despite the citation of the capacity of the health sector as a likely constraining factor to achieving targets for 2004-5, the actual results achieved were slightly above the aspirational target of 750,000.

The major activities in the plan were strengthening and certifying existing and new integrated and stand alone sites in the public health sector, CHAM institutions and in the NGO and CBO sectors. The other major activity was increasing human resources capacity in the provision of HIV Testing and Counselling services through an expanded Counselling and WBRH Test training program

By the end of 2004 there were 146 HIV testing sites in the public health sector, CHAM institutions and the NGO sector providing counselling and HIV testing services. The number of people counselled and tested for HIV was 283,467. This was an increase of 24% from the previous year. The people tested and counselled comprised of 62,396 blood donors (22%), 43,345 pregnant women for Prevention of Mother to Child Transmission of HIV - PMTCT (15%), and 177,726 clients and patients (63%). Of 177,726 clients and patients tested, there were 48,527 persons who were tested in the three MACRO sites where the proportion of persons HIV-positive was 14.5%. There were 129,199 persons who were tested in the integrated health facility sites where the proportion of persons HIV-positive was 34%.[4] Counselling and HIV testing among patients increased by 38% from previous year whilst the numbers being tested at MACRO sites remained almost stagnant at about 48,500

The 146 HIV Testing sites had 711 counsellors and 345 [48%] of these were offering services as full-time counsellors. A detailed analysis was carried out in 62 of the 146 sites and it was found that 61 ran daily CT services, had a dedicated HIV Testing and counselling room and were using the national CT Register. Less than half of the sites had written referral lists for post-test services and less than half had any form of external quality assurance. The stock-outs of test kits in some testing sites were a major concern in 2004[5].

Some of the major achievements of the HIV Testing Scale Up Plan of 2004 – 2005 were:

1. By the end of 2005, there were 239 HIV Testing sites offering HIV testing services fulfilling the minimum standards required by CT Guidelines. The Northern region had 51 sites, the central Region had 72 sites and the Southern Region had 116. MACRO had

[3] Counselling and HIV Testing [CT]: The Two Year Plan to Scale-Up Counselling and HIV testing Services in Malawi 2004 – 2005. MOH and NAC 2004.
[4] Report of the Country Wide Survey of HIV/AIDS Services in Malawi for year 2004 – NTB MOH
[5] ibid

opened three new standalone sites, one in Karonga, one in Kasungu and the third in Zomba.

2. A standardised HTC register had been produced and finalised, and 800 copies had been distributed to HTC sites around the country.

3. A number of documents had been finalised and had been printed. They included: The 2 Year CT Scale Up Plan [2004-5], HTC Guidelines, Site Counsellors Handbook, HTC Training Manual, WBRT Service Providers Handbook, WBRT Training Manual and WBRT Trainers Guidelines.

4. Quality assurance tools were finalized and distributed with other HTC documents.

5. By the end of June 2005, a total of 820 health workers, mainly HSAs and non-health workers had been trained in HTC. 360 of these were trained through Global Funds and 460 by other partners and donors.

6. Between July and December 2005, 354 candidates who went through the CT training and 316 of these successfully completed the training and were certified; bringing the total of HTC counsellors ever trained and certified to 1136.

7. There were also 50 HTC counsellors trained as trainers of HTC counsellors and 27 lab technicians were trained as supervisors of rapid HIV testing in CT sites.

8. From July to December 2005, a total of 91 CT senior personnel from DHOs and the NGO sector went through CT supervision training and 87 were certified as CT supervisors.

9. After a long debate on HIV testing algorithms and the test kits used, MOH endorsed that Determine and UNIGOLD be used for parallel testing (with Bioline as a back-up in case of international stock-outs of UNIGOLD), and Haemastrip used for tie-breaking. In the last quarter of 2005, the algorithm changed, Haemastrip was removed from the protocol and replaced with Bioline as a tie-breaker. Determine remained as a screening test and UniGold as a confirmatory test.

10. The quantities of HIV test kits needed for the period 2004 – 2005 was estimated at 500,000 tests of Determine and UniGold. This proved to be an underestimation as there were reports of stock outs during the last quarter of 2005.

4. THE FRAMEWORK FOR HIV TESTING AND COUNSELLING

HIV Testing services will be implemented on a broader and radically larger scale to allow all Malawians realise their right to know their HIV status and become eligible to benefit from rapidly expanding opportunities for ARV treatment, care and behaviour change interventions. The conducive policy environment for massive scale up of HIV Testing, provided for already through the National HIV Policy[6] and HIV/AIDS Counselling and Testing Guidelines for Malawi [7] [often referred to as CT Guidelines] allows a paradigm shift from a traditional VCT approach that promoted individuals seeking out VCT and voluntarily coming forward for HIV testing, to a health care worker initiated system in which all patients are initiated into HIV testing as part and parcel of on-going treatment and care.

The approach and models that will be adopted in this Scale-Up Plan will be consistent with and will operationalize the National HIV/AIDS Policy and the CT Guideline for Malawi. HIV testing and counselling will become a standard practice wherever and whenever it is likely to enhance the health and well-being of all Malawians. While doing so, the setting up of quality standards, monitoring and maintenance of the quality of service delivery will be strengthened to assure public confidence in HIV testing and counselling and to protect the human rights of patients, clients and members of the public.

4.1 Goal of HIV Testing

The first goal of HIV Testing is facilitation of behaviour change leading to prevention of transmission of HIV. The second goal is facilitation to access HIV/AIDS care, especially HAART, treatment of opportunistic infection and supportive services.

4.2 Models of HIV Testing

As treatment and care become more widely available, it is necessary to move beyond a single, rigid model of testing and counselling used just as a preventive intervention to more models with wider variations allowing testing and counselling in the context of illness and clinical care. This will provide an immediate gateway to ARV treatment, care and support, and to accessing interventions for prevention of HIV infection from mother to child.

The models that will be adopted in this HIV Testing Scale Up Plan are:

Voluntary Counselling and Testing [VCT].

In this model, individuals, couples or a groups of family members initiate the process of going to an HIV Testing site, receive pre-test counselling, individually or in a group format, get HIV tested, obtain their results and receive post-test counselling and appropriate referral. The majority of the clients that will utilise VCT services are often physically well and this model is designed to primarily assess their risky lifestyles, inform them of their HIV status, and receive counselling that is focussed on modification of HIV risky lifestyles.

Diagnostic Counselling and Testing [DCT]

In this model counselling and testing is considered as part of clinical management of patients that present with WHO Stage 111 or IV HIV/AIDS related medical conditions or opportunistic infections. Diagnosis of HIV will allow such patients to receive appropriate medical interventions for HIV positive patients and be considered for ARV treatment. This HIV Testing model will be adopted in all health care institutions primarily to give an opportunity to all patients with known HIV status to become potential candidates for accessing ARVs and treatment of opportunistic infections; and for referral for appropriate psychosocial support.

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[6] National HIV/AIDS Policy. Office of the President and Cabinet / National AIDS Commission. October 2003
[7] HIV/AIDS Counselling and Testing: Guidelines for Malawi. MOH 2004

Routine Counselling and Testing
In this model counselling and testing is offered routinely or is a routine component in specific preventive health interventions, such as HIV testing for prevention of mother to child interventions and for management for sexually transmitted infections. In the former it provides an opportunity for HIV exposed infants to receive preventive ARV therapy and infant feeding interventions that reduce the risk for MTCT; and in the latter, it offers the opportunity for high risk individuals to adopt risk reduction behaviour and benefit from medical treatment and follow up care.

The above models can also be viewed as either ***Provider Initiated HIV Testing and Counselling*** **[PIHTC]** or **[CIHTC]** ***Client Initiated HIV Testing and Counselling.*** As Diagnostic and Routine Counselling and Testing services become more prominent in health care services, it will be useful and somewhat less confusing to refer to these models as Provider Initiated HIV Testing and Counselling Services. In these settings, the normative practice will be for health providers to initiate the HIV testing and counselling process. Voluntary Counselling and Testing Services can then also be viewed as Client Initiated HIV Testing and Counselling as the main initiator for these services are the clients.

HIV Testing services can be provided either in "stand-alone" sites or in "integrated" sites or through an HIV Testing Mobile Unit. "Stand-alone" sites are often located outside of a health facility and are not directly linked to other health services, although arrangements exist for clients who are sick or need medical examination to be referred to health facilities. "Integrated" sites are incorporated into health facilities and are directly linked to the health services delivered by the facility.

HIV Testing providers, irrespective of the model adopted, can outreach their HIV Testing services to institutions that do not offer those services or can operate HIV Testing mobile units to reach communities that have little access to health care and HIV testing and counselling facilities. HIV Testing providers in central, districts and mission hospitals can outreach DCT and RCT to smaller and rural based health care facilities.

4.3 Guiding Principles of HIV Testing and Counselling

Whatever the model of HIV Testing adopted and used, there are some important guiding principles expressed in the National HIV/ AIDS Policy and Malawi Counselling and Testing Guidelines:

- *Counselling and testing must be of the highest quality, and must adhere to standardised guidelines and protocols*

- *Testing must be voluntary.*
  Routine HTC and diagnostic HTC are considered one of the routine interventions of the service or care being provided. However, HIV testing is not mandatory, except for special conditions specified in National HIV/AIDS Policy, and every individual has the right of opting-out by refusing consent for HIV testing.

- *Informed consent must be obtained.*
  Although the process of obtaining informed consent will vary according to different settings and the different models of counselling, all those offered the test should receive sufficient verbal information and should be helped to reach an adequate understanding of what is involved. The crucial elements of informed consent are a) providing pre-test information on the purpose of the testing, b) ensuring understanding of the potential implications of a positive or negative test result and c) respecting the individuals' autonomy.

- *Post-test support must be offered and appropriate referral for appropriate services must be provided.*
  The result of HIV testing should always be offered to the individual along with appropriate post-test, counselling and referral for care and support services

- *Confidentiality must be protected.*
  HIV testing and counselling can be anonymous or confidential. Where HIV testing services are anonymous, testing results are not linked to identifiers of the person and written results for the purposes of referral can only be provided with the consent of the client. Where HIV Testing services are confidential, test results are linked to names and other identifiers of the person. All medical records, including results of HIV testing, should be managed in accordance with appropriate standards of confidentiality. Only health care professionals with a direct role in the management of patients or clients should have access to such records.

- *HIV Testing and counselling, as a service of the Essential Health Package (EHP), should be provided free of charge in health facilities in the public sector and in "stand-alone sites"*

- *HIV testing will primarily be performed with nationally approved Whole Blood Rapid Tests following approved testing protocols and algorithms (WBRT).*
  WBRT has the advantages of rapid test results for the patient, with no need to come back on another day to learn the results of testing. It is a technique, which can be mastered and easily applied by non-laboratory health care workers. It can therefore be performed in a counselling room. HIV testing should be quality assured by testing of known positive and negative controls, direct observations, proficiency testing and/ or rechecking of a sample of specimens on a regular basis.

5. STRUCTURE FOR IMPLEMENTATION OF HIV TESTING AND COUNSLLING[8]

HIV Testing and Counselling service is part of an essential health care package [EHP] and its implementation is within the health sector policies, National HIV/AIDS Policy and the Strategy of Health Sector Response to HIV/AIDS. The specific implementation procedures are guided through the HIV/AIDS Counselling and Testing Guidelines for Malawi [MOH 2004].

The HIV/AIDS Unit in the Ministry of Health has the responsibility for the overall planning and coordination of HIV Testing and Counselling services. It is the primary contact for all National HIV Testing and Counselling issues. In addition to the above, the HIV/AIDS Unit is, among other responsibilities, responsible for:

- Formulating National HIV Testing and Counselling expansion plans
- Reviewing HTC Guideline
- Setting and monitoring national HIV testing and counselling standards
- Developing and reviewing various national HIV Testing and Counselling training curricula
- Setting and coordinating national in-service and pre-service HTC training system.
- Developing and reviewing HTC national quality assurance tools and protocols

The DHO is responsible for the coordination of the District HIV testing and counselling strategy. In consultation with HIV/AIDS Unit, the DHO is further responsible for the assessment, development, implementation and supervision of all HIV testing and counselling services. This is performed within the context of the District Implementation Plan [DIP]. To assist the DHO in performing its HTC responsibilities, the HIV/AIDS Unit developed a HTC Supervision Training Course. A number of personnel in DHO have already gone through this training course, are currently being referred to as District HTC Supervisors and will assist DHOs in implementing HTC specific responsibilities. Refer to Annex 4 for Functions of a District HTC Supervisor.

[8] The information in this section is partly obtained from Chapter 4 of HIV/AIDS Counselling and Testing Guidelines for Malawi, second edition, Ministry of Health 2004,

The HTC Counsellors provide HIV testing and counselling services at HTC sites. They must have completed the national recognised HTC training and certified by MOH. Refer to Annex 3 for Functions of an HIV Counsellor.

The National Reference Laboratory – CHSU –has the responsibility for coordinating HIV testing issues, quality assurance, evaluation and approval of new test kits; and setting of HIV testing standards, protocols and testing algorithms. The laboratory technician at DHO level, who has received training in WBRH Testing and another training in supervision of HIV counsellors performing rapid HIV testing, will supervise HIV counsellors in the district performing HIV testing.

5.1 Institutions providing and expected to provide HIV Testing and Counselling Services

The following institutions are already providing HTC and will be expected to scale up their HIV testing and counselling services:

a) The government health sector; i.e. central and district hospitals, including their outlying health centres

b) CHAM institutions

c) The Malawi Defence Forces, the Police and Prison Service

d) Relevant Government Ministries, e.g. Ministry of Education

e) Non-governmental organizations (e.g., MACRO and possibly BLM).

f) The private health sector: ie the private hospitals and the private clinics.

g) Public sector corporations such as ADMARC.

h) Community-based organizations [CBOs] and organizations of people living with HIV/AIDS such as MANET + and NAPHAM

6. STRATEGIES FOR SCALING UP HIV TESTING AND COUNSELLING SERVICES.

Scaling Up of HIV Testing and Counselling services from 2006 to 2010 will be through the following strategies.

Strategies

1. Enhance equitable access to HIV Testing and Counselling Services by all Malawians.
2. Provide HIV Testing and Counselling Services.
3. Strengthen Quality of HIV Testing and Counselling Services.
4. Development of Human Resource Capacity for delivery of HIV Testing and Counselling Services.
5. Creation of Demand for HIV Testing and Counselling Services.
6. Development and Dissemination of HIV Testing and Counselling Resource Materials.
7. Operational Research.
8. Exchange of Experiences.

1. Enhancing equitable access to HIV Testing and Counselling by all Malawians

1.1 Strengthen Existing HIV Testing Sites and Establish New Sites

By the end of 2005 there were 239 integrated and standalone sites operating in the public health sector, CHAM institutions and among the NGO sector. 18 of these [7.5%] were stand alone and 211 [92.5%] integrated into central and district hospitals, and health centres. Banja La Mstogolo also provides integrated HIV Testing and counseling sites among its clinics. Most of the stand alone sites proving VCT are run by non-governmental sector, and MACRO leads in proving stand alone sites in Blantye, Lilongwe, Kasungu, Mzuzu, Karonga and Zomba.

Provision of HIV Testing through outreach is presently minimal. Most outreach services are being provided by the NGO sector, mostly MACRO; and they outreach to Health Centres that have no resources to run their own HIV testing. Each MACRO site outreach to about three health centres in the district in which they operate. There are currently no mobile HIV Testing services in Malawi.

In this scale up plan hospitals, CHAM institutions and the NGO sectors will be encouraged to strengthen and expand their HIV Testing and counselling services in relation to the increasing demand for HIV testing.

In an effort to increase access to HIV testing for all Malawians, District Health Offices, under whose jurisdiction HIV Testing services are provided, will need to set up new testing sites integrated into health care institutions. All present health care institutions, including clinics either run by NGOs, such as BLM, and all private sector clinics and hospitals have a potential to introduce HIV testing.

The 211 integrated HIV testing and counselling sites operational countrywide by the end of 2005 represented 33% of all the health care institutions that have the potential to introduce and integrate testing services. Development of new testing and counselling sites should be selected considering factors such as: population density, HIV prevalence, easy geographical access, distance from other services and potential for linkage and referral with care and support services.

The projected percentage increase of integrated HIV testing new sites in each district will range from 20% to 30%. It is projected that by the end of 2007, 55% of all health care institutions will have integrated HIV testing and counselling services; and that by the end of 2010, about 95% of all health care institutions will have integrated HIV testing. Refer to Table 1 below.

The procedure for approving new HTC sites will be the same as previously applied in the CT Scale-Up Plan [2004-2005], namely:

- New sites should apply first to the District Health Office
- DHO visit the site to assess if site will meet the minimum CT Guidelines requirements
- DHO, with concurrence of HIV/AIDS Unit in MOH HQ, approves

Refer to Annex 4 to view an Application Form to Develop a new HTC site; and Annex 5 is the HTC Site Assessment Tool. [These tools will be reviewed to reflect name change from VCT/CT to HTC]

Table 1
Projected Growth of HTC sites integrated in Health Care Institutions

Year	# of Sites	% Increase	% of National Coverage	Remarks
2005	211		33%	**There are currently 638 Health Care Institutions with a potential to integrate CT services**
2006	275	30%	43%	
2007	350	27%	55%	
2008	435	24%	68%	
2009	520	20%	82%	
2010	600	15%	94%	

1.2 Procurement of Equipment and refurbishments of new and old HIV testing sites.

Procurement of equipment and refurbishment of existing sites and new sites will continue being done through IPC or through some other mechanism approved by MOH. As HIV testing demand increases, testing sites will require additional counselling rooms and furniture beyond the minimum HIV testing specifications stipulated in the HTC Guidelines.

1.3 Expansion of HIV Testing and Counselling Services through the NGO and CBO sectors

There has been little expansion of non-governmental and community based organisations offering HIV testing and counselling services in the past few years. At present there are 18 stand alone HIV testing sites, 3 in the northern region, 5 in the central regions and 10 in the southern region. MACRO has recently increased its sites to six

Although MACRO contribution to all people HIV tested and counselled in Malawi appear not growing, i.e. 31% in 2003 and 22% in 2004; there is a huge potential for expanding HTC through Banja La Mtsogolo and a number of smaller NGOs and CBOs currently funded and being nurtured by Save the Children [USA] Umoyo Network Project.

The following activities will be undertaken to promote expansion of HIV testing and counselling services in the NGO and CBO sectors

- Encourage a wide range NGOs and CBOs, including faith based NGOs and CBOs, presently providing HIV prevention and mitigation services to integrate HIV testing and counselling services.
- Strengthen HIV Testing and Counselling Project proposals writing skills for NGOs and CBOs as most NGOs and CBOs often fail to secure funding through poorly written project proposals.
- Encourage the donor community to fund NGOs and CBOs intending to introduce HIV testing and counselling.
- Encourage NGO, utilising the VCT model, with high demand for HIV testing to introduce group pre-test counselling and education in order to allow more clients to access HIV testing.

1.4. Development and Expansion of HIV testing and counselling in Government Ministries.

In an effort to ensure that all civil servants easily access HTC services, government ministries will be encouraged to operate either full-time or part time HTC services within their workplaces. The following activities will be undertaken:

- Consultation with HIV/AIDS coordinators in all government ministries to assess suitable modalities for introducing HTC services.
- Assessment of potential HIV testing sites in various government ministries.

- Support HIV testing sites with HIV test kits, HTC record books and other monitoring tools.
- Support training of HIV counsellors seconded from government ministries

1.5 Expansion of HIV Testing and Counselling in the private health sector.
The following activities will be undertaken to expand HTC services in the private sector
- Formal assessment of extent and nature HIV testing and counselling services in the private sector.
- Encourage all private sector health facilities to introduce and integrate HIV testing and counselling services
- Encourage private sector to partner with NGOs/CBOs in the provision of HTC services.
- Assess and certify old and new HTC sites in the private health sector.
- Assist the private sector in training of HIV counsellors
- Encourage all private sector health care institution providing HIV testing and Counselling to comply with HTC reporting systems as required by the DHO.

1.6 Development of Youth Friendly HIV Testing and Counselling Services.
Youths between the ages of 12 and 24 are vulnerable to HIV as they often lack accurate information about their sexual and reproductive health. They tend to use health services less often than adults. Confidentiality and consent issues are more complicated with this age group. Establishing whether young people are voluntarily seeking testing and counselling may be difficult, some may have been pressured by peers or parents or partners to learn their status. Youths may be more interested in counselling and HIV information more than knowing their HIV status. Youth may not always be open about their sexual experiences. It is therefore essential that the scaling up of HIV testing and counselling services recognise the need for setting up youth friendly HIV testing services that meet the special needs of youths.

Youth friendly HIV testing and counselling services will be expanded and promoted through:
- Integrating youth friendly components into existing standalone or integrated HIV testing and counselling services, e.g. building additional counselling rooms to service youths only or opening testing sites on specific hours appropriate for youths.
- Encourage NGOs and CBOs to initiate youth friendly HIV testing and counselling services through involvement of youth themselves.
- Introduce HIV testing and counselling in Youth Friendly Reproductive Health Services.
- Introduce HIV testing and counselling as one of the youth activities implemented in youth centres.
- Extend the present Youth Friendly Health Services Training to all trainees in HIV counselling.
- Promote training of youths in HIV testing and counselling.
- Promote recruitment of youth HIV counsellors to work in youth friendly HIV testing and counselling services.

1.7 Expansion of HIV testing and counselling services to the deaf, dumb and visually challenged.

The provision of HIV testing and counselling services to the deaf, dump and visually challenged communities in not known. It is not known either how many deaf, dumb and visually handicapped people in Malawi have received any form of HIV training. A number of activities will be implemented to ensure that these challenged communities receive training in HTC and that HTC services for them become available in all regions of malawi. The following activities will be undertaken:

- Formal assessment with deaf and dumb organisation on how HTC could be introduced
- Support training of HIV counsellors that are deaf and dumb and visually challenged.
- Support the development of HIV/AIDS and HTC materials for the deaf, dumb and visually challenged.
- Assign these counsellors to specific HIV testing sites in all there regions.
- Inform members of the public through various communication channels on the availability of HTC services for the deaf, dumb and visually handicapped.

2. Provide HIV Testing and Counselling Services

2.1. Targest for HIV Testing Demand.

The HIV testing demand for 2004 and 2005 has approximately increased by about 20%. The projected growth for 2006 and 2007 will be about 20% as well. For 2006, the estimated expected targets for HIV testing demand will be 580,000 and for 2007, the expected target will be 696,000. The estimated expected targets for 2006 -2007 will be 1.3 million people tested and counselled for HIV, and the estimated target from 2006 to 2010 will be 3.8 million.

Table 2.
Yearly Estimates for HIV Testing.

Year	# Tested	% Increase	Remarks
2003	155,000		
2004	283,467	20%	
2005	482,364	20%	For 2004 and 2005, a total of 765,831 were tested.
2006	580,000	20%	
2007	696,000	20%	For 2006 and 2007, estimate a total of 1, 276,000 to be tested
2008	800,000	15%	
2009	848,000	6%	For 2008 and 2009, estimate a total of 1,748,000 to be tested
2010	900,000	5%	**Estimated total to be tested from 2006 to 2010 = 3,824,000**

2.2 Models for Providing HIV Testing Services

The under-mentioned models will be utilised for the provision of HIV Testing Services. The key steps for each model are outlined below.

VCT.

Voluntary Counselling and Testing [VCT] model has been the dominant model of providing HIV Testing.

Key Steps:

- All clients provided with a standard and full pre-test counselling either on one to one basis or in group education format

- Explicit verbal consent for testing is obtained
- HIV testing is done
- Standard and full individual or couple post-test counselling is provided.
- Appropriate referral

DCT:
Because of the wide availability of ARVs and available treatment regimes for opportunistic infections, all health care delivery institutions need to offer and provide HIV testing services to all patients to facilitate referral to ARVs, PMTCT and treatment of opportunistic infections.

Key Steps

- Patient group pre-test education – [optional and appropriate in settings where there are large volumes of patients, e.g. OPDs] - with the aid of posters, flip charts or brochures.
- Health worker informs patient on the need for HIV testing, provides minimal health education if needed and explains how testing is going to be done.
- Unless a patient specifically refuses, consent for testing is assumed.
- HIV testing is done
- Health worker provides HIV test result and the standard post-test counselling
- Appropriate referral – i.e. referral for treatment, care and support.

RCT:
Key Steps

- Group pre-test education – [optional and appropriate in settings where there are large volumes of patients, e.g. OPD] - with the aid of posters, flip charts or brochures.
- HIV testing offered, with minimal additional health information, explanation of how testing is going to be done.
- Unless a patients specifically refuses, consent for testing is assumed.
- HIV testing is done.
- Health worker provides HIV test result and the standard post-test counselling focussing on PMTCT
- Appropriate referral – i.e. ARV prophylaxis for HIV positive pregnant women, infant feeding counselling, nutritional counselling, etc.

Mandatory HIV Testing:
Target:

- Donors of blood plasma, organ or semen
- Anonymous and unlinked HIV testing for surveillance purposes
- In the absence of parent or guardian, mandatory testing of unconscious patients for the purposes of HIV diagnosis, where such knowledge is essential for treatment and management of the patient
- Obligatory testing for pre-recruitment and periodic medical assessment of national security personnel.

Key Steps:

- All clients whose blood or tissue sample is found to be not eligible, due to HIV positive results should:
  - be routinely and systematically offered the opportunity to know why their blood or tissues had been refused.
  - With the consent of the clients, results are provided.

    - Standard post-test counselling is provided at the point of testing or through referral to an HIV Testing site.
    - Referral, as appropriate, is given
- HIV testing for national security personnel:
    - Such testing should be accompanied by full post-test counselling

2.3 Outreach and Mobile HIV Testing Services

Outreach and Mobile HIV Testing Services have not been adequately explored to realise the benefits of these approaches. The results of the outreach services that have to date been operated by MACRO and similar NGOs, albeit to a very little extent, have yielded two significant results. They have shown that outreach sites can successfully be operated and that the demand for HIV testing is as good as demand in integrated or stand alone cites. They have also shown that if testing services are brought to communities and neighbourhoods in which people live, people will access such services and will not shun away from these services. HIV testing data from MACRO is increasingly showing more women accessing HIV testing in outreach sites more than in stand alone sites.

Mobile HIV Testing Services are normally composed of a team of testing providers who move from one location to another providing testing and counselling services. A team of community workers [they could be VCT motivators or community immobilisers] is often sent in advance to a particular locality to prime the community with HIV/AIDS educations and to inform the community on the days that the mobile team will be at that community to provide HIV testing and counselling services. The advance team will also be assessing the availability of referral services for clients that are positive, availability of community support groups, PLWH support groups, HBC groups, etc. The advance team will also be assessing availability of rooms or any other shelter that guarantees privacy that could be offered to the mobile team. If no suitable accommodation is available for use as testing and counselling rooms, the mobile team often have tents that can be pitched as offices; with portable chairs and desks. The mobile team then moves to the locality and offers HIV testing for a day or two or until the demand is exhausted.

Mobile HIV testing and counselling services will be promoted, supported and introduced by DHOs, CHAM institutions and in particular NGOs. It is expected that each District will have at least one Mobile HIV Testing Unit operated by either the DHO itself or operated by a CHAM facility or NGO and supervised by the DHO. Larger districts will be expected to have more than one Mobile HIV Testing Unit.

2.4 Procurement of HIV tests kits

Procurement of test kits will continue being sourced through UNICEF and CMS. HIV/AIDS Unit will work with HTSS to estimate and project number of test kits required quarterly and yearly. They will also ensure that distribution systems for test kits are efficient and that stock outs of test kits at testing sites do not occur. The system for recording test kit usage on a daily/weekly basis by the end users will be strengthened by introducing a daily/weekly test usage record form.

2.5 Coordination and Networking for HIV Testing Services

The coordination and networking of HIV Testing services will be implemented through:

- Quarterly HIV Testing Sub-Group Meeting for HIV Testing and Counselling Stakeholders and technical experts.
- District HIV Testing Services Supervisors half yearly coordination meetings.
- Annual HIV Counselling Trainers meetings.
- On-going meetings with NAC

3. Strengthen Quality of HIV Testing and Counselling Services

The quality of HIV Testing services will continue being maintained and strengthened through a number of activities. The provision of quality services is essential to maintaining public confidence in HIV testing and counselling.

- Mentorship and Supervision of HIV Testing Services. This will be implemented on a quarterly basis and whenever a need arises by District HIV Testing Services supervisors and HIV Testing staff from the HIV/AIDS Unit.
- A national HIV testing client satisfaction survey will be implemented in 2006-7.
- A Mystery Client Surveys will also be done, if funding permits.
- The internal and external quality assurance for rapid HIV testing will be strengthened through consistent supervision of testing sites by laboratory technologist and proper documentation and dissemination of QA procedures and protocols to testing service providers.
- Conduct time flow analysis [on all HIV Testing models].
- Introduce a system of awarding prizes and rewards to HIV testing sites providing the best services.
- Develop Centers of HIV Testing and Counselling Excellence.
- Develop an HIV Testing and Counselling data base in HIV/AIDS Unit within MOH.

4. Development of Human Resource Capacity for HIV Testing and Counselling Services

4.1 In-Service Training

The training of HIV counsellors will continue so that the number of HIV testing and counselling providers at both existing and new sites will continue to be readily available. HIV counselling training, training of HIV counselling trainers, training of HIV testing services supervisors and training in WBRH testing will continue being coordinated by the HIV/AIDS Unit. Training in WBRH test training will be jointly coordinated by HIV/AIDS Unit and HTSS. The total target for training of HIV counsellors in 2006 and 2007 will be 740, and by the end of 2010, at least 2000 HIV counsellors would have been trained. The target for training counselling trainers will be 50 and supervisors 75 in 2006 and 2007.

HIV Trainings being funded through CHAM facilities, the NGO sector and other training institutions approved by MOH to run HIV counselling trainings will be coordinated and approved by HIV/AIDS Unit. The process that must be followed is as follows:

1. The agency that wishes to sponsor and run the training must officially apply to the HIV/AIDS Unit providing the following information:

    a) The source of funding as MOH needs to acknowledge local and international partners contributing to building up HTC human resource capacity.
    b) The number of candidates that are to be training. The ideal number is twenty and this needs to be gender balanced.
    c) The names of the HIV testing sites or health care settings where the candidates will provide testing and counselling services either on full time or part-time basis after the training.
    d) The proposed dates of the training.
    e) The proposed venue of the training.
    f) The proposed HIV testing sites where candidates will be attached for supervised field work practice.
    g) A letter from head of the institution giving approval for the trainees to be attached for supervised field work.

2. The HIV/AIDS Unit will then approve and provide required trainers for that training. The HIV/AIDS unit will liaise with the trainers during the running of that training and will also provide the set of examinations that will be written for that group.

The purpose of this central coordination and approval is to ensure that:

- The standard of training as set out in HTC curricula is maintained.
- The trainees enlisted for training meet the criteria as set out in CT Guidelines.
- The trainees enlisted for training will work in HIV testing sites after training and certification
- The trainers are MOH certified HIV counselling trainers
- Government approved HTC Training curricula and the standard field work practice will be used.

4.1.1 HTC Basic Training [5 weeks training].

This is the standard 5 weeks HIV Testing and Counselling training based on the testing and counselling training curricula approved by MOH. The trainers are provided by HIV/AIDS Unit and approved HTC training institutions. The training is composed of:

- Three weeks counselling theory taught through lectures, group discussions and role plays;
- One week of supervised field work practice attached to an HIV testing site,
- One week of WBRH Test training composed of two days theory and three days of supervised field work practice attached to an HIV testing site.
- There is on-going assessment during the training and examinations are written at the end of the training. Candidates that pass are certified by MOH and are officially recognised to work as HIV counsellors in HIV Testing sites. Refer to Annex 3 for a generic list of responsibilities for an HIV counsellor.

The period for the above standardized training will be reduced in situations where the cadres being trained are professional health care and social welfare personnel, e.g. clinical officers, doctors, state registered nurses, social welfare officers who have received generic counselling training in post secondary education, etc. The specific training periods for HTC training for specific professional groups mentioned in this paragraph, or any other professional groups, will be determined by the HIV/AIDS Unit.

The selection criteria for HIV testing and counselling training will be maintained as set out in the HTC guidelines; namely:

- Counsellors should be at least 21 years of age.
- Must have an MSCE certificate or junior certificate. Those with additional related professional qualifications [clinical, teaching, social work, etc] will have an added advantage.
- Need to be fluent in English and be familiar with the culture of the community they intend to work in.
- Must have one year working experience and have no criminal record.
- They may be health or non health personnel
- HIV positive people need to be encouraged to participate in HIV Counselling training.

4.1.2 HIV Counselling Refresher Training.

The HIV Counselling refresher training will be introduced and will be facilitated by the current HIV counselling trainers. The cadres that will be targeted for this training are those HIV counsellors that received various counselling trainings following a number of curricula that were available in Malawi before 2003 – e.g. The Counselling Care Model. The objective is to bring

them to the same level of standardized HIV counselling as those undergoing the current five weeks training and will be certified by MOH if they successfully go through the training. The HIV refresher training is composed of two modules, HIV counselling and WBRHT training and will be taught over two weeks. 260 counsellors have been targeted to go through this training in 2006 and 2007.

4.1.3 TOT HIV Testing and Counselling.

The present pool of counselling trainers is getting smaller due t o attrition against a growing demand for HIV counselling training. To replenish the pool of trainers, two groups of 50 trainers will be trained in 2006 and 2007. The trainees will be senior HIV counsellors or HIV testing services supervisors recommended by their heads of departments. The training is composed of two weeks of intensive training, one week of counselling theory and the other week of teaching theory and instructional methodologies.

4.1. 4 TOT in DCT and RCT [HTC in Clinical Care Setting]

A TOT in diagnostic and routine counselling and testing will be introduced. The objective of this training is to orientate clinical staff to DCT and RCT and enhance their skills in introducing and offering a provider-initiated HTC service in all clinical care settings, emphasizing ANC and RH settings for PMCT, TB Clinics, STI clinics and medical and in patients and outpatient facilities. It is expected that 75 clinical care personnel will go through this training and will in-turn train other clinical care and nursing staff at DHO level as DCT/RCT continues to be introduced and strengthened in all clinical care settings.

4.1.5 Couple HIV Counselling Training. It is expected that more and more couples will come for HTC as HTC promotion get strengthened with more promotional messages targeting couples in marital and sexual relationships. In order to strengthen couples counselling skills of counsellors, a one week couples counselling training will also be introduced. It is planned that over the next five years there should be at least one counsellor at each HIV Testing site with specialist couple counselling skills.

Table 3 Types of Training and Numbers to be training.

Type of Training	**#s To be Trained**					**Total # Trained**
	2006	**2007**	**2008**	**2009**	**2010**	
1. CT [basic] Training	360	380	400	420	440	**2000**
2. HIV Refresher Training	200	60	20			**280**
3. TOT - Counselling Training	25	25	25		25	**100**
4. HIV Testing Services Supervision Training	50	25	25	50	25	**175**
5. Couples Counselling	50	75	150	175	225	**675**
6. TOT – Orientation Training in DCT and RCT	50	25	25			**100**
7. Training in WBRH Testing Supervision	25	25		25		**75**
Total Trained						**3,230**

4.2 Pre-Service Training.
In 2006 consultations on feasibility of introducing HIV testing and counselling training as a component in various health care trainings undertaken by various health care training institutions will begin. Pre-service training in HIV counseling and testing will be introduced in Health Care Training Institutions so that all health care staff have completed basic counselling and testing training on graduation and will be capable of providing HIV testing services wherever they will be deployed.

5. Creation of Demand for HIV Testing and Counselling

It is estimated that 15% to 20% of the sexually active reproductive age-groups know their HIV status, and that 70% of them wish to know their status. There is therefore a huge need for on – going promotion and social marketing of HIV testing services. The promotion, social marketing and mobilization of communities for HIV testing will be led by the Health Education Unit in consultation with and being assisted by the HIV/AIDS Unit. The participation of traditional authorities and community based workers in the planning and implementation of community based HIV testing promotional activities will be essential. Community based HIV testing mobilization activities for catchment communities of health care centres will therefore become an on-going feature of community based health care activities.

The on-going HIV testing promotional activities will include:

i. Adoption of HIV testing weeks in the national calendar, preferably one week in every six months for intense promotion and provision of HIV testing services nationwide. A committee will be set up by HEU to organize these testing promotional weeks.
ii. Commissioning of free telephone hotlines, one in the Northern Region, one in the Central Region and the other in the Southern Region.
iii. On-going development, publication and distribution of Counselling and Testing I.E.C. promotional materials.

6. Development and Dissemination of HIV Testing and Counselling Resource Materials

A number of HIV testing and counselling resource materials will be reviewed, printed and disseminated.

- HTC Training Curricula will be reviewed to keep up with emerging testing and counseling issues. It will be made more comprehensive with the inclusion of more extensive materials on PMTCT and ARVs
- Couples Counselling Curricula will be developed, printed and disseminated to HIV counseling trainers.
- An HIV Counselling Refresher Training Curricula will be printed and disseminated to HIV trainers.
- A Supervision Handbook will be printed and disseminated to HIV testing services supervisors.
- Counselling Training Videos/DVDs will be developed as teaching aids for HIV training.
- HTC Guidelines will be reviewed. Protocols and flow charts for all HIV Testing models will be explained further and made more explicit.
- Guidelines for beneficial serostatus disclosure will be written for use by HIV testing providers.

7. Operational Research

HIV counselling and testing operational research has been minimal, notwithstanding the long experience Malawi has had in providing these services. Scientific based counselling and testing information and evidence is now urgently required to guide further development and scale up of

HIV testing services; and revision of policies and operational guidelines. Current barriers include lack of skills in research proposals and designs among counselling and testing providers and stakeholders.

The following activities will therefore be implemented in this scale up plan to redress the problem.

- Planning meetings for HTC Operational research will be held during the first quarter of 2006 to plan and document a CT research agenda.
- A qualitative and quantitative research methods training workshop will be held and facilitated by experts in operational research.
- A minimum of three operational research projects will be implemented, published and disseminated each year.

8. Exchange of Experiences

HIV testing and counselling senior staff need to be occasionally exposed to opportunities for professional growth. Study tours and exchange visits to other HIV testing sites within Malawi and within the Southern African region offer opportunities to gain wider counselling and testing knowledge and to increase motivation to remain in this field.

This Scale Up Plan intends to implement the following activities.

- Plan and implement study tours in the Southern African region.
- Attend International HIV/AIDS Conferences.

Plan and Host an Eastern and Southern African HIV Testing Conference.

The Eastern and Southern African countries are experiencing an HIV epidemic with common features and interventions. Sharing of best practices and challenges in Testing and Counselling interventions within the Southern African countries will enhance scale up of HIV testing across the whole Eastern and Southern African Region.

This HIV Testing Scale Up Plan intends to host an Eastern and Southern African HIV Testing conference in the first quarter of 2008.

A series of consultations with HIV testing stakeholders and donors will take place during the second quarter of 2006, and decide whether this activity will be feasible in Malawi.

7. KEY OPERATIONAL ACTIVITIES FOR 2006 and 2007.

1. Strengthen Equitable Access for all Malawians to HIV Testing and Counselling Services

- Provide HTC Services [VCT,DCT &RCT]
- Establish New HTC sites
  - Integrated
  - Stand alone
  - Outreach
  - Mobile
- Audit and assess needs of HTC services in the Private sector
- Procure equipment and refurbishments for new HTC sites.
- Procure HIV test kits.
- Forecast # of test kits for each quarter.

2. Coordination and Networking

- Quarterly HTC sub-group meeting.
- Hold networking and coordination meetings for HTC Supervisors and Trainers.

3. Strengthen Quality of HTC Services

- Quarterly Mentoring and Supervision of HTC services.
- Review Quality Assurance systems for Counselling in HTC sites.
- Review Quality Assurance Systems for Rapid HIV Testing, i.e. internal quality control and external quality control of Rapid HIV testing.
- Conduct national HTC client satisfaction survey.
- Conduct Mystery HTC Client surveys.
- Conduct Time Flow Analysis – comparative analysis across various models of HTC.
- Introduce a reward system for HTC sites providing "the best HTC Practice'.
- Review HTC Quality Control Tools.

4. Develop and Strengthen Human Resource Capacity for Delivery of HTC Services

- TOT in DCT/RCT for Clinical Staff/CT Counsellors.
- Refresher Training for 'old' HTC Counsellors.
- TOT HTC Counsellors, include Couple Counselling.
- Train HTC Counsellors.
- Train HTC Supervisors.
- Train laboratory technician in supervision of WBRH Testing.
- Train in Couple Counselling.
- Integrate HTC Curricula into pre-service training.

5. Develop and Disseminate CT Resource Materials

- Review and Print HTC Training Curricula.
- Review and Print HTC Counsellors Handbook.
- Print Refresher Training Curricula.
- Develop and Print Couples Counselling Curricula.
- Print with MOH Logo all Quality Assurance Tools.
- Review and Print HTC Register.
- Develop Counselling Video/DVDs as Teaching Aids in Chewa, Tumbuka and English.
- Pilot Test, Print and Disseminate Post-test Club Materials.
- Print and Disseminate HTC Supervision Handbook.
- Review HTC Supervision Training Curricula and Handbook.
- Review of HTC Guidelines – especially development of protocols for different HTC models [DCT/RCT].

6. Creation of Demand for CT Services

- Identify and promote HTC Days in the National Calendar.
- Work with DHOs to develop an HTC District Community Mobilization Plan.
- Introduce Free Telephone Hotlines for HTC.
- Develop I.E.C materials – pamphlets, flyers, posters, radio sports, etc

7. Exchange of Experiences

- Study Tours Visits to HTC Services in other countries.
- Attend International AIDS Conferences.
- Attend ICASA.

8. Operational Research

- HTC Operational Research Planning Meeting.
- Implement Research.
- Write research papers for publication.
- Dissemination of Research Results.

For a detailed HTC work plan for 2006 -2007, refer to ANNEX 1.

8. HIV TESTING AND COUNSELLING SCALE-UP ACTIVITIES AT DISTRICT HEALTH CARE LEVEL.

The HIV/AIDS Unit will work with NAC, DHOs, CHAM, the private health sector and NGOs to ensure that scaling up of HTC activities are consistent with this plan. During the fist quarter of 2006, regional meetings will be held with DHOs, CHAM institutions and the private sector to share, discuss and build consensus on this HTC Scale up Plan.

Specific activities expected to be taking place at DHO level include:

1. DHO and DHMT need to include and budget for HTC scale up activities in the district DIP
2. Plan the renovations and improve infrastructure for HTC services
3. Continuously assess the feasibility of integrating HTC services in all health care institutions on a gradual basis.
4. The HTC Guidelines are available in every counselling unit which provides the service.
5. There is a standardised registration and recording system.
6. There is an established (written) referral system for care and support after HTC.
7. Ensure that HTC sites are operating efficiently, that there are no stock outs of tests kits.
8. Manage, monitor and supervise all HTC sites operating in the district.
9. Ensure that HTC sites are meeting and maintaining all requirements as stipulated in the CT Guidelines.
10. Ensure that newly qualified HIV Counsellors are being mentored and supervised.
11. Ensure that there is a QA system for HIV rapid testing at HTC sites.
12. Ensure that HIV Counsellors at HTC sites performing rapid HIV testing are being supervised by laboratory technologist.
13. Collect and compile all data of HTC sites, using HTC registers at each site, to HIV/AIDS in MOH.
14. Assess and plan for the human and material resource requirements needed to scale up HTC services.
15. Consult, liaise and seek support from local and international NGOs willing to support scale up of HTC services.

9. HIV TESTING AND COUNSELLING INDICATORS TO MEASURE PROGRESS

Input indicators:

1. HTC Scale Up Plan [2006-2010]

2. Number of approved sites offering HTC, either "stand-alone" and "integrated".

3. Number of Outreach HTC services.

4. Number of Mobile HTC Units.

5. Number of staff who have undergone a formal training in HTC
6. Number of staff working as full-time HIV counsellors (ie 5 days a week from 8am to 5pm)

7. Number of trained HTC supervisors

8. Number of sites reporting no stock-outs of HIV test kits.

Output indicators:

1. Number of HTC sites approved and operating according to HTC Guidelines.

2. The number of clients in integrated facilities, who undergo counselling and the number who receive their results of HIV testing - an indicator of counselling uptake: [measured by the number of clients entered in the HTC register and the number who are HIV tested and receive their results]. In particular, the following type of clients or patients will be monitored.

   - Number of clients receiving HTC at stand-alone facilities and number testing positive.

   - Number of patients with TB who have received HTC and number testing positive.

   - Number of adult medical patients who have received HTC and number testing positive.

   - Number of child patients who have been tested for HIV and testing positive with parents/guardians counselled.

   - Number of Patients with sexually transmitted infections [STI] who have received HTC and number testing positive.

   - Number of Women who have received HTC in ANC and PMTCT clinics, MCH and RH settings and number testing positive.

3. The number of blood donors HIV tested in each health facility laboratory and the number testing positive.

10. POSSIBLE CONSTRAINTS TO SCALING UP HIV TESTING AND COUNSELLING SERVICES

- **Capacity and commitment of the health sector to provide HIV testing services.**
  The health sector (public and CHAM, the Defence Forces, the Private Sector and MACRO type centres) needs to be committed to the provision of HTC services as a part of an Essential Health Care Package. Planning for scaling up of the district HTC services need to be integrated into district DIP, and adequate resources allocated for district HTC activities. Adequate infrastructural and human resources for new HTC sites, mobile and outreach services and for regular HTC supervision ad monitoring will be needed and is essential for meeting HTC targets set for the next five years. In the absence of a designated HIV Counselling cadre in the health system, health surveillance assistants are often the preferred cadre who are being trained to provide HTC services on a full-time basis. In addition, it is expected that DHOs will make decisions on other staff, including clinical officers and nurses, to work as full-time counsellors, or released on a part-time or rotational basis to provide daily HTC services.

- **Commitment and Support to HIV Testing Services by the Donor Community**
  The current situational analysis of HTC sites shows that distribution and concentration is high among districts with good donor and international NGO support. There are a number of districts, e.g. Ntchisi, Phalombe and Nsanje, and HIV testing services are not growing at all. The scale up of HTC services will therefore be correlated with the amount of donor support.

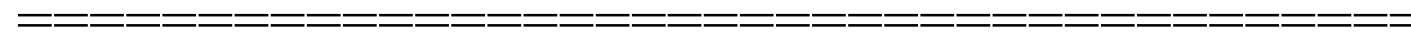
  The potential for HTC growth, especially among the NGOs and CBOs sectors, will not be realised without adequate donor support.

- **Capacity of Central Medical Stores and UNICEF to provide HIV test kits.**
  During the last quarter of 2005, there were reports of stock outs of HIV test kits at some health facilities. Again in 2003, through a country-wide situational analysis, a number of health facilities had stock outs of test kits. It is essential that HIV test kits be always available at HTC sites. A stock out of test kits is an unacceptable and bad HTC practice and may lead to members of the public losing confidence in HTC services. It takes a lot of courage for people to decide to go for HTC and non-availability of test kits becomes a missed opportunity for HIV prevention and access to HIV treatment.

  HIV test kits need to be always available at central and regional medical stores. CMS and HTSS need to constantly review the distribution system and ensure that logistical bottlenecks, including human attitudinal bottlenecks, are identified and rectified.

- **Equitable Access to HIV Testing sites.** A large proportion of Malawian population is rural-based, and the issue of equitable distribution and access to HTC services is pertinent. This HHTC scale-up envisages that nearly all health care centres will have an integrated HTC service by the end of 2010. Even, if this is achieved, rural populations will still have problems in reaching health care centres because of poor road infrastructure and non-availability of public transport serving rural communities.

  In order to ensure that rural communities access HTC services, DHOs and NGO partners running HTC services need to introduce and operate mobile and outreach services on a regular basis.



ANNEX 1

Work-plan for HIV Testing and Counseling Activities 2006 - 2007

Activity	**Activities for 2006**				**Activities for 2007**			
	Jan-Mar	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**
1. Strengthen Equitable Access for all Malawians to HIV Testing and Counseling Services								
1.1 Development of the HTC Scale Up Plan [2006-2010] • Circulate Draft to HTC Stakeholders • Present Draft to HTC Sub-Group • Present Draft to DHOs for their input through three regional DHOs meetings • MOH Approve HTC Scale Up Plan	X							
1.2 Provide HCT Services [VCT,DCT &RCT]	X	X	X	X	X	X	X	X
1.3 Establish New HTC Sites	X	X	X	X	X	X	X	X
• Integrated	X	X	X	X	X	X	X	X
• Stand alone	X	X	X	X	X	X	X	X
• Outreach	X	X	X	X	X	X	X	X
• Mobile	X	X	X	X	X	X	X	X
1.4 Consult with Blood Transfusion Service to include a full package of HTC in Blood/Tissue/organ donation				X	X	X		
1.5 Audit and Assess needs of HTC services in Private Sector	X	X						
1.6 Procure equipment and refurbishments for new HTC sites.	X	X	X	X	X	X	X	X
1.7 Procure HIV test kits	X	X	X	X	X	X	X	X
• Forecast #s of test kits for each quarter	X	X	X	X	X	X	X	X
2. Coordination and Networking								
2.1 Attend HIV/AIDS Unit Management Meetings	X	X	X	X	X	X	X	X
2.2 Quarterly HTC Sub-Group Meetings	X	X	X	X	X	X	X	X
2.3 Network meetings for Counsellors	X	X	X	X	X	X	X	X
2.4 Network meetings for HTC trainers				X				X

2.5 Network meeting for HTC Supervisors	X		X		X		X	
3. Strengthen Quality of HTC Services								
	Jan-Mar	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**
3.1 Quarterly Mentoring and Supervision of HTC services	X	X	X	X	X	X	X	X
3.2 Review Quality Assurance systems for Counseling in HTC sites		X						
3.3 Review Quality Assurance Systems for Rapid HIV Testing, i.e. internal quality control and external quality control of Rapid HIV testing		X						
3.4 Conduct national HTC client satisfaction survey			X				X	
3.5 Conduct Mystery HTC client surveys			X			X		
3.6 Conduct Time Flow Analysis – comparative analysis across VCT sites, DTC sites in clinical settings, Mobile and Outreach				X		X		X
3.7 Introduce Pricing System for HTC sites providing "the best HTC Practice' [cf JHPIEGO system for giving prizes to Health Care Institutions with best IP Practices]					X	X	X	X
3.8 Review HTC Quality Control Tools					X	X		
4. Develop and Strengthen Human Resource Capacity for Delivery of HTC Services								
4.1 TOT in DCT/RCT for Clinical Staff/CT Counsellors	X	X						
4.2 Refresher Training for 'old' HTC Counsellors	X	X						
4.3 TOT HTC Counsellors, include Couple Counselling		X						
4.4 Train HTC Counsellors [include WBRH Test Training]	X	X	X	X	X	X	X	X
4.5 Train HTC Supervisors		X			X			
4.6 Train Laboratory technician in supervision of WBRH Testing			X			X		
4.7 Train in Couple Counselling			X		X	X		
4.8 Train in Youth Friendly HTC Services			X	X			X	X
4.9 Integrate HTC Curricula into pre-service training for SR Nurse, Clinical Officers, State Enrolled			X	X	X	X	X	X

Nurses, HSAs, Pharmacy Technicians, Laboratory Technicians.								
4.10 Work with Institutions of Higher Learning to introduce advanced generic counseling training leading to Diploma or Degree in counseling.				X	X	X	X	X
5. Develop and Disseminate HTC Resource Materials	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**
5.1 Review and Print HTC Training Curricula	X	X						
5.2 Review and Print HTC Counsellors Handbook	X	X						
5.3 Complete Refresher Training Curricula	X							
5.5 Print Refresher Training Curricula	X							
5.6 Develop Couples Counselling Curricula		X						
5.7 Print Couples Counselling Curricula		X						
5.8 Print with MOH Logo all Quality Assurance Tools	X							
5.9 Print HTC Register				X				
5.10 Develop Counselling Video/DVDs as Teaching AIDS in Chewa, Tumbuka and English.			X	X	X	X	X	X
5.11 Pilot Test, Print and Disseminate Post-test Club Materials	X	X	X	X				
5.12 Print HTC Supervision Curricula		X						
5.13 Print and Disseminate HTC Supervision Handbook		X	X					
5.14 Review HTC Supervision Training Curricula and Handbook							X	X
5.15 Review HTC Guidelines – especially development of protocols for different HTC models [DCT/RCT]				X	X			
6. Creation of Demand for HTC Services	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**
6.1 Identify and promote HTC Days in the National Calendar	X	X	X	X	X	X	X	X
6.2 Work with DHOs to develop a HTC District Community Mobilization Plan		X	X	X	X	X	X	X
6.3 Introduce Free Telephone Hotlines for HTC		X		X		X		

6.4 Develop I.E.C materials – pamphlets, flyers, posters, radio sports, etc	X	X	X	X	X	X	X	X
7. Exchange of Experiences	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**
7.1 Study Tours Visits to HTC Services in Kenya and Uganda		X						
7.2 Attend International AIDS Conference in Toronto 2006			X					
7.3 Attend ICASA 2007 in Gabon								X
8. Operational Research								
8.1 HTC Operational Research Planning Meeting	X	X						
8.2 Implement Research			X	X	X	X	X	X
8.3 Write research papers for publication			X	X	X	X	X	X
8.4 Dissemination of Research Results				X		X		X
9. Organize and Host a Southern African HTC Conference								
9.1 Consult and seek consensus among HTC Stakeholders							X	
9.2 Set up a planning committee								X
9.3 Planning Meetings								X
9.4 Host the HTC Conference								

ANNEX 2

FUNCTIONS OF AN HIV COUNSELLOR

1. Position Function

The HIV Counsellor will provide HIV Counselling and HIV whole blood rapid testing consistent with HTC Guidelines, PMTCT Guidelines, HIV/AIDS Policy and other related health and government policies and guidelines. The HIV Counsellor will provide these services at the HTC site, with a mobile HTC unit or an outreach HTC. In addition to the above, the HIV counsellor will provide HIV pre-test education to groups of patients or clients waiting for HIV testing and may also be involved in community mobilisation for HTC.

2. Key Tasks

a) Conducting individual[including youths], couple or group HIV, ART and PMTCT education,

b) Provide pre-test and post test counseling in generic HTC services, in PMTCT setting and in ARV clinics. In all settings ensure on-going psychosocial support to individuals and couples tested for HIV, especially those testing positive.
c) Provide all required PMTCT related counseling, e.g. infant feeding counseling, family planning counseling, couple counseling, etc.
d) In ARV Clinics, provide all ARV related psychosocial support counseling, including adherence to treatment counseling.
e) Perform Whole Blood Rapid HIV testing,
f) Perform appropriate referrals for:
    - Clinical Care and Management
    - ARV
    - TB Treatment, STI Treatment, etc
    - PMTCT
    - HBC
    - Ongoing psychosocial support
        i. Post-test clubs (PTC)
        ii. PLWHA Support groups
    - Social Welfare, according to specific needs of each patient
g) Collect and compile, on a regular basis, client data using HTT and PMTCT registers and other data collection tools. Analyze that data using simple statistical methods.
h) Network with other NGOs and CBOs providing HIV Counselling, HIV testing and psychosocial and nutritional support.
i) Perform other selected duties as requested.

3. Minimal Entry Requirements for Training as an HIV Counsellor

a) MSCE Certificate or its equivalent, or JC with additional qualifications.
b) Those with additional related professional qualifications (clinical, teaching, social work, etc.) will have an added advantage.
c) May be of health or non-health background
d) Be at Least 21 years of age.
e) They should have at least lived in Malawi and are conversant with Malawi culture.
f) Able to communicate adequately in English, both verbal and written.
g) Able to communicate and counsel in at least one vernacular language of the community in which the counselor is working in.
h) Have no criminal record
i) Attributes include maturity, interest in providing HIV Counselling services, understanding and respect of peoples' values and attitudes.
j) Those living openly with HIV/AIDS will be highly encouraged to be trained and to work as HIV counsellors

ANNEX 3

FUNCTIONS OF A DISTRICT HTC SUPERVISOR

Position Function:
To ensure that HIV counsellors are performing their duties in such a way as to meet departmental or organisational objectives effectively by following national policies, guidelines and protocols.

Minimum Requirements to be an HTC Supervisor:
1. Should have a health background
2. Should have completed a nationally recognised training in Counselling and Testing and CT supervision
3. The supervisor should have a minimum of one year experience in counselling and testing; and may be a practising counsellor in their work.

Major Roles and Responsibilities:

CT Supervisors at every level and in all organisations should maintain a system for Quality Assurance (QA) by performing the following roles and responsibilities:

1. **Plan, implement and monitor QA activities and provide feedback to management/ DHMT**
    a. Design a supervisory plan that is approved by management
    b. Prepare a supervisory schedule of upcoming supervisory session which shows the date and time of each session and list any content that can already be foreseen, which needs to be updated periodically as needs arises.
    c. Setting individual performance objectives with the CT counsellors so that they know what is expected of them
    d. In liaison with management, the supervisor should provide guidance on professional development including the amount of time staff are permitted from their posts for trainings
    e. Ensure that new sites are assessed and certified by MOH
    f. The supervisor should report directly to management

2. **Mentorship:**
    a. Develop highly skilled counsellors through mentoring,
    b. Conduct direct observation of HIV counselling sessions immediately followed by provision of feedback.
    c. Ensure that counsellors practice infection prevention procedures according to protocols.
    d. Checks whether necessary materials and counselling aids are available at the CT sites which includes condoms, I.E.C. Materials, test kits and related supplies by following stipulated logistics procedures
    e. Manage any performance problems and conflicts that arise.
    f. Motivating and encouraging counsellors to do their best
    g. Conduct counselling sessions to maintain the supervisor's own skills

3. **Collaboration/ Coordination:**
    a. Ensure that regular meetings are conducted to share experiences, discuss challenges and prevent burn out.
    b. Coordinate the development of provider networks
    c. Ensure that referral systems and mechanisms for clients are in place and functioning.
    d. Promote a spirit of team work among counsellors and enhance a sense of individual responsibility and commitment to provide quality HIV counselling and testing to all clients.

4. **M&E:**
    a. Ensure accurate and timely data collection, analysis, and reporting to the DHO. Use the findings to enhance counsellor performance and improve service delivery.
    b. Compile regular reports to be submitted to management.

ANNEX 4

APPLICATION FORM TO DEVELOP NEW HTC SERVICES

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 you be assisted by a Donor / Implementer/ Partner ? If Yes, please describe:
____

Services Planned

Voluntary Counselling and Testing ☐

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

Estimate the MAXIMUM number of clients to be test per month ________________

(Note:- Assume no more than 8 VCT clients per counselling room per full work day.)

Human Resources

Identify Counsellor who will be responsible for the VCT site. Discuss and agree this new role with the selected person, and ask him/her to sign below that he/she accepts this responsibility;

Name ____________________________

Signature ____________________________

What cadre of staff is this person and what is his/ her experience in VCT?

____

____

Who will replace him/her in normal duties while the VCT site is running?

____
(name, position)

Other staff required to run the VCT

Role : Counsellor ____________________________
(name)

Role : ________________ ____________________________
(name)

Role : ________________ ____________________________
(name)

At least two counsellors, trained and certified in the National Guidelines, must be assigned to the VCT site.

Policy, Standards and Guidelines

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

National VCT guidelines ☐
VCT counselling protocols ☐
VCT testing protocols ☐
Safety guidelines ☐

Please 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, 1 table and separate testing surface if testing in the room
- Adequate waiting area (chairs 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;

____

____

____

Please describe how you intend to perform whole blood rapid testing

Who will perform HIV Rapid Testing

Tester for HIV rapid test___________________________*(Name)*

Position/ Title: ___________________________________

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 (to reflect kits used in country)

Kit		Use (Tick One box for each test)			
Determine	☐	Parallel ☐	First ☐	Second ☐	Tie-break ☐
Unigold	☐	Parallel ☐	First ☐	Second ☐	Tie-break ☐
Hemastrip	☐	Parallel ☐	First ☐	Second ☐	Tie-break ☐
Other	☐	Parallel ☐	First ☐	Second ☐	Tie-break ☐

If other, please specify Kit ________________ Source ______________
Kit ________________ Source ______________
Kit ________________ Source ______________

Will there be any cost to the client?

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

For Other please describe

____

____

____

Other materials/ supplies:

Condoms Latex Gloves Lancets
Sharps containers Cotton wool Methylated Spirit/ Antiseptic
Log book/ register for counselling and testing
Written list of referrals for: TB/ STE screening and treatment, Family Planning

Form Submitted by

Name ______________________________

Position in Institution ______________________________

Signature ______________________________

Date: ________________

Please note that the VCT Guidelines state:
VCT sites must be further that 8 km apart in rural areas or serve a catchment population of 10,000 in urban areas

> *"inexistence of any other site in the immediate catchment area of 10,000 people in urban areas, and an 8 km radius in the rural areas."*

Sites should seek approval from the Local Government Assembly and DACC:

> *"Local Government Assembly, in liaison with the District AIDS Coordinating Committee, has the responsibility to inspect potential VCT providers and sites before approving and recommending locations for authorization by MOHP"*

ANNEX 5

MINISTRY OF HEALTH
HTC SITE ASSESSMENT TOOL

Purpose:
1. To assess how well the HTC site complies with minimum national standards stated in the HTC Guidelines for the purpose of certification by the Ministry of Health
2. To monitor ongoing compliance with HTC Guidelines as deemed necessary by sites or districts
3. To create a plan for strengthening the HTC site

Objectives:
1. Assess and monitor availability of trained personnel
2. Assess and monitor adherence to counselling, testing and safety protocols
3. Assess physical infrastructure for HTC service delivery
4. To provide written feedback on an agreed action plan to strengthen the HTC site

CT Site Name:

DATE: TIME STARTED:
TIME FINISHED:

Facility Type: (please circle one) Stand alone Integrated

(circle all that apply) Govt / NGO/ CBO/ CHAM

(CT= counselling and testing, Govt = Government of Malawi, NGO = non-governmental organization, CBO = community-based organization, CHAM = Christian Health Association of Malawi)

DHO (Name):
DAC (Name):
Hospital or Facility Administrator/ Manager (Name):
Contact person on day of assessment:
Assessors:

SITE OPENING HOURS

Days of the Week	Opening Hours
Monday – Friday	
Saturday	
Sunday	

During opening hours, are counselors:
☐ Dedicated full time in the counseling room as their only responsibility?

□ Called from other duties when clients request CT?

Where are your clients tested for HIV? (Check all that apply.)
□ On site, in the CT room
□ On site, in the laboratory
□ Clients are sent somewhere else for testing. Where? ______________________
□ Other _________________________________

Number of Clients Counsel and Tested in last three months: ________
Please include PMTCT visits but do not include blood donors (unless they went through CT).

STAFF PROFILE
Please complete table for each member of staff working on HTC in the facility including HTC in the antenatal clinics.

Name	**Position** (counselor, lab tech, receptionist)	**How many days/ week On HTC ?**	**Completed national HTC curriculum training** (date?)
1			__ weeks counseling
			__ weeks testing
2			__ weeks counseling
			__ weeks testing
3			
4			
5			

HTC SUPERVISOR PROFILE

Name	**Position/** (DAC, Senior counselor, Site manager, Administrator) **Organization**	**How often supervising HTC?**	**What kind of supervision?** Check all that apply
1.		____ days/ month	□ Checks registers □ Does session observation □ Holds counsellor meetings □ Performance evaluation □ Site management □ Other
2.		____ days/ month	□ Checks registers □ Does session observation □ Holds counsellor meetings □ Performance evaluation □ Site management □ Other

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 trained and certified CT 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 CT guidelines available in CT centre				
5	CT counseling protocols available and on display				
6	CT testing protocols available and on display				
7	Safety protocols available and on display (including infection prevention, waste management and PEP)				
8	Registered by Medical Council of Malawi and certificate visibly displayed				

	Infrastructure	Yes	No	Comments	Action Plan
9	Clear sign showing directions to CT 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 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 MOH and in date i. Screening test________________ ii. Confirmatory test ________________ iii. Tie breaker ________________	 ☐☐ ☐☐ ☐☐			
18	Provision for storing test kits at < 30° C				
19	Penile model available				

		Yes	No	Comments	Action Plan
20	Male condoms freely available and on display 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 labelled with client's number				
32	Samples recorded CT register				

	Records and Information System	**Yes**	**No**	**Comments**	**Action Plan**
33	National CT register available				
34	System for anonymous client coding in place				
35	Written referral list for care and support of people with HIV. At least TB, PMTCT and STI referral must be functional				
36	Quality assurance system for testing in place or being developed?				
37	Quality assurance system for counseling in place or being developed?				

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

____

____

____

____

Action Plan

Problem:	Action/ Solution	Timeframe	Person responsible
1.			
2.			

ANNEX 6

HTC Sites in the Northern Region by end of 2005

#	Name	Ownership	Integrated	Served by Outreach	Stand Alone
1	Chambo Health Centre	Cham	X		
2	Chitipa District Hospital	MOH	X		
3	Ifumbo Health Centre	MOH	X		
4	Kameme Health Centre	MOH	X		
5	Kapanda Health Centre	MOH	X		
6	Kaseye Rural Hospital	Cham	X		
7	Misuku Health Centre	MOH	X		
8	Nthalire Health Centre	MOH/LG	X		
9	Wenya Health Centre		X		
10	Mahowe (new)				
11	Kapoka (New)				
12	Kayilizi (New)				
13	Tutulane		X		
14	Chisenga Health Centre		X		
2-					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**
1	Chilumba Rural Hospital	MOH	X		
2	Fulirwa Health Centre	MOH			
3	Hara Dispensary	MOH			
4	Iponga Health Centre	MOH	X		
5	Kaporo Rural Hospital	MOH	X		
6	Karonga District Hospital	MOH	X		
7	Lupembe Health Centre	MOH/LG			
8	Lwezga Health Centre	LG			
9	Mpata Health Centre	MOH			
10	Nyungwe Health Centre	MOH	X		
11	Sangilo Health Centre	Cham			
12	St. Annes Health Centre	Cham			
13	Wiliro Health Centre	MOH			
14	Chilumba Garrison Dispensary	Military			
15	Karonga BLM	BLM			
16	Ngana health Centre	MOH			
17	Maneno Private Clinic	Private			
18	Kasoba Health centre	MOH			
19	Wovwe Escom Clinic	Private			
20	Karonga Old District Hospital	MOH			
21	Mlare (New) Health Centre				
22	MCRO Karonga				X
3-					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**
1	St. Mary's/Chizumulu Health	Cham			

	Centre				
2	Likoma/St. Peters Health Centre	Cham	X		
4-					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**
1	Moyale Health Centre	Military	X		
2	Bulala Health Centre	MOH			
3	Chaoma Health Centre	MOH			
4	Edingeni Rural Hospital	MOH			
5	Ekwendeni Hospital	Cham	X		
6	Embangweni Hospital	Cham	X		
7	Emfeni Health Centre	MOH			
8	Emsizini Health Centre	MOH	X		
9	Endindeni Health Centre	MOH/Cham			
10	Euthini Rural Hospital	MOH	X		
11	Hoho Health Centre	MOH			
12	Jenda Health Centre	MOH			
13	Kafukule Health Centre	MOH/LG	X		
14	Kalikumbi Health Centre	Cham			
15	Kamteteka Health Centre	MOH			
16	Katete Rural Hospital	Cham	X		
17	Khosolo Health Centre	MOH			
18	Kabuwa Health Centre	MOH			
19	Lunjika Health Centre	Cham	X		
20	Luvwere Health Centre	MOH			
21	Luwerezi Health Centre	MOH/LG			
22	Mabiri Health Centre	Cham			
23	Madede Health Centre	MOH/LG			
24	Malidade Health Centre	MOH			
25	Manyamula Health Centre	MOH			
26	Mbalachanda Health Centre	MOH			
27	Mpherembe Health Centre	MOH	X		
28	Msese Health centre	MOH			
29	Mtenda Health Centre	MOH			
30	Mtwalo Health Centre	MOH			
31	Mzalangwa Health Centre	MOH/LG			
32	Mzambazi Rural Hospital	Cham	X		
33	Mzimba District Hospital	MOH	X		
34	Mzuzu Urban Health Centre	MOH	X		
35	Njuyu Health Centre	MOH			
36	Nkholongo Health Centre	Cham			
37	St. Johns Hospital	Cham	X		
38	St. John of God	Cham			
39	Mzuzu Central Hospital	MOH	X		
40	Matuli Dispensary	LG			
41	Kabwafu Health Centre	MOH			
42	Mkoma Health Centre	MOH			
43	Chikangawa Health Centre	Forestry			
44	Vibangalala Dispensary	MOH			
45	Luwawa Health Centre	MOH/LG			
46	Nkhuyukuyu Health Centre	MOH			

47	Lusangazi Dispensary	MOH			
48	Mumbwe Medical Centre	Private			
49	Mzimba BLM	BLM			
50	Mzuzu Police Dispensary	Police			
51	Ehehieni Dispensary	MOH			
52	MACRO Mzuzu	NGO			X
53	Mhalaunda Health Centre	Cham			
54	Mzuzu BLM	BLM			
55	Raiply Dispensary	Private			
56	Ekwaiweni Dispensary				
57	Tovwirane (New)				X
58	New				
59	New				
60	New				
5-					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**
1	Bula Health Centre	MOH			
2	Tchesamu Health Centhre	MOH			
3	Chikwina Health Centre	MOH			
4	Chilambwe Health Centre	Cham			
5	Chintheche Rural Hospital	MOH	X		
6	Chitheka Health centre	MOH			
7	Kachere Health Centre	MOH	X		
8	Kande Health Centre	MOH	X		
9	Khondowe Dispensary	MOH			
10	Liuzi Health Centre	MOH			
11	Luwazi Health Centre	Cham	X		
12	Mpamba Health Centre	MOH	X		
13	Mzenga Health Centre	MOH			
14	Nkhata Bay District Hospital	MOH	X		
15	Old Maula Health Centre	MOH	X		
16	Ruarwe Dispensary	LG			
17	Usisya Health Centre	MOH	X		
18	Nthungwa Health Centre	MOH			
19	Kavuzi Dispensary	Estate			
20	Kawalazi Estate Clinic	Estate			
21	Vizara Dispensary	Estate			
22	Chombe Estate Dispensary	Estate			
23	Chisala Health Centre	MOH			
24	Nkhata Bay BLM	BLM	X		
25	Mazamba Dispensary				
26	Chizumulu (St. Mary's) Health Centre	Forestry			
6-					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**
1	Bolero Rural Hospital	MOH	X		
2	Bwengu Health Centre	MOH/LG			
3	Chitimba Health Centre	MOH/LG	X		
4	Livingstonia Hospital	Cham	X		

5	Engucwini Health Centre	MOH/LG			
6	Enukwenu Health Centre	Cham			
7	Kamwe Health Centre	MOH			
8	Katowo Rural Hospital	MOH/LG	X		
9	Luwuchi Health Centre	Cham			
10	Luzi Health Centre	MOH/LG			
11	Mhuju rural Hospital	MOH	X		
12	Mlowe Health Centre	Cham			
13	Mphompha Health Centre	MOH			
14	Mwazisi Health Centre	MOH			
15	Mzokoto Health Centre	MOH	X		
16	Nthenje Health Centre	Cham			
17	Rumphi District Hospital	MOH	X		
18	St Patrick's Rural Hospital	Cham			
19	Tcharo Health Centre	Cham			
20	Thunduwike Health Centre	MOH			
21	Eva Demaya Private Clinic	Private			
22	Jalawe Health Centre	MOH			
23	Kasambala Health Centre	Private			
24	Ngónga				
25	Chisimuka				
26	Lusani (New)				
27	Junju (New)				
28	Rumphi BLM	BLM	X		

ANNEX 7

HTC Sites in the Central Region by end of 2005

#	Name	Ownership	Integrated	Served by Outreach	Stand Alone
1	Kaundu Health Centre	Private			
2	Mtakataka Health Centre	MOH			
3	Nakalanzi Health Centre	MOH			
4	Mtakataka/Police College Health Centre	Police			
5	Bembeke Health Centre	Cham			
6	Chikuse Health Centre	MOH			
7	Chimoto Health Centre	MOH			
8	St. Joseph Rural Hospital	Cham			
9	Chitowo Health Centre	MOH			
10	Chingoni Health Centre	MOH			
11	Dedza District Hospital	MOH	X		
12	Dzindevu Health Centre	MOH/LG			
13	Kafere Health Centre	MOH			
14	Kalulu Health Centre	MOH			
15	Kanyama Health Centre	Cham			
16	Kanyezi Health Centre	MOH	X		
17	Kaphuka Rural Hospital	MOH			
18	Kasina Rural Hospital	Cham			
19	Lobi Health Centre	MOH	X		
20	Maonde Health Centre	MOH/LG			
21	Matumba Health Centre	Cham			
22	Mayani Health Centre	MOH/LG	X		
23	Mayani Maternity	LG			
24	Mikonde Health Centre	Cham			
25	Mulangali Dispensary	MOH			
26	Mphati Health Centre	MOh			
27	Mphunzi Maternity	LG			
28	Mtendere Health Centre	Cham			
29	Tsoyo Health Centre	MOH			
30	Dedza BLM	BLM			
31	Kaname/Mdeza Dispensary	MOH			
32	Mjini Dispensary	MOH			
33	Mua Mission Hospital	cham	X		
2-					
#	**Name**	**Ownership**	**INTEGRATED**	**Served by Outreach**	**Stand Alone**
1	Bowe Health Centre	MOH			
2	Chakhaza Health Centre	MOH			
3	Chankhungu Health Centre	MOH	X		
4	St. Mary's Rehabilitation	Cham			
5	Chinkhwiri Health Centre	MOH			
6	Chisepo Health Centre	MOH			
7	Dowa District Hospital	MOH	X		
8	Dzaleka Refugee Camp Clinic	MOH			
9	Dzoole Health Centre	MOH			

10	Kayembe Health Centre	MOH			
11	Madisi Hospital	Cham	X		
12	Mbingwa Health Centre	MOH			
13	Mponela Rural Hospital	MOH	X		
14	Msakambewa Health Centre	MOH	X		
15	Mtengowanthenga Hospital	Cham	X		
16	Mvera Army Clinic	Military			
17	Mvera Mission	Cham	X		
18	Mwangala Maternity	LG			
19	Nalunga Health Centre	LG			
20	Thonje Health Centre	MOH	X		
21	Dowa BLM	BLM			
22	Family Planning Association Of Malawi				
23	Chezi Rehabilitation Unit				
24	Matekenya (New)				
25	Mpala (New)				
26	Chisolowonde (New)				
27	Dowa Youth Centre				X
3-					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**
1	Bua Dispensary	MOH			
2	Chamwabvi Dispensary	MOH			
3	Chulu Health Centre	MOH			
4	Dwangwa Dispensary	MOH			
5	Kaluluma Rural Hospital	MOH	X		
6	Kamboni Health Centre	MOH			
7	Kapelula Health Centre	MOH			
8	Kasungu District Hospital	MOH	X		
9	Kawamba Health Centre	MOH/LG			
10	Mkhota Health Centre	MOH			
11	Mtunthama Health Centre	MOH	X		
12	Mpasazi Health Centre	Cham			
13	Nkhamenya Hospital	Cham	X		
14	Santhe Health Centre	MOH	X		
15	Similemba Health Centre	MOH			
16	Wimbe Health Centre	MOH/LG			
17	Chisinga Dispensary	MOH			
18	Kasauka Nutr. Rehab Unit	LG			
19	Linyangwa Health Centre	Private			
20	Gogode Dispensary	MOH			
21	Offesi Dispensary	LG			
22	Banja La Mtsogolo	BLM			
23	Khola Health Centre	MOH			
24	Lojwa Dispensary	MOH			
25	KTFT/Mziza H Centre	Cham			
26	80 Block Clinic	Private			
27	St. Andrews H Centre	Cham			
28	Gogo LEA Pvt. Clinic	Private			
29	Thupa Health Centre	Private			
30	Chamama Health Centre	MOH			

31	Kapyanga Health Centre				
32	Mziza Health Centre				
33	New facility construction				
34	New facility construction				
35	New facility construction				
36	New facility construction				
37	New facility construction				
38	New facility construction				
39	New facility construction				
40	New facility construction				
41	New facility construction				
42	New facility construction				
43	New facility construction				
44	Estate 81 Clinic	Private	X		
4-					

#	Name	Ownership	Integrated	Served by Outreach	Stand Alone
1	Area 18 Health Centre	MOH	X		
2	Area 25 Health Centre	MOH			
3	Bottom Hospital	MOH	X		
4	Chikowa Health Centre	MOH			
5	Chileka Health Centre	MOH			
6	Chimbalanga H Centre	MOH			
7	Chitedze Health Centre	MOH	X		
8	Chunjiza Health Centre	MOH			
9	Chiwamba Health Centre	MOH/LG	X		
10	Chiwe Health Centre	Cham			
11	Diampwe Health Centre	LG			
12	Dickson Health Centre	LG			
13	Dzenza Health Centre	Cham			
14	Kabudula	MOH	X		
15	Kangómbe Health Centre	MOH			
16	Katchale Health Centre	MOH			
17	Kawale Health Centre	MOH	X		
18	Khongani Health Centre	LG			
19	Likuni Hospital	Cham	X		
20	Lilongwe Centre Hospital	MOH	X		
21	Lumbadzi Urban H Centre	MOH/LG	X		
22	Malingunde Health	Cham			
23	Maluwa Health Centre	LG			
24	Matapila Health Centre	MOH/LG			
25	Mbabzi Dispensary	MOH			
26	Mbangombe Health Centre	LG			
27	Mbangómbe II Health Centre	MOH			
28	Mbwatalika Health Centre	Cham			
29	Mingóngo Health Centre	MOH			
30	Mitundu Rural Hospital	MOH	X		
31	Mlale Rural Hospital	Cham	X		
32	Mtethera Health Centre	MOH			
33	Nambuma Health Centre	Cham			
34	Nathenje Health Centre	MOH			
35	Ndaula Health Centre	MOH			
36	New State House	MOH			
37	Ngoni Health Centre	LG			

38	Nkhoma M Hospital	Cham	X		
39	Nsaru Health Centre	MOH			
40	Nthondo Health Centre	MOH			
41	St. Gabriel Hospital	Cham	X		
42	Ukwe Health Centre	MOH			
43	Dzalanyama/Kapombeza Clinic	Forestry			
44	Police (Area 30) Dispensary	Police	X		
45	Khasu Health Centre	Private			
46	Chimwala Clinic	Cham			
47	Chinsapo Health Centre	LG			
48	City Assembly Health Centre	LG			
49	ABC Community Clinic	Cham	X		
50	Adventist Health Centre Area 14	Cham			
51	Area 25 BLM	BLM			
52	Bunda Clinic	UNIMA			
53	Chanza/Unit 33 H. Centre	MOH			
54	Chilobwe/Majiga Health Centre	MOH			
55	Falls BLM	BLM			
56	Kawale BLM	BLM			
57	Lemwe Dispensary	MOH			
58	Macro Lilongwe	NGO			X
59	Malangalanga Clinic	ADMARC			
60	Malawi Army Air Wing Clinic	Military			
61	SOS Medical Centre	Private	X		
62	Malembo Health Centre	MOH			
63	Mlodza/Seventh Day Clinic				
64	TA (Chimutu New)				
65	Malili (New)Health Centre				
66	Kalumbu (new) H. Centre	Cham			
67	Kamphata Youth Centre				X
68	Dimon Private Clinic	Private	X		
69	Mitundu Youth Centre				X
70	Kawale Youth Centre				X
71	Lighthouse, KCH	MOH	X		
72	Partners in Hope	Partners In Hope	X		
73	David Livingstone Clinic		X		
5-					
#	**Name**	**Ownership**	**INTEGRATED**	**Served by Outreach**	**Stand Alone**
1	Chioshya Health Centre	MOH			
2	Chipumi Health Centre	MOH			
3	Gilime Rural Hospital	Cham	X		
4	Kaigwazanga Health Centre	MOH			
5	Kapanga Health Centre	MOH			
6	Kapiri Mission Hospital	Cham	X		
7	Kochilila Rural Hospital	MOH	X		
8	Ludzi Rural Hospital	Cham			
9	Mchinji District Hospital	MOH	X		
10	Mikundi Health Centre	MOH			
11	Mkanda Health Centre	MOH	X		

12	Nkhwazi Health Cemtre	MOH	X		
13	Tembwe Dispensary	MOH			
14	Kazyozyo/Sakhuta Maternity	MOH			
15	Namizana Dispensary	Police			
16	Gumba Health Centre	MOH			
17	Chimwamkango Health Post	MOH			
18	Mching BLM	BLM			
19	Mzama (New)				
20	Tsamphale (New)				
6-					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**
1	Benga Health Centre	MOH			
2	Bua Dispensary	MOH			
3	Chididi Health Centre	Cham			
4	Dwambazi Rural Hospital	MOH			
5	Kapiri Health Centre	Cham			
6	Luwaladzi Health Centre	Cham			
7	Mpamantha Dispensary	MOH			
8	Mtosa Health Centre	MOH			
9	Mwansambo Health Centre	MOH			
10	Ngala Health Centre	MOH			
11	Nkhotakota District Hospital	MOH	X		
12	Nkhunga Health centre	MOH			
13	Alinafe Rehabilitation Centre	Cham	X		
14	Katimbira Health Centre	MOH			
15	St. Annes Hospital	Cham	X		
16	Malowa Dispensary	MOH			
17	Msenjere Health Centre	MOH			
18	Dwangwa BLM	BLM			
19	Centre 3 Clinic	Private			
20	Dwangwa Cane Grower Ltd Clinic	Private	X		
21	Kasasa Clinic	Private			
22	Kasitu Health Centre	Cham			
23	Ukasi Clinic	Private			
24	Nyamvuu Clinic	Private			
25	Matiki Health	Private			
26	Nkhotakota	BLM			
7-					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**
1	Chinguluwe Health Centre	MOH	X		
2	Chinthembwe Health Centre	Cham			
3	Kamsonga Health Centre	MOH	X		
4	Kangolwa Health Centre	MOH	X		
5	Khuwi Health Centre	MOH	X		
6	Malomo Health Centre	MOH	X		
7	Mkhuzi Health Centre	MOH	X		
8	Mpherere Health Centre	Cham			
9	Ntchisi District Hospital	MOH	X		
10	Mzandu Health Centre	MOH	X		

11	Nthondo Dispensary	MOH	X		
12	Mndinda Dispensary	MOH			
13	Mthirasembe Dispensary				
14	Kaomba Dispensary	MOH			
8-					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**
1	Bilira Health Centre	MOH			
2	Biriwiri Health Centre	MOH			
3	Bwanje Health Centre	MOH			
4	Chigodi Health centre	Cham			
5	Chikande Health Centre	MOH			
6	Doriko Dispensary	MOH			
7	Dzunje Dispensary	MOH			
8	Ganya Maternity	Cham			
9	Gowa Health Centre	Cham			
10	Kalonga Maternity	LG			
11	Kampanje Health Centre	LG			
12	Kandeu Dispensary	MOH			
13	Kapeni Health Centre	MOH			
14	Kasinje Health Centre	MOH			
15	Katsekera Health Centre	MOH			
16	Lizulu Health Centre	MOH			
17	Manjawira Health centre	LG			
18	Mlanda Health Centre	Cham			
19	Mlangeni Health Centre	Cham			
20	Mlangeni/Polic Dispensary	MOH			
21	Mphempozinai Dispensary	MOH			
22	Ntonda Rural Hospital	Cham			
23	Mluma Health Centre	Cham			
24	Nsipe Rural Hospital	Cham			
25	Nsiyaludzu Health Centre	MOH			
26	Ntcheu District Hospital	MOH	X		
27	Mzama Health Centre	Cham			
28	Senzani Health Centre	Cham			
29	Sharpe Valley Health Centre	Cham			
30	Tsangano Health Centre	Cham			
31	Masasa Dispensary	MOH			
32	Namisu Dispensary	Cham			
33	Dzonzi Mvai Dispensary	MOH			
34	Lake View Health Centre	Cham	X		
35	Sister Theresa Rural Hosp	Cham	X		
36	Chiole				
37	Ntcheu BLM	BLM			
9-					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**
1	Chinguluwe Health Centre	MOH			
2	Chipoka Health Centre	MOH			
3	Chitala Health Centre	Cham			
4	Golomoti Health Centre	MOH			
5	Khombeza Health Centre	MOH	X		
6	Lifuwu Health Centre	MOH			
7	Maganga Health Centre	MOH	X		

8	Makiyoni Health Centre	MOH			
9	Mchoka Health Centre	MOH	X		
10	Mua Hospital	Cham			
11	Ngozi Health Centre	Cham			
12	Salima District Hospital	MOH	X		
13	Senga Bay Baptist Health Centre	Cham	X		
14	Thavite Health Centre	Cham			
15	Kaphatenga Health Centre	Cham			
16	Mafco Health Centre	Military			
17	Salima Admarc Dispensary	ADMARC			
18	Chagunda Dispensary	MOH			
19	Salima BLM	BLM			
20	Parachute Battalion Dispensary	Military			
21	Lifeline Dispensary	Cham	X		

ANNEX 8

HTC Sites in the Southern Region by end of 2005

1- BALAKA DISTRICT						
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Balaka District Hospital	MOH	X			
2	Balaka Health Centre	MOH				
3	Kalembo Dispensary	MOH	X			
4	Kankao Health Centre	Cham	X			
5	Mbera Health Centre	MOH				
6	Phalula Health Centre	Cham	X			
7	Phimbi Health Centre	MOH				
8	Ulongwe Health Centre	Cham				
9	Utale 1	Cham				
10	Utale 11 Health centre	Cham				
11	Balaka BLM	BLM				
12	Chiendausiku	MOH	X			
13	Comfort	Cham				
14	Kwitanda		X			
15	Namanolo Health Centre	MOH				
2-	**BLANTYRE**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Blantyre Civil Centre Health Centre	LG	X			
2	Chabvala Health Centre	MOH				
3	Chikowa Health Centre	MOH				
4	Chileka Health Centre	MOH				
5	Chilomoni Health Centre	MOH	X			
6	Chimembe Health Centre	MOH				
7	Dziwe Health Centre	MOH				
8	Limbe Health Centre	MOH	X			
9	Lirangwe Health Centre	MOH	X			
10	Lundu Health Centre	MOH				
11	Madziabango Health Centre	MOH				
12	Makata Dispensary	MOH				
13	Mdeka Health Centre	MOH				
14	Mitsidi Dispensary	Cham				
15	Mlambe Hospital	Cham	X			
16	Mpemba Health Centre	MOH				
17	Namikoko Dispensary	MOH				
18	Ndirande Health Centre	MOH	X			
19	Soche SDA Dispensary	Cham				
20	Soche Maternity	LG				
21	South Lunzu Health Centre	MOH				
22	Zingwangwa Health Centre	MOH				
23	Chileka SDA	Cham				
24	Bangwe Health Centre	MOH/LG				
25	Queen Elizabeth Central Hospital	MOH	X			
26	Midima BLM	BLM				

27	Ndirande BLM	BLM				
28	Railways CEAR Clinic	Private				
29	Zingwangwa BLM	BLM				
30	Blantyre Adventist	Private				
31	Chichiri Prison Dispensary	Prisons				
32	Limbe ADMARC Health Centre	ADMARC				
33	Lunzu BLM	BLM	X			
34	Macro Blantyre Clinic	NGO			X	
35	Lunzi Dapp		X			
3-	**CHIKWAWA**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Ching'ambika H Centre	MOH				
2	Chapananga Health Centre	MOH				
3	Chikwawa District Hosp	MOH	X			
4	Chapwaila Health Centre	MOH				
5	Dolo Health Centre	MOH				
6	Gaga Health Centre	MOH				
7	Kakoma Health Centre	MOH				
8	Kasinthula Dispensary	MOH				
9	Lengwe Dispensary	MOH				
10	Makhwira Health Centre	MOH	X			
11	Maperera Health Centre	MOH	X			
12	Misomali Health Centre	MOH				
13	Mkumaniza H Centre	MOH				
14	Ndakwela Health Centre	MOH				
15	Ngabu Rural Hospital	MOH	X			
16	St. Montfort Hospital	Cham	X			
17	Chithumba Maternity	LG				
18	Kapichira Clinic	Private				
19	Beleu Health Centre	MOH				
20	Gola Health Centre	MOH				
21	Ngabu BLM	BLM				
22	Ngabu SDA H Centre	Cham				
23	Sucoma Illovo Clinic		X			
24	Mitondo (New) Health Centre					
25	Nkhate (New) Health Centre					
26	Finish (New) H Centre					
27	Chafudzika (New) Health Centre					
28	Thereza Health Post	MOH				
4-	**CHIRADZULU**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Chiradzulu District Hosp	MOH	X			
2	Chitera Health Centre	MOH	X			
3	Mauwa Health Centre	MOH	X			
4	Milepa Health Centre	MOH	X			
5	Namadzi Health Centre	MOH	X			
6	Namotambo H Centre	MOH	X			
7	Ndunde Health Centre	MOH	X			
8	St. Joseph Hospital	Cham	X			

9	Nkalo Health Centre	MOH/LG	X			
10	PIM Health Centre	Cham	X			
11	Bilal Dispensary	Private	X			
12	Mbulumbudzi H Centre		X			
13	Maoni (New) H Centre		X			
14	Kadewere (New) Health Centre					
15	Ntchema (New) Health centre					
16	Malavi Health Centre		X			
17	Mikolongwe H Centre		X			
18	Maloya Dapp		X			
19	Mwanse Dapp		X			
5-	**MACHINGA**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Chamba Dispensary	MOH				
2	Chikweo Health Centre	MOH				
3	Gawanani Health Centre	Cham				
4	Kawinga Health Centre	MOH				
5	Machinga District Hospital	MOH	X			
6	Mangamba					
7	Machinga Health Centre	LG				
8	Mbonechela Dispensary	MOH				
9	Mlomba					
10	Mkwepere					
11	Mpiri Health Centre	Cham				
12	Mposa Health Centre	Cham				
13	Namandanje Health Centre	Cham				
14	Namanja Health Centre	MOH/LG				
15	Nayinunje Health Centre	MOH				
16	Nayuchi Health Centre	MOH				
17	Ngokwe Health Centre	MOH				
18	Nsanama Health Centre	Cham				
19	Ntaja Health Centre	MOH	X			
20	Nyambi Health Centre	MOH				
21	Liwonde SDA Health Centre	Cham	X			
22	Madalitso Health Centre	Private				
23	Liwonde BLM	BLM				
24	Ntholowa Health Post	Cham				
6-	**MANGOCHI**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Chikole Dispensary	MOH/LG				
2	Chilipa Health Centre	Cham	X			
3	Chilumbangame Health Centre	MOH				
4	Jalasi Health Centre	MOH				
5	Kapire Health Centre	Cham				
6	Katema Health Centre	Cham				
7	Katuli Health Centre	MOH				
8	Koche Health Centre	Cham				
9	Kukalanga Dispensary	MOH/LG				
10	Lugola Health Centre	Cham				
11	Lulanga Health Centre	Cham				

12	Lungwena Health Centre	MOH				
13	Luwalika Health Centre	Cham				
14	Makanjira Health Centre	MOH				
15	Malembo Health Centre	Cham				
16	St. Martin Hospital		X			
17	Mangochi District Hospital	MOH	X			
18	Mase Health Centre	Cham				
19	Mkumba Health Centre	MOH/LG				
20	Monkey Bay Health Centre	MOH	X			
21	Mpondasi Health Centre	Cham				
22	Namalaka Health Centre	Cham				
23	Namwera Health Centre	MOH	X			
24	Nancholi Dispensary	MOH/LG				
25	Nangalamu Health Centre	MOH				
26	Nankhwali Health Centre	Cham				
27	Nankumba Health Centre	MOH				
28	Nkope Health Centre	Cham				
29	Phirilongwe Health Centre	MOH				
30	Sister Martha Health Centre	Cham				
31	Assalam Clinic	Private				
32	Chiponde Health Centre	MOH				
33	Malawi Army Marine Dispensary	Military				
34	Mangochi BLM	BLM				
35	Maldeco Dispensary	Private				
36	Mulibwanji Hospital	Cham				
37	Nyangu Health Centre	MOH				
38	Sable Health Centre	Estate				
39	Chilunda Dispensary					
40	Malombe Dispensary					
41	Chapola Dispensary					
42	Chironga Dispensary					
43	Mtimbati Dispensary					
44	Chiphole Health Post					
7-	**MULANJE**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Bondo Health Centre	MOH/LG				
2	Chambe Health Centre	MOH/LG	X			
3	Chinyama Health Centre	MOH/LG				
4	Chonde Health Centre	MOH/LG	X			
5	Dzenje Maternity	LG				
6	Kambenje Health Centre	MOH				
7	Mbiza Health Centre	MOH/LG	X			
8	Milonde Health Centre	MOH				
9	Mimosa Dispensary	MOH/LG				
10	Mpala Health Centre	MOH	X			
11	Mulanje District Hospital	MOH	X			
12	Mulanje Mission Hospital	Cham	X			
13	Mulomba Health Centre	MOH/LG	X			
14	Muloza Health Centre	MOH/LG				
15	Namasalima Health Centre	Cham				

			X			
16	Namphungo Health Centre	MOH				
17	Namulenga Health Centre	Cham				
18	Thembo Health Centre	Cham				
19	Thuchila Health Centre	MOH	X			
20	Chisitu Health Centre	MOH	X			
21	Mulanje BLM	BLM				
22	Naphimba Health Centre	MOH	X			
23	Cross Borders - Mulanje	Project Hope			X	
8-	**MWANZA**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Chifunga Health Centre	MOH				
2	Kunenekude Health Centre	MOH				
3	Lisungwi Health Centre	MOH/LG	X			
4	Luwani Health Centre	MOH				
5	Magaleta Health Centre	MOH				
6	Matandani Health Centre	Cham				
7	Matope Rural Hospital	Cham	X			
8	Mwanza District Hospital	MOH	X			
9	Neno Rural Hospital	MOH	X			
10	Neno Parish Health Centre	Cham				
11	Nsambe Health Centre	Cham				
12	Thambani Health Centre	MOH	X			
13	Tulokhondo Health Centre	MOH	X			
14	Nkula Clinic	Private				
15	Mwanza BLM	BLM				
16	Cross Border Initiative	Project Hope			X	
17	Zalewa	DAPP			X	
18	Moyenda Bwino				X	
19						
9-	**NENO**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
10-	**NSANJE**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Chididi Health Centre	Cham				
2	Kalemba Health Centre	Cham	X			
3	Lulwe Health Centre	Cham				
4	Makhanga Health Centre	MOH				
5	Masenjere Health Centre	MOH				
6	Mbenje Health Centre	MOH				
7	Mlolo Health Centre	MOH				
8	Ndamera Health Centre	MOH				
9	Nsanje District Hospital	MOH	X			
10	Nyamithuthu H Centre	MOH				
11	Sankhulani Health centre	MOH				
12	Sorgin Health Centre	MOH				
13	Tengani Health Centre	MOH				

#	Name	Ownership	Integrated	Served by Outreach	Stand Alone	Partner
14	Trinity Hospital	Cham	X			
15	Chingóma Health Centre	MOH				
16	Mkango Health Centre	MOH				
17	Phokera Health Centre	MOH				
18	Misamvu Health Centre	MOH				
19	Kanyimbi Health Centre	MOH				
20	Mchacha Health Centre	MOH				
21	Kamphata Health Centre	MOH				
22	Nkhande Dispensary	MOH				
11-	**PHALOMBE**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Chiringa Cham H Centre	Cham				
2	Chiringa Maternity	LG				
3	Chitekesa Health Centre	MOH/LG				
4	Phalombe Mission Hosp	Cham				
5	Kalinde Dispensary	MOH				
6	Migowi Health Centre	MOH	X			
7	Mkhwayi Health Centre	MOH/LG				
8	Mpasa Health Centre	MOH/LG				
9	Mwanga Health Centre	Cham				
10	Nambazo Health Centre	MOH/LG	X			
11	Nkhulamba Health Centre	MOH				
12	Phalombe Dispensary	MOH				
13	Sukasanje Health Centre	Cham				
14	Nambiti 1 Health Post	MOH				
15	Nambiti Health Post	MOH	X			
16	Holy Family M. Hospital	Cham	X			
12-	**THYOLO**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Bvumbwe Makungwa	MOH	X			
2	Bvumbwe Research Health Centre	MOH	X			
3	Changata Health Centre	MOH/LG	X			
4	Chimaliro Health Centre	MOH	X			
5	Chimvu Maternity	LG				
6	Chingazi Rural Hospital	Cham				
7	Gombe Maternity	LG				
8	Halena Oakely (mtambanyama) Clinic	Cham				
9	Khonjeni Health Centre	MOH/LG	X			
10	Makapwa Health Centre	Cham	X			
11	Malamulo M Hospital	Cham	X			
12	Mangunda Clinic	LG				
13	Mbalanguzi Cham	Cham				
14	Mikolongwe H Centre	MOH/LG	X			
15	Nkhataombera Maternity	LG				
16	Nsabwe Dispensary	MOH	X			
17	Mitengo Health Centre	Cham				
18	Molere Health Centre	Cham				
19	Thekerani Health Centre	MOH	X			

20	Thomasi Health Centre	Cham	X			
21	Thyolo District Hospital	MOH	X			
22	Zoa Health Centre	MOH/LG	X			
23	Chipho Health Centre	Cham	X			
24	Mapanga Clinic	LG	X			
25	Bvumbwe BLM	BLM				
26	Namileme (New)					
27	Chafuta (New)					
28	Honesi (New)					
29	Satemwa Clinic		X			
30	Makungwa Health Centre		X			
31	Conforz Clinic		X			
32	Amalika Health Centre		X			
13-	**ZOMBA**					
#	**Name**	**Ownership**	**Integrated**	**Served by Outreach**	**Stand Alone**	**Partner**
1	Bimbi Health Centre	MOH	X			
2	Chamba Dispensary	MOH				
3	Chilipa Health Centre	Cham				
4	Chingale Health Centre	MOH	X			
5	Chipini Rural Hospital	Cham	X			
6	Domasi Rural Hospital	MOH	X			
7	H Paker Sharp Dispensary	Cham				
8	Lambulira Health Centre	MOH				
9	Likangala Health Centre	MOH				
10	Magomero Health Centre	Cham				
11	Makwapala Health Centre	MOH				
12	Matiya Health Centre	Cham	X			
13	Mayaka Health Centre	Cham	X			
14	Namasalima H Centre	MOH				
15	Namikango Health Centre	Cham				
16	Ngwelelo Health Centre	MOH				
17	Nkasala Health Centre	Cham	X			
18	Pirimit Health Centre	Cham	X			
19	St Luke’s Rural Hospital	Cham	X			
20	State House Dispensary	MOH				
21	Thondwe Health Centre	MOH				
22	Zomba Centre Hospital	MOH	X			
23	Municipal Clinic	LG				
24	Matawale Health Centre	MOH	X			
25	Nasawa/Chimwalira Health Centre	MOH	X			
26	Forestry Dispensary	Forestry				
27	Zomba Mental Hospital	MOH				
28	Police Hospital	Police	X			
29	Cobbe Barracks Hospital	Military	X			
30	Zomba Prison Dispensary	Prison				
31	Zomba BLM	BLM	X			
32	Sadzi Dispensary					
33	Chisi Dispensary					
34	Sunizi (New)					
35	Jokala (New)					
36	Ngotangota (New)	BLM				

37	Thondwe Youth Centre				X	
38	Jali Youth Centre				X	
39	Nasawa Youth Centre				X	
40	Hope for Life				X	
41	MACRO - Zomba	MACRO			X	
41	Chancellor College	U of Malawi	X			
42	Zomba Theological College	Zomba Theological College	X			

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